UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

ROBERT F. BACH, et al. versus AMEDISYS, INC., et al.,	**Civil Action No. 10- 00395-BAJ-SR** **Consolidated with:** No. 3:10-cv-00464-BAJ-SR No. 3:10-cv-00470-BAJ-SR No. 3:10-cv-00497-BAJ-SR

FIRST AMENDED CONSOLIDATED SECURITIES CLASS ACTION COMPLAINT

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Lead Plaintiffs the Public Employees' Retirement System of Mississippi ("Mississippi PERS") and the Puerto Rico Teachers' Retirement System ("Puerto Rico TRS") bring this consolidated class action alleging violations of the federal securities laws against Defendant Amedisys, Inc. ("Amedisys" or the "Company") and seven current or former members of the Company's senior management (collectively, "Defendants") on behalf of themselves and all other persons and entities who purchased or otherwise acquired the publicly traded securities of Amedisys from August 2, 2005 through and including September 30, 2011 (the "Class Period") and were injured thereby (the "Class").[1]

I. NATURE OF THE ACTION

1. This securities class action arises out of Defendants' scheme to defraud Medicare. Amedisys is a health care company that provides home health services to patients who are covered by the U.S. Government's Medicare insurance program. Throughout the Class Period, Amedisys's business model depended almost exclusively on its ability to collect Medicare reimbursement payments, which accounted for approximately 90% of the Company's net service revenue from 2005 through 2011.

2. During the Class Period, Amedisys told investors that the Company was achieving record revenue growth through innovative new programs and a srong business model. Amedisys and the Individual Defendants also repeatedly represented that the Company was in compliance with all applicable laws, emphasizing that the Company had a supposedly "strong compliance program" that

[1] The individually named defendants are Amedisys's former Chairman and Chief Executive Officer ("CEO") (from 1982 until February 20, 2014), William Borne ("Borne"); its former Chief Operating Officer ("COO") (from January 1999 until his sudden resignation on September 3, 2009), Larry Graham ("Graham"); its Chief Financial Officer ("CFO") (from February 2007 to January 1, 2012), Dale Redman ("Redman"); its former CFO (from May 2002 to October 2006), Gregory Browne ("Browne"); its former CFO (from October 2006 to February 2007), John F. Giblin ("Giblin"); its former Chief Information Officer ("CIO") (from September 2004 until her sudden resignation on September 3, 2009), Alice Ann Schwartz ("Schwartz"); and its Chief Compliance Officer ("CCO") during the Class Period, Jeffrey Jeter ("Jeter") (collectively, the "Individual Defendants").

was overseen by top executives. For example, in the Company's filings with the U.S. Securities and Exchange Commission ("SEC") during the Class Period, Defendants represented that "we develop, implement and maintain comprehensive compliance and quality improvement programs as a component of the centralized corporate services provided to our home health and hospice agencies," and that "our consistent focus on compliance and quality improvement provides us with a competitive advantage in the market."[2]

3. Defendants told investors that the Company's centralized "Point-of-Care" computer system was a key component of their compliance efforts. As Defendant Jeter, the Company's CCO, stated on an October 28, 2008 conference call with investors, "our point-of-care system represents a fundamental compliance control" that helps ensure "our adherence to Medicare rules and regulations." Jeter stated that "one simply cannot overemphasize the importance of this technology as a means for strengthening our compliance with the law." Similarly, Defendant Graham, the Company's former COO, told investors that the "most important" area of focus for the Company was its "compliance controls."

4. These and many similar statements were critical to investors. As Defendants knew, investors and analysts were focused on Amedisys's compliance with Medicare's rules and regulations because Medicare was essentially the Company's only customer. The legitimacy of Amedisys's reported revenue received from Medicare – and any threats to Amedisys's Medicare business – were therefore highly material to the market.

5. Unfortunately for investors, Defendants' statements were false. In reality, and unbeknownst to investors, Amedisys was engaged in a widespread scheme to defraud Medicare by providing medically unnecessary care to patients, overcharging Medicare for home health services,

[2] All emphasis in quoted material herein is added, except where othwerwise indicated.

and paying kickbacks to doctors in return for patient referrals. The astonishing breadth and audacity of the scheme has been well-documented in multiple *qui tam* complaints, through statistical studies, in interviews with multiple former Amedisys employees, and in investigations and actions brought by the U.S. Department of Justice (the "DOJ"), U.S. Attorneys' Offices for five separate states, the U.S. Senate Finance Committee, and the U.S. Department of Health and Human Services ("HHS") Office of Inspector General.

6. On October 3, 2011, the Senate Finance Committee released its "Staff Report On Home Health And The Medicare Therapy Threshold" (the "Senate Report"). The Senate Report concluded that, based on its investigation of the Company, Amedisys had "at best" abused the Medicare home health program and may well have "defraud[ed] the Medicare home health program at the expense of taxpayers." In particular, based on internal Amedisys documents obtained by the Senate Finance Committee that previously had not been publicly released, the Senate Report concluded, among other things, that "Internal documents from Amedisys show that, prior to the 2008 Centers for Medicare & Medicaid Services ("CMS") therapy payment changes, managers were encouraged to meet the 10-visit therapy threshold [to trigger additional payments];" and "Amedisys management directed employees to adjust the number of home health care therapy visits to maximize Medicare payout to the company after the 2008 changes to the Medicare payment system."

7. Further, on April 22, 2014, the DOJ entered into a settlement agreement with Amedisys whereby the Company agreed to make a cash payment of $150 million – equal to two years of the Company's profits – and to enter into a "corporate integrity agreement" with the U.S. Government. In the settlement agreement, the DOJ represented that the government had valid civil claims against Amedisys for:

> improperly billing and failing to refund overpayments for Medicare home health care services that Amedisys: (a) provided to non-homebound patients, (b) provided to patients lacking a need for skilled nursing and/or skilled therapy services, (c) provided

> to patients without regard to medical necessity, and (d) overbilled by upcoding patients' diagnoses[.]

8. The DOJ also represented that it had valid civil claims against Amedisys "arising from Amedisys's billings to the Medicare program, during the period from April 1, 2008 through April 30, 2012, in violation of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, and the Stark Law, 42 U.S.C. § 1395nn…." In commenting on the settlement, on April 23, 2014, the U.S. Attorney for the Northern District of Alabama stated "Amedisys made false Medicare claims, depriving the American taxpayer of millions of dollars and unlawfully enriching Amedisys" and "Health care dollars must be reserved to pay for services needed by patients, not to enrich providers who are bilking the system."

9. Amedisys's settlement with the DOJ resolved allegations of an extremely widespread fraud taking place for many years throughout the Company. The settlement resolved seven *qui tam* complaints that had been filed under the False Claims Act by separate whistleblowers in the Northern District of Alabama, the Eastern District of Pennsylvania, the Northern District of Georgia, and the Western District of New York. The settlement covered allegations of Medicare fraud taking place at Amedisys care centers throughout the country, including nine centers in Alabama, seven in Florida, six in Georgia, four in Mississippi, seven in Oklahoma, two in Pennsylvania, six in South Carolina, eleven in Tennessee, and three in Virginia. As part of the settlement agreement, the DOJ agreed to pay the *qui tam* whistleblowers collectively more than $26 million in whistleblower awards for their work in unveiling the fraud.

10. The same fraudulent conduct that was at issue in the *qui tam* actions and settled by the DOJ lies at the heart of the misconduct alleged herein by Lead Plaintiffs. As described below, Lead Plaintiffs allege that Amedysis lied to investors and falsely concealed that it was defrauding Medicare in various ways during the Class Period, including the following:

> (a) Amedisys knowingly and intentionally provided medically unnecessary treatment visits to patients in violation of Medicare law. This included certifying (and then recertifying) patients for medically unnecessary 60-day

treatment episodes. As discussed below, Amedisys implemented corporate-wide practices that were expressly designed to ensure that the Company would hit highly-lucrative Medicare reimbursement triggers, regardless of whether those triggers were justified under Medicare regulations.

(b) Defendants knowingly or recklessly caused Amedisys to overcharge Medicare by implementing fraudulent "clinical tracks," such as its "Balanced for Life" and wound care programs, that automatically resulted in the provision of a pre-set number of therapy visits for patients in those programs irrespective of their genuine medical need;

(c) Amedisys engaged in rampant improper upcoding, *i.e.*, the practice of entering codes (*e.g.*, on a patient's OASIS form (as defined below at ¶30)) that reflect a more severe illness or condition than the patient actually had (such as diabetes, congestive heart failure, and chronic obstructive pulmonary disease), or that attributed a patient's "primary diagnosis" to a medical condition other than the one giving rise to the need for therapy, in order to take advantage of higher billing rates associated with the "upcoded" data. Amedisys specifically used its computer systems and Quality Care Coordinators ("QCCs") to command the nurse or therapist completing the OASIS form to select the therapy that would lead to the highest reimbursement for Amedisys – without regard to genuine medical need; and

(d) Amedisys paid improper and illegal remuneration to doctors to solicit the certification of profitable Medicare patients and facilitate improper patient recertifications.

11. Lead Plaintiffs' allegations against Defendants are supported not only by the massive U.S. Government and *qui tam* lawsuits and investigations, but through interviews with a wide range of former Amedisys employees from Amedisys branches across the country, including numerous separate confidential witness ("CW") accounts quoted in detail here and in Appendix A to the Complaint (which is incorporated herein by reference). In fact, Lead Plaintiffs' initial complaint pre-dated the Government settlements. The former employees cited herein have consistently described how Amedisys used its centralized data monitoring and Point-of-Care systems so that top management could systematically apply pressure on Amedisys's employees to change patient evaluations and to provide medically unnecessary services to trigger significant additional Medicare payments for Amedisys.

12. The truth about Defendants' fraud began to be revealed to investors in a series of

partial disclosures during the Class Period. As information concerning the true nature and extent of Amedisys's practices gradually became known – including through an April 27, 2010 front-page *Wall Street Journal* ("*WSJ*") article and an October 2011 Senate Finance Committee report into Amedisys's misconduct – Defendants repeatedly (and falsely) denied that the Company was engaged in any wrongdoing. Nonetheless, the value of Amedisys securities fell sharply as investigations were launched by the DOJ, the Senate Finance Committee and others. As Amedisys's stock price declined, Lead Plaintiffs and the Class suffered enormous losses. By contrast, during the Class Period, the Individual Defendants (including Amedisys's former CEO, Borne, and former CIO, Schwartz) reaped illicit proceeds of roughly $23.4 million from lucrative insider sales of Amedisys securities at artificially inflated prices.

13. From April 26, 2010, the day prior to the release of the *WSJ* article, to October 4, 2011, in the aftermath of the release of the Senate Report, Amedisys's stock price dropped by a cumulative total of $48.97, or more than 80 percent, from $60.50, to $11.53. Lead Plaintiffs, on behalf of themselves and the Class members whom they seek to represent, bring this action to recover damages for the substantial losses they and other Class members suffered as a result of Defendants' false and misleading statements in violation of the federal securities laws.

II. JURISDICTION AND VENUE

14. This action arises under Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 ("Exchange Act"), 15 U.S.C. §§78j(b) and 78t(a), and the rules and regulations promulgated thereunder, including SEC Rule 10b-5, 17 C.F.R. §240.10b-5 ("Rule 10b-5").

15. This Court has jurisdiction over the subject matter of this action pursuant to Section 27 of the Exchange Act, 15 U.S.C. §78aa and 28 U.S.C. §1331.

16. Venue is proper in this District pursuant to Section 27 of the Exchange Act, 15 U.S.C. §78aa. At all relevant times, Amedisys maintained its headquarters and principal place of business

in this District. Many of the acts and violations of law alleged herein occurred in this District.

17. In connection with the acts alleged in the Complaint, Defendants, directly or indirectly, used the means and instrumentalities of interstate commerce, including, but not limited to, the U.S. mails, interstate telephone communications and the facilities of national securities exchanges.

III. THE PARTIES

A. Co-Lead Plaintiffs

18. Court-appointed Co-Lead Plaintiff Mississippi PERS is a pension fund established for the benefit of current and retired public employees of the State of Mississippi. Mississippi PERS provides benefits to over 60,000 retirees, and is responsible for providing retirement benefits to more than 250,000 current public employees. Mississippi PERS purchased shares of common stock of Amedisys during the Class Period and suffered damages as a result of the violations of the federal securities laws alleged herein.

19. Court-appointed Co-Lead Plaintiff Puerto Rico TRS is a single employer pension plan that provides retirement, death, and disability benefits to teachers in the Commonwealth of Puerto Rico, including all current and pensioned teachers of the Department of Education. Puerto Rico TRS purchased shares of common stock of Amedisys during the Class Period and suffered damages as a result of the violations of the federal securities laws alleged herein.

B. Defendants

20. Defendant Amedisys is a provider of home health services. Its common stock is traded on the NASDAQ Global Select Market under the trading symbol "AMED." Amedisys's principal executive offices are located at 5959 S. Sherwood Forest Boulevard, Baton Rouge, LA 70816. Amedisys's services are paid for primarily by Medicare, with Medicare reimbursements accounting for roughly 93%, 93%, 89%, 87% and 88% of the Company's net service revenue in 2005, 2006, 2007, 2008 and 2009, respectively.

21. Defendant Borne served as CEO and Chairman of the Board of Amedisys from its founding in 1982 until his retirement in February 2014 (at age 57), two months before Amedisys completed the $150 million settlement of claims related to the DOJ investigation and *qui tam* actions.

22. Defendant Graham served as Amedisys COO from January 1999 until September 3, 2009, when (at age 43) the Company announced his abrupt resignation to "pursue other interests." Defendant Graham was a direct, substantial and primary participant in the wrongdoing.

23. Defendant Redman served as the Company's CFO from February 2007 through January 1, 2012. Redman was a direct, substantial and primary participant in the securities fraud alleged herein.

24. Defendant Giblin served as the Company's CFO from October 2006 until February 2007, when at age 50 he abruptly left the Company "for personal reasons." Giblin was a direct, substantial and primary participant in the securities fraud alleged herein.

25. Defendant Browne served as the Company's CFO from May 2002 until October 2006, when he left Amedisys "to pursue other professional interests." Browne was a direct, substantial and primary participant in the securities fraud alleged herein.

26. Defendant Schwartz served as the Company's CIO from September 2004 until September 3, 2009, when the Company announced her abrupt resignation at age 42 to "pursue other interests." Defendant Schwartz was a direct, substantial and primary participant in the wrongdoing.

27. Defendant Jeter started with Amedisys in 2001 and during the Class Period served as the Company's CCO and Corporate Counsel. Defendant Jeter was a direct, substantial and primary participant in the wrongdoing.

IV. MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

28. Medicare uses a prospective payment system, or "PPS," which reimburses service providers like Amedisys in advance for a substantial portion of the total payment they are entitled to

receive for a given patient. It is based on (a) a predetermined rate schedule established by Medicare, and (b) a pre-treatment assessment of the patient's condition and proposed plan of care during a standardized 60-day time period, known as an "episode." As a result, Amedisys's Medicare revenues were primarily determined by Amedisys's patient assessments at the start of each treatment episode.

A. The HHRG Scoring System and the OASIS Form

29. A key element of Medicare's PPS system for home health care companies involves the Home Health Resource Group ("HHRG") classification or scoring system, under which an "HHRG score" (or "case-mix score") is determined for each patient. The case mix score reflects a patient's medical characteristics and expected level of required home health care services, and in turn corresponds to the amount that Medicare will pay for providing home care services to that patient.

30. A patient's case mix score is based on information that the home health care company collects, before the start of home treatment, on a form known as **"OASIS"** (**O**utcome and **AS**sessment **I**nformation **S**et). The OASIS form includes a long questionnaire covering the patient characteristics and attributes specified in Medicare guidelines, which information is reported to Medicare as part of the home health care company's request for reimbursement.

B. Treatment Episodes and Patient Certifications

31. If treatment for a patient is authorized beyond the initial 60-day "episode," the patient is "re-certified," and each subsequent 60-day period is a new "episode." A typical patient's first "episode" begins when, following discharge from medical treatment in a hospital or physician's office, she is deemed to require nursing and/or therapy services at home. Typically, the patient and her physician will first choose a particular home health agency, after which a nurse or therapist from that company will evaluate the patient, complete the OASIS form, and prepare a proposed "plan of care" – and will also determine the patient's case mix score.

32. A therapy visit is a home health visit by a therapist, such as a physical therapist,

occupational therapist or speech therapist. All other visits (such as home visits by a nurse or home health aide) are "non-therapy visits." A "therapy episode" is a 60-day treatment episode that includes at least one therapy visit, while a "non-therapy episode" is a 60-day treatment episode without any therapy visits. Therapy episodes are typically far more lucrative for home health care companies than non-therapy episodes.

C. Medicare's Pre-2008 10-Therapy Visit Threshold

33. From 2000 through December 31, 2007, Medicare's PPS system provided that home health agencies would be paid based on services provided during each 60-day episode of care. During that period, Medicare would pay between $1,231 and $3,935 for anywhere from 1 to 9 therapy visits to a given patient during a given 60-day therapy episode.[8]

34. Under the 2000-2007 PPS system, however, once a patient received his or her tenth therapy visit, the home health care provider received an additional payment of approximately $2,200. Accordingly, until December 31, 2007, Defendants had strong financial incentives to maximize the number of patients who reached the 10 therapy visit threshold. Medicare did not generally provide additional payments for therapy visits beyond the 10 visit threshold.[10] Accordingly, although Defendants had a strong financial incentive to provide at least 10 therapy visits to its patients under the pre-2008 PPS system, they also had strong incentives not to significantly exceed the 10-visit level.

D. In January 2008, Medicare Replaced the 10-Therapy Visit Threshold

35. Beginning January 1, 2008, the PPS system changed. As of that date, home health care companies received significant additional payments not upon 10 therapy visits, but upon

[8] The variation within this range depended ***not*** on the number of visits provided, but solely on the patient's OASIS scores.

[10] There are certain limited exceptions, not material to the analysis herein. For example, Medicare does allow additional payments for certain small numbers of "outlier" patients who require a very large number of visits and incur unusually large costs. The outlier payments are made for episodes whose imputed cost exceeds a threshold amount for each HHRG score.

providing their patients with 6, 14, or 20 therapy visits per episode.

36. For a patient to transition from one completed episode to a subsequent episode, a physician must approve continuation of home health services. However, as with initial treatment plans, a nurse or therapist employed by the home health agency typically prepares the revised plans for each episode and physicians typically rely on the nurse's or therapist's recommendations.

37. Also, under the revised PPS payment system (which was proposed in early 2007), certain patients with clinically complex conditions – such as those with a "primary diagnosis" of diabetes, congestive heart failure or chronic obstructive pulmonary disease – could be given higher scores correlating to higher Medicare reimbursement.

E. The Financial Incentive to Avoid "LUPAs"

38. In addition, throughout the Class Period, Medicare's PPS system provided for a "LUPA," or low-utilization payment adjustment, for patients who receive four or fewer total (therapny and/or nursing) visits in an episode. LUPAs are financially expensive and undesirable for Amedisys, because Amedisys is paid only a low, service-specific, per-visit amount for an episode that involves a LUPA. Amedisys might have to pay back to Medicare the substantial difference between (a) the amount originally advanced based on the patient's original OASIS form and plan of care, and (b) the small amounts payable under the per-visit payment formula applicable to "LUPAs."

F. The Severe Consequences of Seeking Reimbursement for Services that Are Not Medically Necessary

39. Under federal regulations, medical necessity – not private financial gain – governs the provision of home health services to Medicare patients. If a home health care company requests reimbursement for treatment that is not medically necessary, it is committing Medicare fraud.

40. Medicare defines "medically necessary" services as those "needed for the diagnosis or treatment of [a patient's] medical condition, meet the standards of good medical practice in the local area, and are not mainly for the convenience of [the patient] or [his or her] doctor."

www.medicare.gov/Glossary. The Social Security Act further states that home health services shall be provided to Medicare patients only if they (1) are homebound, (2) have medical necessity, and (3) are under a physician's plan of care. Social Security Act §§1814(a)(2)(C) and 1835(a)(2)(A), 42 U.S.C. §§1395f and 1395n(a)(2)(A).

41. Violating those requirements carries severe penalties, including civil liability under the False Claims Act, 31 U.S.C. §§3729-3733, which protects the government from being overcharged or sold substandard goods or services, and provides that it is illegal to knowingly or recklessly submit false or fraudulent claims for payment to Medicare. Filing false claims can result in fines of up to three times any loss incurred by Medicare on any fraudulent claims, plus an additional $11,000 for each false claim filed. Because under the statute, each fraudulently billed item or service is a separate false claim, civil fines and penalties can add up quickly to staggeringly large amounts in the case of a company that has systematically defrauded Medicare.

42. A home health agency that commits Medicare fraud can also be prosecuted for fraud by the Office of the Inspector General ("OIG") of the HHS. Under the federal Exclusion Statute, 42 U.S.C. §1320a-7, the OIG is legally required to exclude individuals or entities convicted of Medicare fraud from participation in all federal health care programs. In addition, the OIG may exclude home health care companies from participating in Medicare for, *inter alia,* providing unnecessary or substandard services, submitting false or fraudulent claims to a federal health care program, or engaging in unlawful kickback arrangements.

43. In addition, the Anti-Kickback Statute ("AKS"), 42 U.S.C. §1320a-7b(b), prohibits the knowing and willful "remuneration" to induce or reward patient referrals or the generation of business involving the provision of any medical products or services where the cost of providing such goods or services is reimbursable by Medicare. "Remuneration" as used in this statute includes anything of value, not only cash. The AKS covers both payors and recipients of kickbacks. Criminal

penalties and administrative sanctions for violating the AKS include fines, jail terms and exclusion from participation in Medicare and other federal health care programs. Under the Civil Monetary Penalties Law, persons or entities who pay or offer to pay kickbacks also face civil penalties.

G. The Filing of Whistleblower ("*Qui Tam*") Suits Against Amedisys

44. The U.S. False Claims Act includes *qui tam* provisions that allow a private person, known as a "relator," to bring a lawsuit on behalf of the United States, where the private person has information that the named defendant has knowingly submitted or caused the submission of false or fraudulent claims to the U.S. Government.

45. Under the False Claims Act, the Attorney General (or a DOJ attorney) must investigate the allegations of violations of the False Claims Act. The investigation usually involves one or more law enforcement agencies (such as the OIG of the victim agency). At the conclusion of the investigation, or earlier if so directed by the Court, the DOJ must either:

(a) intervene in one or more counts of the pending *qui tam* action, thereby expressing the Government's intention to participate as a plaintiff in prosecuting the complaint;

(b) decline to intervene in one or all counts of the pending *qui tam* action. If the United States declines to intervene, the relator may prosecute the action on behalf of the United States, but the United States is not a party to the proceedings apart from its right to any recovery; or

(c) move to dismiss the relator's complaint, either because there is no case, or the case conflicts with significant statutory or policy interests of the United States.

46. Between January 22, 2010 and March 23, 2012, relators filed at least seven *qui tam* lawsuits against Amedisys. Those complaints were filed under seal, and their factual allegations were not public until the complaints were unsealed in April of 2014:

(a) On January 22, 2010, April Nicole Brown ("Brown") filed Case No. CV-10-BE-0135-S (N.D. Ala.);

(b) On May 18, 2010, CAF Partners ("CAF") filed Case No. 10-cv-2323 (E.D. Pa.);

(c) On February 15, 2011, Shelby L. Umberhandt ("Umberhandt") filed Case No. 4 11-CV-0041-HLM (N.D. Ga.);

(d) On March 29, 2011, Natalie Raven and Christy Curtis filed Case No. 1 11-CV-0994 (N.D. Ga.);

(e) On June 17, 2011, Ellen Maffit ("Maffit") and Brion Frix ("Frix") filed Case No. 1 11-CV-1976 (N.D. Ga.);

(f) On July 22, 2011, Margaret Ognen and Malcolm Dulock, MD filed Case No. 1 11-CV-2421 (N.D. Ga.); and

(g) On March 23, 2012, Charles H. Lewis, Jr. filed Case No. 12 CV 0237 (W.D.N.Y.).

47. The *qui tam* actions alleged that Amedisys defrauded Medicare out of hundreds of millions of dollars and made illegal kickbacks to doctors, and each reinforced and corroborated the information provided by Plaintiffs' CWs, the Senate Report, and Amedisys's settlement with the DOJ.

V. DEFENDANTS' FRAUDULENT SCHEME

48. Defendants' fraud consisted of four primary elements, as detailed herein and confirmed by, among other things, the CWs, Senate Report, DOJ Settlement, and *qui tam* complaints:

49. First, Defendants knowingly or recklessly caused Amedisys to fraudulently overcharge Medicare by causing it to provide medically unnecessary therapy visits on a massive scale (i) to enable the Company to "hit" (or only modestly exceed) the therapy visit threshold levels that triggered significantly increased payments from Medicare; and (ii) to fraudulently minimize LUPAs by minimizing the number of patients who received fewer than 5 total visits per episode.

50. Second, Defendants knowingly or recklessly caused Amedisys to overcharge Medicare by implementing fraudulent "clinical tracks," such as its "Balanced for Life" and wound care programs, that automatically resulted in the provision of a pre-set number of therapy visits for patients in those programs irrespective of their medical need.

51. Third, Amedisys engaged in rampant improper upcoding, *i.e.*, the practice of entering codes (*e.g.*, on a patient's OASIS form) that reflected a more severe condition than the patient actually had, or that attributed a patient's "primary diagnosis" to a medical condition other than the one giving rise to the need for therapy, in order to take advantage of higher billing rates associated with the

"upcoded" data. Amedisys specifically used its computer systems and QCCs to command the nurse or therapist completing the OASIS form to select the therapy that would lead to the highest reimbursement for Amedisys – without regard to medical need.

52. Fourth, Amedisys paid improper and illegal remuneration to doctors to solicit the certification of profitable Medicare patients and facilitate improper patient recertifications.

53. Defendants' improper practices artificially inflated Amedisys's reported financial performance during the Class Period by fraudulently increasing Amedisys's revenue from Medicare. As a result, investors were materially misled as to Amedisys's noncompliance with relevant laws governing Medicare payments and massive liability exposure for Medicare fraud, and the extent to which Amedisys's previously reported revenue and earnings were the product of illegal and improper activity.

54. Numerous CWs contacted by Lead Counsel attested to multiple aspects of Defendants' wrongful conduct, including the pressures placed by Amedisys's senior management on lower-level employees to defraud Medicare and manipulate the PPS system, and a work environment that forced health care workers to either give in to pressures from "corporate" or resign (assuming they were not terminated for "un-cooperativeness" first). *See* Appendix A. For example, CW-6, a former Administrator in charge of five Illinois branches, described how the Company pressured branch Directors to hit the 10 therapy visit threshold and to upcode patient assessments in order to obtain higher reimbursements, and how CW-6's refusals to go along with the Regional Director's repeated demands to override the professional judgments of therapists and nurses in the field are the reason CW-6 is no longer employed at Amedisys. There are numerous other examples. *See* Appendix A.

A. Defendants Put in Place Systems to Defraud Medicare

1. Amedisys's Computer Systems

55. During the Class Period, Amedisys utilized a highly-sophisticated centralized

computer system to collect patient information. As Defendant Borne told *American Executive* magazine in 2004, "Through technology, we can manage and oversee all of the 8,000-plus active patients we have at any given time." Amedisys's computer capabilities in fact allowed senior management to instantly create and analyze detailed reports of statistics for each Amedisys branch, including the number of patients enrolled in treatment, their recertification or discharge status, the number of visits each patient had received, and the number of remaining visits each patient was scheduled to receive before the end of his or her current 60-day episode.

56. Amedisys's technology also allowed Defendants to create a feedback loop that management used to constantly pressure clinicians in the field and their local supervisors to hit (or only modestly exceed) the thresholds needed to trigger lucrative additional Medicare payments and avoid LUPAs, irrespective of whether such visits were medically necessary. The system also allowed Amedisys management, through remote monitors, to apply real-time pressure on nurses and other branch personnel (who were actually seeing paients) to override their independent assessments of patients and alter and manipulate OASIS coding, thereby inflating Medicare reimbursements.

a) Amedisys's Point-of-Care System Allowed Corporate Headquarters to Closely Monitor Treatments

57. As of December 31, 2006, the Company had rolled out its "Point-of-Care" system in approximately 100 branches and, as of the February 27, 2008 filing of its 2007 Form 10-K, had "completed the implementation" of that system in all branches. Through that system, Amedisys provided nurses and therapists with computers that allowed them to document the relevant clinical information for the OASIS form and electronically submit that information to the corporate billing database (known as "AMS2").

58. Once OASIS data was collected from patients, it became available to both clinicians in the field (and their immediate supervisors) and to corporate management at Amedisys headquarters through what Amedisys refers to as its "dashboard." The dashboard is a pop-up screen in the

Amedisys computer system that provides an overview of patients, including OASIS data. The system also tracks inputs and changes, showing who made changes and at what times.

59. As numerous CWs have confirmed, Amedisys's computer system allowed the Company's management to generate scores of reports. *See* Appendix A. For example, CW-2, a former Area VP of Operations who worked at Amedisys during almost the entire Class Period, stated that the computer system could generate virtually any statistical report concerning patient visits, all corporate managers had access to it, and the Company constantly monitored reports on, among other things, numbers of patient visits, lists of patients who were coming due for possible recertification, and patients at risk of LUPAs. Similarly, CW-3, a former Director of Operations at an Amedisys branch in California, noted that "corporate" generated daily reports on who was going out to see whom, how long patients were being seen, and how much money they were making on each patient – and that, basically, corporate "knew everything."

b) Amedisys Used Point-of-Care and AMS2 to "Upcode" Patient Treatments

60. During the Class Period, the Point-of-Care system did not simply collect information. It was also designed to actively inflate the number of patient visits and reimbursement that patients supposedly required. For instance, the system allowed corporate officers called "Episode Managers" and "QCCs" to access the system remotely while Amedisys clinicians were in the field initially inputting patients' information into the OASIS form. These Company officers routinely reported "uncooperative" field personnel – *i.e.*, those who refused or resisted increasing patient visits and purported reimbursement rates – to their supervisors in corporate headquarters.

61. In various earnings calls and investor presentations, Amedisys claimed that its high Medicare reimbursement rates were due to a sicker-than-average patient population. For example, Defendant Graham stated on Amedisys's October 28, 2008 conference call that "only 10% of the Amedisys patients are assessed as low or very low risk compared to 23% of patients nationally."

However, while Amedisys claimed a "sicker" patient population, its data suggested that it spent less on patients on average than competitors, $77 versus $113 per visit. CAF ¶¶106-07. In reality, Amedisys simply created the appearance to Medicare of the Company having very sick patients, in part by "upcoding" patients' medical conditions.

62. As part of Amedisys's training process for its Directors of Operations ("DOOs"), a 2005 Training Manual repeatedly emphasized the corporate drive to increase revenue through high case-mix scores. Specifically, DOOs were instructed that "high case-mix referrals will positively impact the agency financially." Further, DOOs were directed to "Focus marketing efforts on referral sources that have patients with increased rehabilitative needs (i.e. orthopedic patients) as these patients typically have higher case-mix scores resulting in greater revenue." CAF ¶110.

63. Point-of-Care was designed in close coordination with Amedisys Clinical Operations, Project Management, and the Amedisys information technology ("IT") department, to include prompts, known as "smart edits," to nurses in the field. The prompts, according to dozens of former employees, were virtually impossible to override and resulted in higher OASIS scores, and higher case-mix and base reimbursement rates. CAF ¶117.

64. According to a former employee and member of Relator CAF, the smart edits were designed to consistently trigger therapy recommendations that, in turn, would increase the number of visits and trigger the bonus payment. The smart edits prevented free-form input by clinicians and instead permitted the clinician only to click on pre-fabricated selections. CAF ¶118.

65. After a nurse collected data through Point-of-Care, the nurse would connect her laptop to the AMS2 billing system at Amedisys headquarters in order to sync the patient's medical profile data with billing data previously entered. AMS2 was designed to process the information through a series of "look up tables." Designed solely to maximize case-mix scores, the look up tables process all the OASIS data downloaded from the Point-of-Care laptop and cross reference that

data with potential secondary diagnoses, to increase a patient's case mix assignment. CAF ¶120.

66. For example, if a patient had a post-operative knee replacement, AMS2 was programmed to automatically search that patient's medical history, as collected by the field clinician, for potential additional diagnoses and potential additional upcodes. If AMS2 identifies that the patient has a medication listed for hypertension, it will automatically suggest adding hypertension as a secondary diagnosis (called "co-morbidity"), thereby making the patient appear sicker and increasing Amedisys's reimbursement. CAF ¶121.

67. Amedisys has a standing instruction that specific co-morbidities (such as hypertension) "always" be coded even where they only may impact care. Hypertension is extremely common among adults, affects most home health therapies, and, therefore, should not be considered as a co-morbidity. Because hypertension is ripe for abuse as a way to add case mix points, as of January 2011, CMS eliminated any points attributable to hypertension. CAF ¶122.

68. An analysis of 300,000 start of care ("SOC") assessments showing the "top" secondary diagnoses for the years 2005, 2007 and 2008 evinces the abuse of hypertension. Indeed, 46.9% of secondary diagnoses present in all SOC OASIS assessments by Outcome Concept Systems, an Amedisys partner, were for hypertension. CAF ¶123.

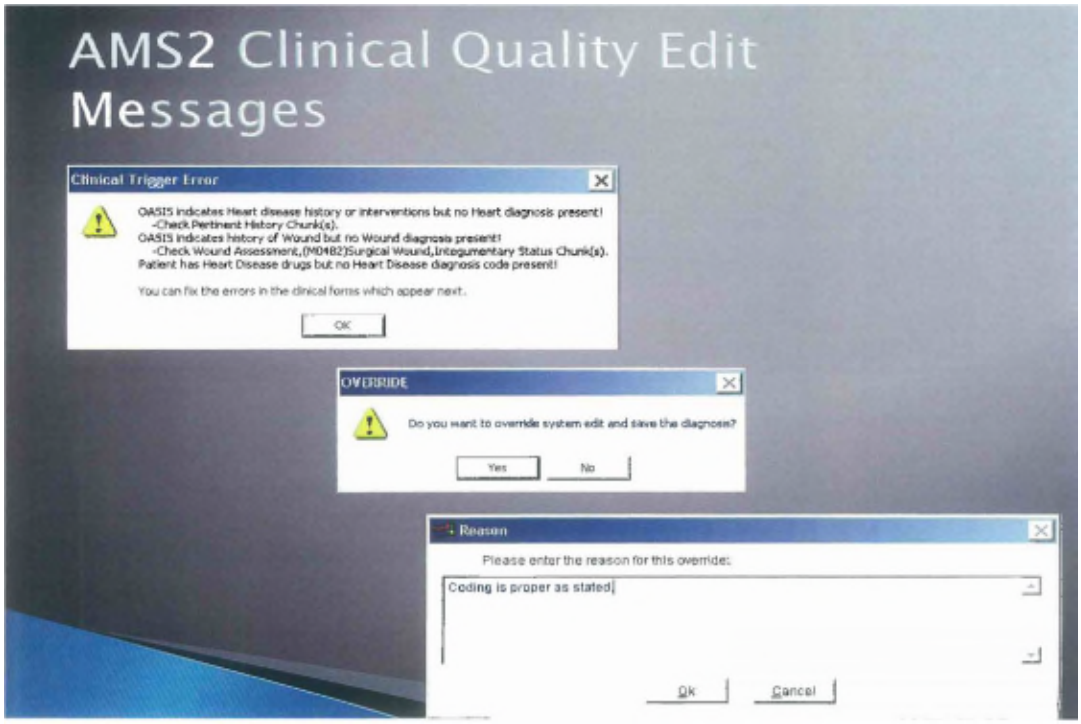
69. Once AMS2 processes OASIS data, it generates a list of potential secondary diagnoses to be reviewed by QCCs and added to the patient's profile, often regardless of whether the alleged secondary event arises in the episode or requires attention from home health services. CAF ¶124.

70. Prior to the creation of the QCC position, Clinical Managers were responsible for supervising field clinicians, reviewing OASIS assessments, and determining patient coding, including the addition of any secondary diagnoses. In or around September 2008, Amedisys replaced numerous agency-based Clinical Managers with remotely located QCCs. The QCCs worked directly for the Episode Management department headed by Tasha Mears, whereas the Clinical Managers fell under

Clinical Operations. Both the Clinical Managers and the QCCs were given basically unfettered access to OASIS assessments and were responsible for reviewing and coding as the assessments came in. CAF ¶125.

71. The Clinical Manager would review the new patient record and OASIS assessment through agencies' Clinical Manager Dashboard, which issued pop-up prompts called "Clinical Trigger Errors" apparently designed to generate secondary diagnoses to maximize scores. CAF ¶126.

72. In the following example, from a 2008 presentation to the Amedisys Board of Directors by Tasha Mears, the trigger error is designed to have the Clinical Manager code the patient for a heart diagnosis as well as a wound diagnosis (CAF ¶127):



73. The first box ("Clinical Trigger Error") demonstrates how AMS2 was programmed to "hunt" for additional diagnoses by reviewing the patient medication list and medical history, regardless of the relevance of such a diagnosis to the home health referral, and make the suggestion that those diagnoses be added as part of the coding. CAF ¶128.

74. The second box ("OVERRIDE"), which asks "Do you want to override system edit?,"

also evidences that AMS2 was designed to automatically add additional diagnoses to the patient's assessment unless otherwise instructed. Potential reimbursement for each patient was thereby deliberately maximized through a system of programmed manipulation. CAF ¶129.

75. Relator Brown described this in detail. Relator Brown, as of the date of her First Amended Complaint (April 5, 2012), had nine years' experience as a registered nurse ("RN"). Upon becoming employed by Amedisys in Monroeville, Alabama in April 2009, Ms. Brown "immediately became aware that Amedisys's business practices [were] designed to fraudulently maximize billing to the United States by falsely representing the type and severity of patients' medical conditions." Ms. Brown was met with hostility and terminated shortly after communicating her concerns to her superiors at Amedisys, including her Regional Manager. Brown first reported Amedisys's fraud to the OIG of HHS in October 2009, and has served upon the United States a written disclosure of the material evidence upon which her claims are based. Brown ¶4. Brown received approximately $6.6 million in compensation for her assistance leading to the $150 million DOJ settlement and her allegations are entitled to substantial weight.

76. Accoridng to Relator Brown, through incessant prompts and error messages, the Point-of-Care software not only suggests that an RN record the most severe level of illness and debility, but renders it nearly impossible to do otherwise. An RN attempting to record a less-acute condition finds it extremely difficult to complete his or her paperwork – a requirement for retaining employment – due to repeated error messages and unwanted information automatically supplied by the software. When Brown discussed this situation with the Clinical Manager at Amedisys's Monroeville location, the Manager said, "sometimes you just have to lie to get through it." As a result, the need for and cost of treatment is systematically exaggerated. Brown ¶13.

77. For example, during her employment with Amedisys, Brown frequently performed assessments on patients diagnosed with congestive heart failure. When Brown input basic patient

information, Point-of-Care supplied standardized notes of clinical conditions corresponding with the most severe form of congestive heart failure – many of which were not exhibited by the actual patient. Point-of-Care even supplied information about fictitious phone conversations between Brown and the patient's referring physician. In order to faithfully record true information, Brown had to laboriously erase the software's suggestions and attempt to input the actual data – fighting pop-ups and error messages. This occurred nearly every time Brown admitted a patient to Amedisys's care. Nurses were told that these standardized notes were intended to validate – on paper, though not in fact – the medical necessity of skilled nursing visits and the homebound status of patients. Brown ¶14. On other occasions, off-site QCCs would access the OASIS forms and override the clinician's assessment and substitute more remunerative diagnoses – including diabetes. Brown ¶¶15-24.

78. An internal Amedisys OASIS Reference Guide reveals the motivation for the addition of some of these diagnoses. Specifically, the guide sets forth the CMS point values for different diagnoses, revealing, for example, that adding a neurological diagnosis results in 20 additional case-mix points, and adding an orthopedic diagnosis results in an 11 point increase, substantially increasing the Medicare reimbursement paid to Amedisys. CAF ¶131.

79. In addition, Point-of-Care would automatically switch a patient's "primary diagnosis" for a "lower" diagnosis which would result in higher payment to Amedisys, or direct that the patient be designated to receive therapy – even if the new diagnosis was not the primary diagnosis or the patient was not indicated for therapy in the professional judgment of the clinician who actually assessed the patient. As various CWs confirmed (such as CW-1, an RN/Case Manager based out of an Amedisys office in Kentucky during 2005-2010), in such circumstances Point-of-Care would often not let the clinician submit the OASIS until it was in the form required by the system – i.e., containing the false diagnosis. *See* Appendix A.

80. Amedisys therapists were also routinely coerced to give inaccurate information when

completing OASIS assessments. Initially, Amedisys therapists were told to "score one step lower than what you see, for safety purposes." In other words, if a therapist observed that a patient ambulated at level 2, the therapist would record the patient as level 3. The patient's initial assessment would thereby routinely make the patient appear to be in a worse condition than was actually the case, increasing the case-mix adjustment and the amount paid by Medicare for an episode of care. In addition, such scoring created an artificially low baseline from which to judge improvement at the end of an episode. Maffit ¶46.[14]

81. Upon the conclusion of an episode, the reverse would occur, and therapists would be coerced into scoring patients higher than actually observed, in order to make it appear that the patient had improved. Amedisys built into Point-of-Care a prompt that made it difficult for therapists to record that a patient's condition had declined. If a therapist entered a lower score than that in the initial assessment, Point-of-Care generated a warning prompt that (i) informed the therapist that her observation reflected a decline in condition, (ii) told the therapist what the patient's score was in the initial assessment, and (iii) asked the therapist whether her assessment was correct. Significantly, the Point-of-Care system did not prompt the therapist to reconsider her score if she recorded that the patient improved – Amedisys only asked them to reconsider their score if it showed a decline. The continuous prompts created significant pressure upon therapists to change their scores, and they routinely did so. Maffit ¶¶48, 50.

82. The Point-of-Care prompts were reinforced by management, which pressured therapists to show functional gains in therapy patients. This is illustrated in an April 28, 2010 email from Daniel Miller (Regional Director of Rehab Specialty Programs for the Georgia region) stating

[14] According to the First Amended *Maffit* Complaint, Maffit is a PT who worked for Amedisys in Georgia for more than five years, and her co-Relator, Frix, is a former management employee at an Amedisys home health agency in Georgia. Maffit ¶6.

that "We need to always be showing functional gains in out patients when therapy is involved, ... and have to be able to show how therapy services will lead to improvements in function for the patients." As a result of the various pressures and incentives, Amedisys therapists routinely recorded OASIS scores that did not reflect their actual observations of patients' conditions. Maffit ¶51.

83. AMS2 was also designed to generate "Episode Countdown" reports on a daily basis and send them to DOOs at the Company's agencies. For example, before 2008, these reports were used to maximize billing by identifying patients who had "2 weeks left in their current episode and have only 7-8-9 therapy visits completed," prompting DOOs to reach 10 visits in order to receive the 10-visit bonus payment. CAF ¶132.

84. The Financial Management section of the 2005 DOO Operating Manual specifically instructs the DOOs to run the aforementioned Episode Countdown report from their AMS2 dashboard function a minimum of twice a week in order to maximize reimbursement. CAF ¶133.

2. Amedisys's "Clinical Tracks," Quotas, and Financial Incentives

85. To systematically achieve "high-therapy" bonus thresholds, Amedisys also created proprietary "clinical tracks" with standardized recommendations for the number of therapy visits by diagnosis. The "clinical tracks" were used primarily to justify high therapy rates and maximize reimbursement. CAF ¶138.

86. For example, according to an internal document titled "Rehab Clinical Tracks" from February 2003 when the bonus therapy reimbursement threshold was 10, the maximum suggested number of visits for a patient requiring any kind of balance therapy was 12. However, an internal document from September 2007 shows that, in anticipation of CMS implementing the threshold change, Amedisys instituted suggested minimum therapy visits at 16 for the same balance therapy patient. CAF ¶139.

87. Up until the PPS changes in 2008, Amedisys indoctrinated its DOOs to believe that

"the therapy threshold is 10 or more visits in a 60 day episode" and "the OASIS assessment should have a functional score that supports the patient requiring this much therapy." CAF¶141. Similarly, a PowerPoint presentation by Episode Management in 2007 reiterates to DOOs that the CMS had determined that 10 visits per episode constituted "meaningful therapy," and anything less was not meaningful or suitable for Amedisys patients. CAF ¶142.

88. Amedisys also tied employee compensation to quotas, rather than providing medically necessary care. Amedisys established a quota of Medicare admissions and recertifications – which increased each year – and strongly encouraged regional offices to meet the quota. At the time of Relator Umberhandt's termination, Amedisys had a monthly quota of 95-103 Medicare admissions and 126 Medicare recertifications each month.[15] Account Managers and Account Executives made visits to physician offices and hospitals to secure additional Medicare admissions. If the quotas were met, Amedisys paid quarterly bonuses to Account Managers, Account Executives, DOOs, Business Office Managers, Clinical Managers, and field staff. Umberhandt ¶10.

B. 2005-2007: Amedisys Provided Medically Unnecessary Visits to "Hit" The 10-Visit Threshold

89. In an article first published online on April 26, 2010, the *WSJ* publicly revealed statements by Tracy Trusler, a former nurse who worked at an Amedisys branch in Tennessee for two years prior to the end of 2007. The article quoted Ms. Trusler stating, "I was told 'we have to have ten visits to get paid.'" Alongside the simultaneous publication of the results of a previously nonpublic Amedisys-specific analysis prepared by Professor Dove of Yale University in the same

[15] Relator Umberhandt worked for Amedisys as a field nurse in Rome, Georgia from 1993 until 1999, when her position was discontinued. Umberhandt ¶7. She returned to Amedisys in April 2004, became a team leader in 2005, a Clinical Manager in 2008, and was terminated by her supervisor, Jan King, in August 2010 after questioning Amedisys's fraudulent billing practices. Umberhandt ¶8. Umberhandt also alleged that Amedisys's business practices encouraged Amedisys employees to bill Medicare for unnecessary and ineffective home health services, including fraudulently billing Medicare for patients who were not homebound and or otherwise did not require skilled nursing care. Umberhandt ¶¶9, 23-24, 26-29, 32-63.

WSJ article, Ms. Trusler's statements provided new evidence of Amedisys's improper practice of requiring employees to provide unnecessary therapy visits to obtain the additional Medicare reimbursement payable upon reaching the 10-visit threshold under the 2000-2007 PPS System – and constituted a partial disclosure of the alleged fraud (including Amedisys's practice of fraudulently inflating its reported revenue).

90. In conformity with the allegations above concerning the Amedisys Episode Countdown reports, Ms. Trusler also told the *WSJ* that her supervisors asked her to identify patients "who were just shy of the 10-visits mark and call their assigned therapists to remind them to make the extra appointment" – and that "[t]he tenth visit was not always medically necessary."

91. Since the publication of the April 2010 *WSJ* article, Lead Counsel have identified and contacted dozens of additional former Amedisys employees (including CWs 7-11, 13-15, 19, 20, 22, 25, 29, 57 and 58 who have confirmed – and significantly expanded upon – Ms. Trusler's statements concerning the steps that Amedisys management took to maximize the number of Amedisys patients who hit (or just slightly exceeded) the 10 therapy visit threshold prior to 2008. *See* Appendix A. For example:

(a) CW-5, who had significant contact, including weekly conference calls, with both the Regional Director and Amedisys's National Director of Operations Cheryl Lacey,[16] stated that directives came down from both of these individuals – including the directive that "you will have 10 PT [physical therapy] visits." Lacey repeatedly admonished CW-5 for nurses' refusals to code patient conditions at a higher level to trigger increased reimbursements.

(b) CW-7 stated that the "rule" at Amedisys was that therapists had to get in 10 visits, or if you didn't, you would be in trouble. CW-7 would be reprimanded for discharging patients who no longer needed home health services. When visiting offices and sitting in on case conferences in other regions, CW-7 would hear other employees being instructed to get 10 visits of PT in, and observed that the same pressures existed in other offices in CW-7's region. For example, if a patient was going out-of-town and it appeared that it would be difficult to complete the 10th therapy visit before the end of the episode, the physical

[16] Although CW-5 described the Regional Manager ("Cecilia") as bad, National Director of Operations Lacey was worse and CW-5 believes that Cecilia was just following orders from Lacey. Cecilia apparently left the Company just a few months after CW-5 resigned.

therapist would be told to go on visits every day, even though PT is normally done only three times a week. These instructions came down in regular conference calls with other branch directors of operations in Texas that were led by CW-7's Regional Director (Maggie Suggs), and Suggs's boss "Cheryl" (presumably Amedisys National Director of Operations, Cheryl Lacey). CW-7 also recalled a week-long Amedisys conference in Florida for Amedisys sales and branch directors of operations, which likely took place in 2006, where Defendants Borne and Jeter and all of upper management talked to them about having to get 10 therapy visits (or at least 5 total visits to avoid a LUPA). Indeed, CW-7 stated that everyone who was giving direction at this conference said this, and it was a given."

(c) Even working on the sales side of Amedisys, CW-11 said she witnessed numerous practices on the operations side of Amedisys that she said raised red flags to her – including efforts calculated to maximize reimbursement. CW-11 reported attending meetings where the practice of reaching the goal of 10 visits every time – whether the patient needed them or not – was discussed. CW-11 also reported discussions with Maggie Suggs, the Area VP of Operations (who reported to National Director of Operations Cheryl Lacey) about having case conferences with physical therapists in her region about how they needed to keep their patients on longer**.**

(d) CW-58 confirmed that Amedisys pressured employees to hit therapy visit thresholds. Initially the focus was on the 10 visit threshold, which changed to the new thresholds of 6, 14 and 20 visits following the changes to the Medicare reimbursement system in 2008. CW-58 stated that all employees were made aware of the reimbursement "buckets" and received formal training on them through conference calls with supervisors and, later, Rehab Specialty Directors. According to CW-58, the information came down from a higher level, such as the regional managers and Defendant Borne. Prior to the 2008 Medicare reimbursement changes taking effect, CW-58 recalled Defendant Borne specifically discussing the coming therapy reimbursement "buckets" at a yearly leadership meeting attended by DOOs, Vice Presidents and Area Vice Presidents. According to CW-58, Defendant Borne discussed how to make money with the new reimbursement system and the Company had a plan in place. However, CW-58 stated that Amedisys stopped discussing the reimbursement "buckets" completely once the SEC started its investigation into Amedisys (as discussed herein).

See Appendix A (citing further examples).

C. Medicare's 2008 Changes Posed Serious Risks to Amedisys

92. In response to the 2008 changes to the PPS system detailed above (including the number of therapy visits that triggered bonus reimbursements), Amedisys decided to overhaul the AMS2 software system to target the new reimbursement thresholds. CAF ¶199.

93. On July 24 and 25, 2007, Amedisys's Board of Directors met to discuss efforts to mitigate revenue loss resulting from the anticipated 2008 changes in the home health care PPS.

According to the minutes, Defendants Borne, Graham, Redman, and Schwartz attended in person, and Defendant Jeter attended by phone for a portion of the meeting.

94. According to the minutes of the meeting, Amedisys CIO Defendant Schwartz "addressed the [anticipated loss of revenue resulting from the] 'case mix adjustment' rules recently proposed by the [CMS] and informed the Board that the Company had formed a committee called the 'A-Team' whose specific purpose was to develop strategic clinical programs and cost-current efficiency measures to address the proposed case mix reference." Schwartz "noted that this committee was meeting on a bi-monthly basis." Schwartz responded to "various questions from the Board members."

95. An "Executive Summary" of "Amedisys Strategic Planning," attached to the minutes, confirmed that "strategic planning" was "spearheaded by [Defendant] Borne."

96. During a staff meeting in September 2007, Defendant Schwartz, tasked the Vice President of Information Services, Dana Voss, to develop a Case Mix Project Plan to plan for the necessary programming changes to AMS2. CAF ¶200.

97. As instructed by Schwartz, Voss created the "Case Mix Project Plan version 1.0," dated October 2007, and named Schwartz as the project's sponsor. The stated purpose of the Project was to "address the [PPS] and Case Mix changes occurring in 2008." As such, the Case Mix Project Plan "identifies AMS code changes that must be made in order to comply with the new 2008 refinements to PPS calculations and case mix." CAF ¶202.

98. Successful implementation of the case mix project was of critical importance. AMS2 is Amedisys's command center that both performs Amedisys's billing functions and also generates patient case mix data that form the basis for Amedisys's Medicare reimbursement claims. CAF ¶203.

99. During an October 25, 2007 Amedisys Board of Directors meeting, Schwartz again presented on Amedisys's plans to maintain reimbursement levels. According to the minutes,

Defendants Borne, Graham, Redman, and Jeter were also present, and "Schwartz updated the Board regarding the impact of the 'case mix adjustment' rules recently adopted by [CMS] on the Company's 'Case Mix Refinement Plan.'" Schwartz "noted that the Case Mix Refinement Plan is designed to promote (i) data consistency automation strategies, (ii) defined cost-cutting/efficiency measures and (iii) defined strategic clinical programs." Schwartz "outlined (x) the impact on the Company's revenue of the new CMS rules had they been in effect in prior fiscal periods, and (y) the impact on revenue for various fiscal periods of promoting (1) data consistency/automation, (2) certain other cost cutting efficiency measures (including . . . OASIS transmission automation . . .) and (3) certain defined clinical programs (including the Company's wound-care program, Balanced for Life campaign and cardiac rehab program)." According to the minutes, "[d]uring her presentation, Ms. Schwartz responded to various questions from the board members."

100. Allegations in the *qui tam* complaints, interviews with the CWs, the Senate Report, and the DOJ Settlement, all state that the programs Schwartz developed (such as Balanced for Life, and modifications to the Point-of-Care and OASIS reporting systems) to record co-morbidities with the highest level of reimbursement as the primary diagnoses, were designed to defraud Medicare by providing and billing for unnecessary therapeutic services.

1. Amedisys Used Wound Care Clinical Tracks to Boost Revenue

101. Among the matters raised by Schwartz at the July and October 2007 Board meetings was the establishment of Wound Care Clinical Tracks. In 2007, Amedisys began pushing agencies to "staff to the lowest discipline" – i.e., assign lesser-qualified (and less expensive) staff to assignments that more qualified staff should have worked on. This approach was discussed within the Company and, according to an internal document outlining the Case Mix Refinement Strategy, was listed as an initiative for August through December 2007. CAF ¶144.

102. At the same time, Amedisys paid physical therapists bonuses of $5,000 to $15,000 to

carry out a new initiative designed to meet the new Medicare bonus thresholds, "Wound Care: A Therapy Approach." Beginning in 2007, Amedisys attempted to reinvent wound care – a common service traditionally performed by trained nurses and covered under the base episode reimbursement at no additional charge – as "therapy" to be performed by comparatively lesser-trained physical therapists and physical therapist assistants in order to inflate therapy visit numbers to obtain bonus payments. CAF ¶¶146-47. The transition to wound care as a therapy was so unusual that many former employees, including a DOO from Maryland, reported that they were not comfortable with having physical therapists perform wound care because they did not have the training that nurses do. CAF ¶148.

103. An Amedisys document from October 2007 showed that Therapy Wound Care tracks for both uncomplicated (exactly 14 visits) and complex (20+) wounds were designed to fraudulently capitalize on the new 2008 CMS thresholds (CAF ¶150):

13. Therapy Wound Care I - 14 visits
    a. Uncomplicated wound
    b. PT and /or OT/SLP
    c. Might need a modality
    d. Stage I or II, Superficial wounds, Surgical wound
    e. Possibly needs positioning/functional mobility retraining/cognitive and/or oral intake management

14. Therapy Wound Care II - 20 + visits
    a. Complex, non-healing wound
    b. PT and /or OT/SLP
    c. Co morbidities
    d. Needs modalities
    e. Possibly needs debridement
    f. Needs positioning/functional mobility retraining/cognitive and/or oral intake management
    g. Stage III and IV, Full thickness wounds

104. As set forth above, Amedisys categorized a patient with an "uncomplicated wound" as group "I." This automatically resulted in that patient receiving 14 therapy visits, thus meeting the new Medicare reimbursement threshold. In addition, a patient with a "complex" wound fell into

group "II" and automatically received 20 or more therapy visits, which met another new reimbursement threshold. By employing this approach, Amedisys mandated that even an uncomplicated wound would require 14 therapy visits (regardless of true medical necessity), thereby increasing amedisys's Medicare reimbuirsement.

2. Amedisys Used "Balanced for Life" Clinical Tracks to Boost Revenue

105. Amedisys patients are assigned to one of several clinical tracks, based upon the initial assessment of condition and therapy needs, including Rehab@Home, Dysphagia@Home, Stroke Rehab@Home, Orthopedics, and Therapy Wound Care. Amedisys has policies and procedures governing the therapy to be provided to patients in the different clinical tracks. Maffit ¶17.

106. In mid-2007, at around the time of Medicare's announcement that it was changing its PPS payment schedule, Amedisys implemented the newly branded fall-prevention therapy "Balanced for Life." CAF ¶151. Balanced for Life was among the programs instituted by Schwartz and the A-Team to defraud Medicare through provision of unnecessary therapeutic services. Specifically, as discussed below concerning the *qui tam* actions, Balanced for Life was designed to target "trigger payments" rather than genuine medical necessity.

107. For example, Amedisys's October 2007 "Rational[e] for Clinical Tracks based on Diagnosis" shows that the first Balanced for Life clinical track (BFL001) purportedly justified an extraordinary 16 therapy visits for "Any diagnosis that scores at fall risk," thereby sufficiently meeting the Company's therapy per episode goals under the tiered PPS bonus system. The sweeping definition of that qualifying diagnosis, justifying 16 therapy visits (25% more than the highest risk patient under the former Better Balance program) without regard for the extent of medical need, evinces Amedisys's intent to abuse the Balanced for Life program to hit therapy thresholds rather than provide medically necessary care. CAF ¶152.

108. The next Balanced for Life clinical track (BFL002) was designated for patients with a

"High Fall Risk," which Amedisys considered to be patients who could trip over things such as rugs, pets, or shoes, -- i.e., nearly anyone -- or who had ever reported inner ear conditions. A BFL002 designation generated a clinical track recommendation of an astounding 22 visits for anyone patient falling into this vast category. This "one size fits all" approach of assigning visits to broad categories of patients was designed to serve Amedisys's financial interests rather than genuine medical necessity. CAF ¶153.

109. Not only did Balanced for Life lack a proper scientific basis, but Amedisys's standards for inclusion in the program were vague and failed to conform to CMS guidelines. According to Medicare guidelines for reimbursement, "services involving activities for the general welfare of any patient, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy." In other words, simply providing a patient with exercises to promote flexibility should not not qualify for therapy reimbursement.

110. Despite these Medicare guidelines, Amedisys's Balanced for Life questionnaire admitted into therapy treatment patients who answered "yes" to very basic questions that should not justify therapy treatment based on medical necessity. Specifically, Amedisys's "Fall Risk Assessment," a part of which is reproduced below, stated that if a patient answered "yes" to three questions – such as "Are you 65 or older?"; "Do you have a fear of falling?"; and, "Do you have painful feet?" – that could qualify the patient for participation in Balanced for Life (CAF ¶156):

ARE YOU AT RISK FOR FALLS?

Falls are a serious health concern related to many diseases, medical conditions or medications you may be taking. Falls can result in serious injury that we want to take proactive precautions to prevent whenever possible. To assist in identifying your level of risk; for a fall check any of the following that apply:

Y	N	
☐	☐	Are you 65 years or older?
☐	☐	Have you fallen within the last 3 months?
☐	☐	Are you unsteady on your feet or have a general weakness?
☐	☐	Are you taking any medications that cause fatigue or dizziness?
☐	☐	Have you had a stroke in the past?
☐	☐	Do you have a progressive neurological disease?
☐	☐	Do you have diabetes?
☐	☐	Do you have neuropathy, arthritis or joint disease of the lower extremities?
☐	☐	Do you have visual disturbances?
☐	☐	Do you have fatigue, dizziness or declined agility?
☐	☐	Do you have a fear of falling?
☐	☐	Do you have painful feet?
☐	☐	Do you have to rush to get to the bathroom in time?

If three or more of these statements apply to you, you may be at high risk for falls and may be a candidate for Balanced For Life. Please discuss with your physician.

111. In the words of this "Risk Assessment," "if three or more of these statements apply" to the patient, they "may be at high risk for falls." As such, patients answering "yes" to any three of the questions above would be entered into the Balanced for Life program and Amedisys would bill Medicare for services that, on the basis of those questions, should more appropriately be carried out by non-skilled personnel under the base reimbursement rate. CAF ¶157.

112. The Company had no proper justification supporting the use of skilled therapists in its fall-prevention program. Again, Medicare's benefits manual states: "Repetitive exercises to improve gait or to maintain strength and endurance and assistive walking are appropriately provided by nonskilled persons and ordinarily do not require the skills of a physical therapist." According to internal documents from 2007, in an attempt to justify the Balanced for Life program, Amedisys initiated the "Balanced for Life Data Project." The stated purpose of the Data Project was to "provide external validation of the Balanced for Life (BFL) program and to advance the Rehab Research agenda." CAF ¶158. The "Rehab Team" formed to ostensibly validate the Balanced for Life program

included Defendant Schwartz. CAF ¶159.

113. In 2008 and into 2009, this "Rehab Team" attempted to substantiate the claim that Balanced for Life was a qualified therapy under CMS guidelines. In furtherance of that effort, the team unsuccessfully sought the assistance of institutions including Yale, Johns Hopkins, and Emory University to justify the use of Balanced for Life clinical tracks as evidence-based medicine. CAF ¶160.

114. Amedisys's Balanced for Life marketing effort, known as "BFL Blitz," was celebrated in the Amedisys employees' weekly newsletter *The Weekly Spirit* on November 11, 2008. The newsletter reported: "In September, Rehab Specialty Directors, agency operations and the business development team had a Balanced for Life Blitz. Due to everyone's effort, there were 590 BFL referrals that week! Congrats to all the Directors and their hard work!" CAF ¶161.

115. Remarks by former COO Defendant Graham to investors in February 2009 quantified the impact the Balanced for Life program had on revenue. Graham stated that in the fourth quarter of 2008, the Company reported $2,960 as the revenue per episode, but that revenue per episode increases by as much as $2000 when a patient is enrolled in Balanced for Life. Based on those figures, Medicare reimbursement from the 590 Balanced for Life referrals in one week in September 2008 was a staggering $2,926,400. CAF ¶162.

116. Because Balanced for Life generated increased revenues for each patient episode, Amedisys pressured managers and therapists to place as many patients as possible on a Balanced for Life track. Among other things, Amedisys developed a "decision tree" to guide its therapists in determining whether a patient should be placed in Balanced for Life. Nearly every pathway on that chart leads to a recommendation of Balanced for Life, regardless of whether a patient is low acuity/high functioning or high acuity/low functioning. In other words, the chart was designed to guarantee that almost any patient likely to be assessed by Amedisys is placed on Balanced for Life,

irrespective of medical need or appropriateness. Maffit ¶23.

117. The expectation at Amedisys is that new patients will be assigned to a Balanced for Life clinical track, and therapists are pressured to place patients on Balanced for Life. Among other things, Amedisys requires its therapists to complete a "Weekly Therapist Report" identifying each patient evaluated or discharged that week, and to turn in such report at a weekly team meeting. The therapist must identify the patient's "Attribute code," and is given only two choices: BFL or BFLA (Balanced for Life with Anodyne Infrared Therapy). If the therapist does not recommend Balanced for Life, he or she must explain why in a column entitled "If not BFL, reason." In other words, Amedisys assumes that patients will be assigned to Balanced for Life, and requires therapists to explain why a patient should not be placed on Balanced for Life. Maffit ¶24.

118. In the *Maffit* Relators' experience, the primary reason for the Weekly Therapist Report, was to allow for easy identification of those therapists who are not assigning patients to Balanced for Life, who were then subjected to pressure from superiors, including being placed on an "action plan" and having supervisors ride along on patient visits and review the therapist's medical notes. Maffit ¶25.

119. Amedisys also provides cash incentives to ensure that patients are assigned to Balanced for Life tracks. Among other things, Amedisys pays therapists a $100 bonus when patients are discharged, but only if those patients are on a Balanced for Life clinical track. Further, Rehab Specialty Directors receive $500 incentive payments if they "[e]stablish 3 accounts that have referred 6 Medicare patients each to Balanced for Life." Rehab Specialty Directors also receive other bonuses based on meeting revenue goals, which are based upon an expectation that patients will be assigned to Balanced for Life tracks. Maffit ¶26.

120. Amedisys's use of the BFL003 track – Balanced for Life with Anodyne, which includes 22 therapy visits – is particularly problematic. In that track, patients are given anodyne

infrared therapy, purportedly to treat pain by improving circulation. However, in determining whether to assign patients to the BFL003 track, Balanced for Life uses the Semmes-Weinstein monofilament test, which is not designed to determine whether patients are experiencing pain that needs medical treatment, but rather measures only the patient's reaction to certain sensations. Because that test does not measure whether someone is experiencing pain, Amedisys's use of the test as a means of placing patients on a 22-visit therapy track is medically unjustified. Maffit ¶¶27-28.

121. Accoirding to the *Maffit* Relators, in order to make it appear that anodyne treatment was medically necessary, therapists routinely used the word "pain" rather than "sensation" in medical notes, even though the test does not measure pain. The *Maffit* Relators recounted discussions with multiple therapists about their experience with using anodyne therapy, and these therapists universally have indicated that they do not generally see improvement in patients' condition. Maffit ¶29.

122. In setting up Balanced for Life, Amedisys ensured that Balanced for Life patients would receive a number of therapy visits that exactly match, or slightly succeed, a payment threshold. As part of its Balanced for Life Operations Manual, Amedisys declared that the standard Balanced for Life track (BFL001) should include exactly 14 therapy visits. For patients assigned to more intensive BFL tracks (BFL002 and BFL003), Amedisys recommended 22 visits. Maffit ¶30.

123. The same applied to patients assigned to non-Balanced for Life tracks. The number of visits recommended for the various non-Balanced for Life clinical tracks is either exactly at or slightly above a post-January 2008 6, 14, or 20-visit payment threshold, and in no case is the number of recommended visits just short of a threshold (Maffit ¶¶31-32):

Rehab @ Home (REH001) – 8 visits
Rehab @ Home (REH002) – 16 visits
Rehab @ Home (REH003) – 22 visits
Dysphagia @ Home (DAH001) – 8 visits
Dysphagia @ Home (DAH002) – 16 visits
Dysphagia @ Home (DAH003) – 22 visits
Stroke Rehab @ Home (CVA002) – 22 visits
Orthopedics I (ORT001) – 8 visits

Orthopedics II (ORT002) – 16 visits
Therapy Wound Care I – 14 visits
Therapy Wound Care II – 14+ visits
Therapy Wound Care III – 20+ visits

124. An Amedisys document titled "BFL Q3,09 Outcomes" notes that Amedisys had nearly 20,000 Balanced for Life outcomes in the first three quarters of 2009, with an average number of therapy visits of 20 – *i.e.*, exactly the level that would provide for the highest Medicare payment. Maffit ¶33.

125. Among other things, Amedisys created a document titled "Disease Management: Clinical Track Selection Sheet," in which clinicians must designate each patient's clinical track. In that document, Amedisys pre-printed the number of therapy visits for each track, and the clinician must override the preprinted numbers to order a different number of visits. Thus, for example, in the entry for the BFL001 track, the number of visits is identified as "14 or ___," and for BFL002 and BFL003 the number of visits is identified as "22 or ___." By making 14 or 22 visits the default entry, Amedisys sets forth a clear, systematized expectation to its therapists regarding the number of visits to be ordered, irrespective of patient need. Maffit ¶34.

126. Amedisys also establishes benchmarks for therapy adjustments, and rewards Rehab Specialty Directors for meeting those benchmarks. In the Balanced for Life Operations Manual, the job description for Rehab Specialty Directors states that one of their "primary roles" includes "Meeting 'Benchmarks' for LUPA's and Therapy Adjustments." In a Quarterly Integrity Survey, RSDs are asked, "Are you meeting benchmarks for LUPA's and Therapy Adjustments?" and "What is your plan if not meeting these benchmarks?" RSDs are given points for meeting those benchmarks. Thus, Amedisys expressly tells its RSDs that they are expected to meet "benchmarks" for "therapy adjustments" – *i.e.*, the additional payments triggered at 14 and 20 visits. Maffit ¶35.

127. This focus on therapy adjustment benchmarks is illustrated by a May 5, 2010 email from Daniel Miller, the Regional Director of Rehab Specialty Programs for the Georgia region,

chastising several agencies that were below therapy utilization expectations. Miller focused on agencies where (i) a lower than average percentage of patients was placed on a therapy track, and (ii) a higher percentage of therapy patients received fewer than 14 therapy visits – i.e., the number required to trigger an additional Medicare bonus payment. Miller stated that (Maffit ¶36):

> [Agency A]: This agency has a very high recert versus new admit rate. We tend to see lower therapy utilization in this type of situation. Ran the Adjusted Revenue Report from January to present and the therapy % for this agency is at 45.7% which is fairly low. We like to see about 70%. ARR also shows that almost 90% of therapy patients had less than 14 visits which is below company average.
>
> [Agency B]: The ARR for the year so far show therapy % at 58% which again is low. 86% of patients fell below the 14 visit mark which is again below company averages. This agency also had a LUPA rate of almost 17%.
>
> [Agency C]: Again a high number of recerts in this agency. Also 63.9% therapy rate which is slightly low. Combine that with 84% of patients having less than 14 therapy visits and a LUPA rate of 17%.
>
> [Agency D]: Here we have a therapy % of about 52%, almost 80% of patients with less than 14 therapy visits, and a 22% LUPA rate.
>
> Many of these agencies have been on staffing crisis in recent times, which has I am sure led to some of the lower therapy rates. Higher numbers of recerts will also decrease therapy percentage of overall patients. All of the agencies show visit numbers that are less than company averages, so it is important to look to see if we are getting the patients all of the services they need at the level they need to achieve their maximum functional outcomes. Of course LUPAs are always an issue as well. Let me know if there is any other info I can help with or questions I can answer.

128. Amedisys also has expected revenues per episode for Balanced for Life agencies, and chastises managers who do not meet those figures. Anna Helms, Amedisys Area Vice-President of Operations, stated in a May 4, 2010 email to her RSDs that "From what I understand, BFL sites have a targeted Revenue per Episode of 3260/episode. I would like for each [underperforming] RSD to get with their respective DOO and develop an action plan by next Monday." In an August 27, 2010 email, Daniel Miller referred to the expected revenues per episode, stating that "RPE [for a particular agency] is up a little at 2946, but that is still fairly well short of the 3265 that is the expected threshold of a BFL agency as well as short of the overall average of over 3400 for all BFL agencies." Maffit

¶37.

129. Amedisys also frequently places its agencies on "action plans" if they are not meeting expected thresholds. Agency heads under action plans are subjected to intensive review from their respective Area Vice President, who requires them to explain what they are doing to increase revenues per episode and meet benchmarks. Amedisys utilizes a document known as a Location Status Report to identify agencies on action plans and their expected revenue goals. Maffit ¶38.

130. Relator Lewis has also observed that many cognitively impaired, chronically ill, and debilitated patients are improperly assessed for Balanced for Life and initially score poorly on the Assessment Tests due solely to their cognitive impairment, chronic illnesses and/or disabilities.[17] By instructing Amedisys staff to assess and admit into Balanced for Life patients without a reasonable basis to believe that Balanced for Life was effective, and for whom Balanced for Life was unnecessary, unreasonable, unsafe and/or otherwise inappropriate, Amedisys management improperly increased Amedisys's claims for Medicare reimbursement. Lewis ¶¶227, 253.

131. Under Medicare guidelines, Amedisys staff members are required to regularly reassess whether Balanced for Life is reasonable and necessary for each patient. Lewis ¶254. If a patient meets his or her functionality goals at any point, then he or she should be discharged from Balanced for Life by the Amedisys staff member providing treatment (regardless of whether he or she has completed the number of sessions in his or her particular Balanced for Life track). Lewis ¶255. However, Amedisys management regularly and routinely instructs Amedisys staff members – primarily physical therapy assistants – to keep patients in Balanced for Life until all sessions of a patient's particular track have been completed. Lewis ¶256.

[17] The *Lewis* complaint alleges that from March 2008 through at least the date of filing of the complaint on March 23, 2012, Lewis worked for Amedisys as a physical therapist assistant out of Amedisys's Vista, California Health Care Facility. Lewis ¶17.

132. Amedisys staff members working at the Vista, California facility were required to contact Vista Director of Operations Collette Armstrong ("Armstrong") and/or Vista Rehabilitation Specialist Warren Smith ("Smith") prior to discharging any patient from Balanced for Life if he or she had not yet completed the indicated number of sessions under Balanced for Life Level 1 or Balanced for Life Level 2. Upon such notification, every effort was made to ensure that the patient completed all remaining sessions for his or her particular Balanced for Life Level, regardless of medical necessity or appropriateness. Lewis ¶257.

133. On each occasion that Lewis contacted Smith and/or Armstrong to recommend that a particular patient not continue in Balanced for Life, Smith and/or Armstrong always instructed Lewis to keep the patient in Balanced for Life. Lewis ¶258. Moreover, under instructions from management, Amedisys staff members regularly retain patients in Balanced for Life, for an extended number of treatment sessions, who physically cannot perform the treatment offered under Balanced for Life, as well as patients for whom they know or should know Balanced for Life is unnecessary or otherwise inappropriate. Lewis ¶259.

3. Amedisys's 2009 Internal Audit Identified Serious Risks To Amedidys

134. Amedisys knew or recklessly disregarded that it was engaged in severe misconduct and rampant Medicare fraud. For example, in the Company's "2009 Annual Internal Audit Risk Assessment," Amedisys managers were asked to respond to an open-ended question about the Company's "Top Overall Risks." CAF ¶99.

135. The results of the internal assessment cited "Billing" as the number one overall risk at Amedisys as judged by Amedisys's own employees. Specifically, employees listed concerns about the following specific billing areas (CAF ¶100):

- Fraudulent billing
- Billing processes not being followed
- Billing for services that are not medically necessary
- Billing without orders to support

136. Following "billing," "compliance" came in second place with the managers interviewed. Specifically, employees listed concerns about the following specific compliance areas (CAF ¶101):

- Medicare compliance
- Selling Amedisys services and DM programs from a compliance standpoint
- Lawsuits relating to compliance
- Inappropriate recertifications (4)
- OIG audit with findings

137. In addition, "Field Staffing Model" also tied with "Compliance" with the respondents citing the main areas of concern as the following (CAF ¶102):

- Employee dissatisfaction
- Our clinical staff is so thinly staffed that we run the risk of poor service
- Overextending the existing top management staff
- Intake of patients
- QCC roll-out happened too fast to adequately get staff trained
- The current staffing model for clinical managers having 1 CM to oversee 275 patients does not provide adequate oversight of care or oversight of quality of the care that we provide. The model is a huge risk for us and our patients.
- Assuring clinical accountability
- Lack of supervisory personnel at the agency level
- Inadequate nursing staff levels
- Ineffective branch oversight and support at the AVP level, allowing agency processes to fall apart, resulting in decertification and / or patient injury.

138. According to this survey of the Company's own staff, which included all four of its "C[hief]-Level executives," Amedisys operates fraudulently; is out of compliance with CMS rules; and is so understaffed in nursing (having forced nurses out in order to hire more physical therapists to support corporate therapy goals) that patients run the risk of receiving poor service. CAF ¶103.

D. 2008-2011: Amedisys Abused the Revised Therapy Visit Thresholds

139. As discussed above, in January 2008 Medicare restructured its PPS system so that instead of paying home health care companies a single additional $2,200 lump sum upon hitting the 10 therapy visit threshold, such companies would now receive additional payments upon hitting the 6, 14, and 20 therapy visit thresholds within a given 60-day episode. Following that shift,

Amedisys repeatedly emphasized to its employees that they needed to change their patient coding and treatment patterns in order to track the new reimbursement thresholds.

140. For example, as the Senate Report uncovered, Tasha Mears, Amedisys's Vice President of Quality Management and Analytics, sent an email on February 25, 2008 to Directors of Office Operations, VP Operations, Regional Administrators, Senior Vice Presidents of Operations, and Episode Management, with the subject "Therapy Management in 2008." Defendant Graham was copied on the email. Senate Report at 14 n.40, 468-487. The email stressed to Amedisys management the "company wide differences in reimbursement in 2008 versus 2007 based on the total therapy visits per episode." *Id.* at 14, 469. Specifically, Mears stated that "in 2007 there were only 2 categories (buckets) of therapy visits, less than 10 [and] 10 or more … There are now NINE different categories of therapy visits (buckets)." *Id.* at 469. Mears's email included a chart showing "the changes in revenue per episode, moving from 'bucket' to 'bucket' in 2008. For example, moving from 11-13 visits to 14-15 visits, increases $813.13 per episode in 2008 (increased $34.38 in 2007). *Id.* at 14, 469-70. Mears's email "included a report ranking 'individual agencies, AVP's and VP's by 14+ total therapy visits per episode, and shows how many episodes are in each therapy 'bucket' [range]." *Id.* at 14, 470.

141. As a result, recipients of Mears's email pressured their staff to target the new therapy thresholds for maximum reimbursement. *Id.* at 14-15. A February 27, 2008 email from Vice President of Florida Operations, Dan Cundiff, to Amedisys managers stated: "We need to work immediately to adjust our '10 therapy threshold' mindset. See the email from Tasha yeserday. At 10, our episode value drops by over 880.00. 14 – 15 is where we need to be … and yes, I understand that our visits per episode will go up … but I would rather be profitable than have a low visits/episode." *Id.* at 14-15 n.42, 490-91. On February 26, 2008, Amedisys Vice President of Operations in North Alabama Teresa Mills also emailed her staff: "It is imperative that we are

compliant with the clinical tracks for Rehab that were made available to your agency [in] December 2007 … [I]t is evident that we as a region are not following the established guidleines for clinical management of therapy utilization. 65 percent or greater of your episodes that have ended this month fell under the 2008 PPS rules and discovery is that most of your episodes have . . . 0-13 therapy visits." *Id.* at 14 n.41, 488-489.

1. Amedisys Pressured Its Employees to Hit The Revised Medicare Therapy Thresholds

142. In addition, as many CWs reported (including CWs 1, 6, 13, 15, 22, 25, 29-32, 36, 39, 55, 60, 63, 65 and 66), Amedisys's fraudulent practices with respect to imposing unnecessary home therapy visits to hit Medicare's reimbursement thresholds continued, although after 2007 they were modified to reflect the new "trigger" levels. For example:

(a) CW-55 said that, in March 2008, s/he attended a leadership convention in Orlando, Florida at which Defendant Borne discussed the changes to the Medicare system. In attendance at the meeting were all Amedisys directors of operations, regional vice presidents, and sales personnel as well as the top executives, including Defendants Graham, Jeter and Schwartz. CW-55 remembered Borne announcing that many smaller home health companies were going to close down because they had not figured out a way to get to the higher reimbursement rates. However, Borne said that Amedisys was ahead of the game and on top of the new system because it had developed programs to obtain a higher reimbursement, which would be put in place in time for the changes to the Medicare payment system. According to CW-55, Borne communicated that Amedisys put the new programs in place specifically to deal with the new reimbursement system. CW-55 stated that it was obvious to anyone on the frontline that these new programs were specifically designed to obtain higher Medicare reimbursements.

(b) CW-30 recalled how Amedisys's corporate headquarters provided the branch DOOs with a large volume of information and written materials on Medicare's revised therapy visit thresholds that came into effect in 2008, and how much money was associated with them. The branch DOOs were directed to thoroughly train their staff on that material. Around January 2010, however, there was a panic about having distributed those materials, and the Company's DOOs were all directed to return them. Amedisys's corporate management was so concerned about retrieving the materials that an Amedisys Assistant Vice President was dispatched to CW-30's office in person to stress that the Company needed to get all the information back. It was clear to CW-30 that headquarters had dispatched the AVP to the branches only to get the written materials back. During the same visit, at management's instruction, the AVP told CW-30 to continue "working" the weekly reports (which continued to be distributed) of patients who were scheduled to fall short of the 6, 14, or 20 visit thresholds, but that going forward CW-30 was to shred the reports after CW-30's

branch had finished "working them." In addition, the AVP also instructed CW-30 to shred all of the therapy visit reports and related "alerts" from 2009 (and CW-30's notes thereon). As CW-30 stated, that instruction was the "polar opposite" of CW-30's prior instructions – which had been to keep the very same documents so that CW-30 could show his/her superiors that CW-30 had diligently "worked them" – and CW-30 and other branch directors actually "all laughed" about management's about-face.

(c) CW-33 reported to Cheryl Lacey during part of the Class Period. CW-33 described "struggling" when CW-33 started reporting to Lacey because there were "things that went against my grain" as an ethical person. One major and troubling issue was Amedisys's launch into new therapy programs, such as Balanced for Life, immediately after it became known that Medicare was going to implement the revised therapy visit payment "buckets" in 2008. CW-33 believed that if patients really needed so much additional care going forward, then those patients would have needed that care before the revised therapy buckets were put in place. CW-33 also recalled attending a quarterly regional meeting in Chattanooga, TN in the spring of 2007, at which Amedisys Senior Vice President Jill Cannon stated that Amedisys was implementing new therapy programs to meet the new visit thresholds for reimbursement. CW-33 also recalled that, in CW-33's region, Amedisys would send therapists to do wound care visits – even though this was a task that only nurses were qualified to perform – in order to increase the number of therapy visits.

See Appendix A (citing additional examples).

2. Statistical Analysis Shows Amedisys's Massive Switch in Billing Practices Between 2007 and 2008

143. Amedisys's systematic efforts to fraudulently manipulate the number of patient therapy visits during the Class Period are confirmed by statistical analysis of Amedisys patient visit data for the years 2005-2008. That data, collected by CMS, are not public, and are made available by CMS only to qualified researchers subject to strict confidentiality provisions.

a) Comparison of 2007 Data to 2008 Data

144. Lead Plaintiffs' Amedisys-specific statistical analysis (which is similar to certain analyses that were partially disclosed in the April 26, 2010 *WSJ* article) shows that Amedisys's distribution of therapy visits clustered at (or just slightly above) the relevant thresholds for increased Medicare reimbursement payments in both 2007 and 2008 – even though the relevant reimbursement thresholds changed significantly in 2008 compared to 2007.

145. Table A below sets forth the distribution of therapy visits per episode (excluding

LUPAs) for Amedisys patients who received 5 to 16 therapy visits (expressed as a percentage of all Amedisys patients receiving any therapy visits), for 2007 and 2008. For example, in 2007, the percentage of Amedisys's patients who received exactly seven (7) therapy visits per episode was 3.2%, the percentage of Amedisys patients who received eight (8) therapy visits per episode was 2.9%, and the percentage of patients who received nine (9) therapy visits was also 2.9%. *In other words, the percentage of Amedisys patients who fell one to three visits short of what was then the key "10 visit" threshold was only* 9.1%. However, in 2007 the percentage of Amedisys patients who received exactly ten (10) therapy visits per episode was 9.5%, the percentage of Amedisys patients who received eleven (11) therapy visits was 9.1%, and the percentage of patients who received twelve (12) visits was 9.9%. *In other words, the percentage of Amedisys patients who met or just slightly exceeded the 10 visit level in 2007 was* 28.5% -- or more than three times the percentage of patients (9.1%) who fell only slightly short of ten visits.

TABLE A

(Shaded data reflect clusters at or just slightly above key Medicare trigger levels each year)

Percentage of Therapy Episodes with 5 through 16 Therapy Visits (LUPAs excluded)												
	5	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
2007	4.6%	4.5%	3.2%	2.9%	2.9%	9.5%	9.1%	9.9%	6.4%	4.9%	4.4%	4.3%
2008	3.6%	4.9%	4.4%	5.0%	4.3%	4.7%	4.5%	4.9%	4.8%	6.6%	6.0%	5.9%

146. The proportion of Amedisys's patients who received more than 10 to 12 therapy visits in 2007 tapered off sharply as the number of visits moved further away from concentration of visits at (or just slightly above) the 10 visit level. For example, as shown in Table A above, in 2007 only 6.4% of Amedisys's patients received 13 therapy visits, only 4.9% received 14 therapy visits, only 4.4% received 15 therapy visits, etc.

147. The statistical analysis shows that in 2008, after the change to the "bucket" or tiered

system, the distribution of Amedisys's therapy visits changed dramatically in just one year, to cluster around the entirely new visit threshold levels that resulted in increased Medicare reimbursements. For example, as shown in Table A above, from 2007 to 2008, (a) the number of Amedisys patients receiving 6 to 8 therapy visits per episode (*i.e.*, those patients whose visits met or slightly exceeded the new 6 visit "trigger" level) increased from 10.6% to 14.3% -- or nearly 35%; and (b) the number of Amedisys patients receiving 14 to 16 visits (*i.e.*, those patients whose number of visits met or slightly exceeded the new 14 visit "trigger" level) increased from 13.6% to 18.5%, or roughly 36%.

148. Similarly, the number of Amedisys patients receiving 20 or more therapy visits (*i.e.* those patients whose number of visits met or exceeded the new 20 visit "trigger" level) increased from 8.6% to 14.6%, or roughly 69.8%. Table B below sets forth the distribution of therapy visits per episode (excluding LUPAs) for Amedisys patients who received 17 to 20+ therapy visits (expressed as a percentage of all Amedisys patients receiving any therapy visits) for 2007 and 2008.

TABLE B

(Shaded area reflects key Medicare trigger level and above; LUPAs excluded)

Percentage of Therapy Episodes with 17 through 20+ Therapy Visits				
	17	**18**	**19**	**20+**
2007	3.8%	2.8%	1.8%	8.6%
2008	4.6%	3.2%	2.1%	14.6%

149. Moreover, as the number of Amedisys patients receiving visits equal to (or just slightly above) the new 6, 14, and 20 visit trigger levels increased by roughly 37.8% in 2008 (from 27.8% in 2007 to 38.3% in 2008), there was – remarkably – a largely offsetting 49% drop in the number of Amedisys patients who received 10 to 12 therapy visits in 2008 (14.1%) compared to 2007 (28.5%).

150. The extraordinary swings in Amedisys's distribution of therapy visits per patient were sufficiently large, unusual and statistically significant, and occurred within such a short time period,

that a strong presumption arises that those shifts resulted from the deliberate manipulation of patient treatment plans on a massive and well-orchestrated scale to wrongfully inflate Medicare revenues.

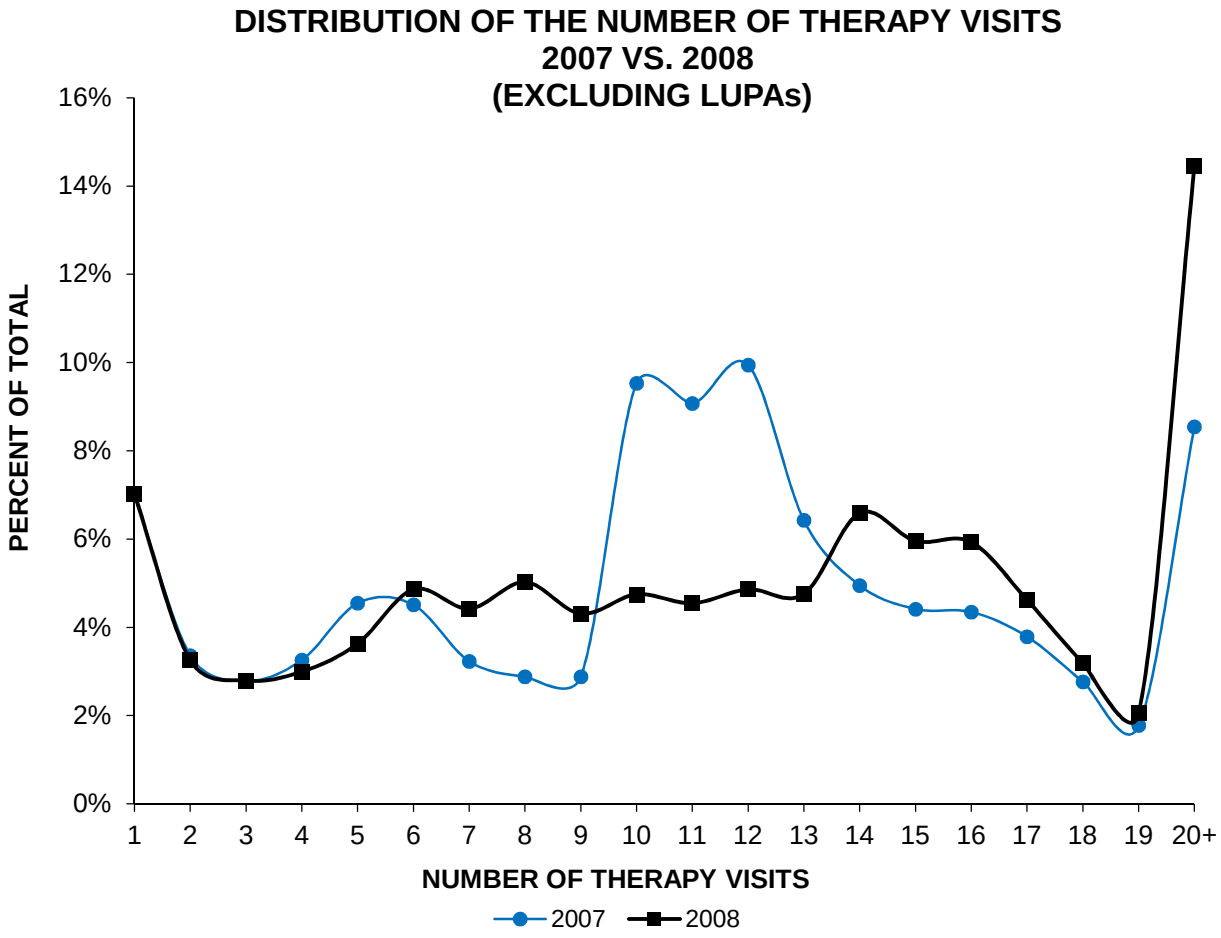
151. The volatility in the swings within specific "buckets" for Amedisys patients who received between 6 to 22 visits (which collectively accounted for 74.0% of all of Amedisys's therapy patients in 2007, and 71.4% of all such patients in 2008) is even more remarkable when contrasted with the stability between 2007 and 2008 in the number of Amedisys patients receiving exactly 1, 2, 3 or 4 therapy visits (which did not qualify for any enhanced payment levels under either the pre- or post 1/1/2008 Medicare fee structures). Table C sets forth the distribution of therapy visits per episode (excluding LUPAs) for Amedisys patients who received 1 to 5 therapy visits (expressed as a percentage of all Amedisys patients receiving any therapy visits), for 2007 and 2008:

TABLE C

Percentage of Therapy Episodes with 1 through 5 Therapy Visits (LUPAs excluded)					
	1	**2**	**3**	**4**	**5**
2007	7.0%	3.4%	2.8%	3.3%	4.6%
2008	7.0%	3.3%	2.8%	3.0%	3.6%

152. The data in Table C above shows that there was virtually ***no*** deviation between 2007 and 2008 with respect to the number of Amedisys patients receiving exactly 1, 2, 3 or 4 therapy visits. And although the data does show a more than 20% decline (4.6% to 3.6%) from 2007 to 2008 in the number of Amedisys patients receiving exactly 5 therapy visits, this decline is unsurprising given that after 2007 Amedisys was strongly motivated to reduce the number of patients it had who received only 5 therapy visits by giving them an extra visit to reach the 6 visit threshold).

153. A line graph that plots the number of therapy visits against the percent of total Amedisys visits in 2007 and 2008 is reproduced below, which demonstrates the significant swings in patient visits between 2007 and 2008:



b) Comparison of 2005-2007 Data to 2008 Data

154. Additional analysis of Amedisys-specific data from 2005 and 2006 performed by Lead Plaintiffs' experts provides further compelling evidence of Defendants' wholesale Medicare abuses.

155. First, analysis of data from 2005 and 2006 clearly shows that the suspect clustering of Amedisys patient visits at (or just slightly above) the 10-visit level in 2007 was not a "one-off" aberration, but was part of a consistent pattern of pre-2008 fraudulent conduct spanning several years. The "clustering" of Amedisys patients receiving 10, 11 or 12 therapy visits was even worse in 2005 and 2006 (*i.e.*, during the first 18 months of the Class Period) than it was in 2007. More specifically, as shown in table D below, the percentage of total Amedisys patients that received 10 to 12 therapy visits was 33.4% in 2005 (*i.e.*, 12.3% + 10.4% + 10.7%), 32.4% in 2006 (*i.e.*, 11.0% + 10.0% +

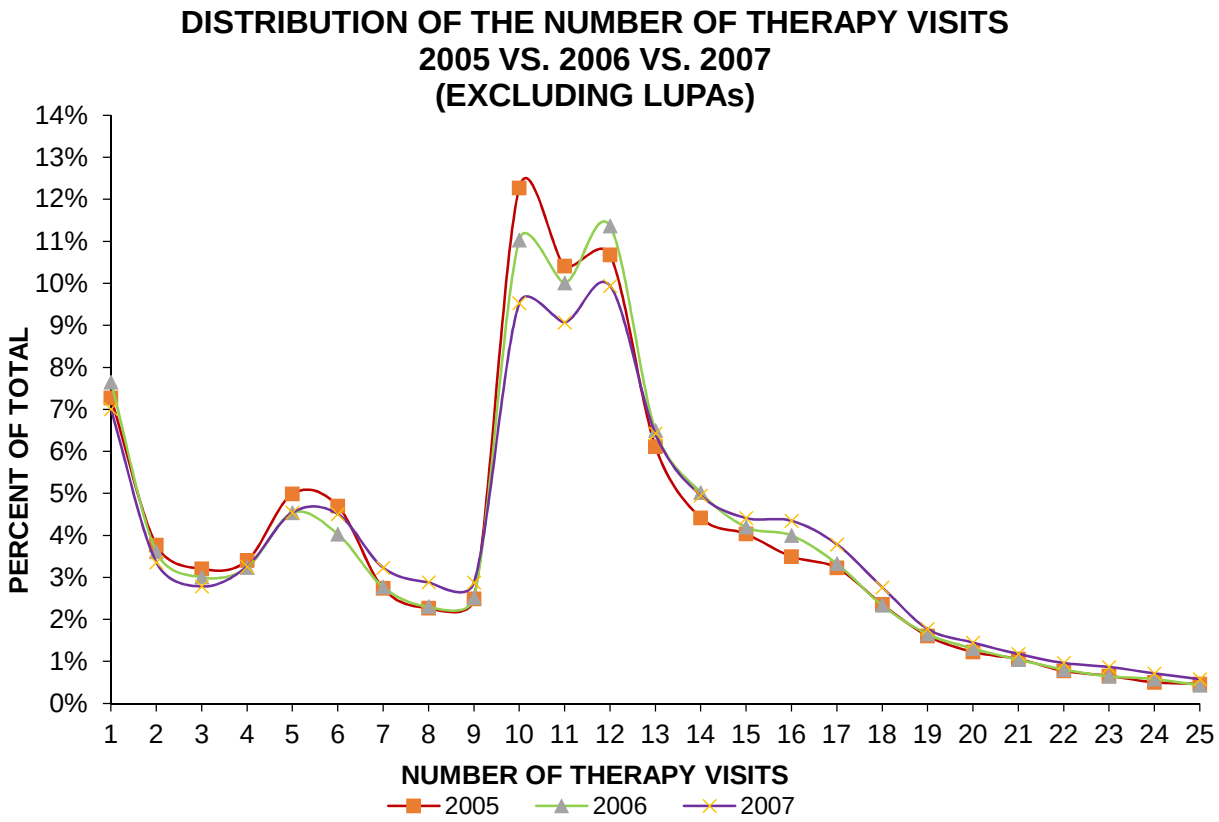
11.4%), and (as previously discussed) 28.4% in 2007 (*i.e.*, 9.5% + 9.1% + 9.9%).

TABLE D

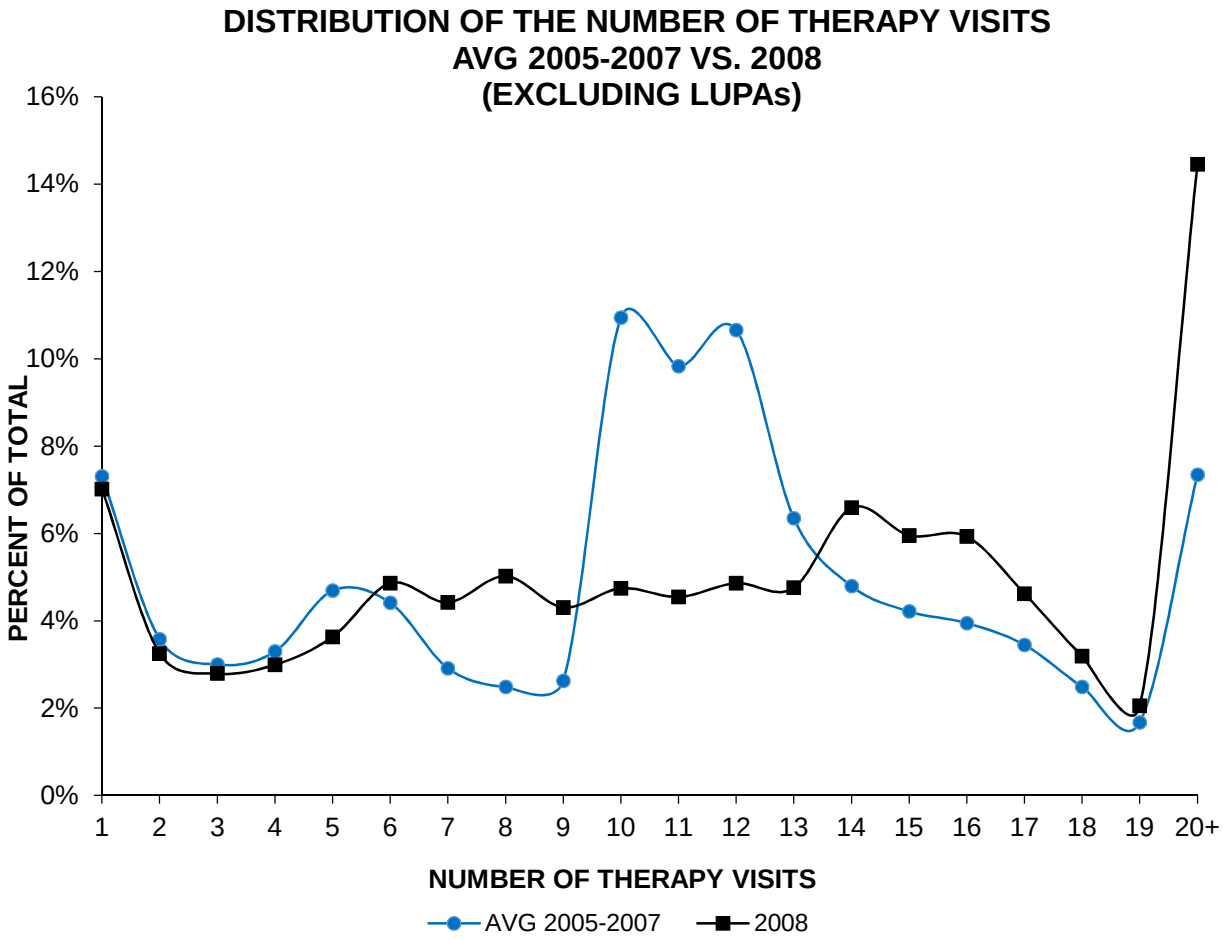
(shaded data reflect clusters at or just slightly above key Medicare trigger levels each year; LUPAs excluded)

Percentage of Therapy Episodes with 5 through 15 Therapy Visits											
	5	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
2005	5.0%	4.7%	2.7%	2.3%	2.5%	12.3%	10.4%	10.7%	6.1%	4.4%	4.0%
2006	4.5%	4.0%	2.8%	2.3%	2.5%	11.0%	10.0%	11.4%	6.5%	5.0%	4.2%
2007	4.5%	4.5%	3.2%	2.9%	2.9%	9.5%	9.1%	9.9%	6.4%	4.9%	4.4%

156. A line graph that plots the number of therapy visits against the percent of total Amedisys therapy visits from 2005 through 2007 is reproduced below, which demonstrates the consistency in the number of Amedisys therapy visits at certain thresholds (including at the 10, 11 and 12 therapy visit thresholds) between 2005 and 2007:



157. Second, these additional data make the contrast between Amedisys's pre-2008 patient data and its 2008 patient data all the more striking, and confirms that the changes in Amedisys's patient visit distribution data in 2008 were highly suspicious not merely because the 2008 data "track" Medicare's new 2008 payment grid, but also because those data break sharply from three years of prior data. A line graph that plots the number of therapy visits against the average percentage of the total number of Amedisys therapy visits from 2005 through 2007 against the percentage of the total number of Amedisys therapy visits in 2008 is reproduced below:



158. In sum, the CW accounts (*see* Appendix A) and statistical data alleged herein support a strong, compelling inference that Defendants fraudulently manipulated the number of therapy visits to patients throughout the Class Period on a truly massive scale, and did so with scienter.

E. Amedisys's Fraudulent Provision of Medically Unnecessary Visits to Avoid LUPAs

159. Defendants also knowingly, or with reckless disregard for the truth, caused Amedisys to further defraud Medicare by providing medically unnecessary therapy and/or nursing visits for the sole purpose of minimizing the number of patients who received fewer than 5 total visits (of any kind) per episode, which in turn allowed the Company to fraudulently minimize the number of LUPAs that would otherwise have required it to refund substantial sums to Medicare. Amedisys's fraudulent provision of medically unnecessary visits to avoid LUPAs is evidenced by the statements of Plaintiffs' confidential witnesses, including CWs 6, 10-11, 15, 19, 26, 31, 36, 42, 43, 56, 63, and 66. *See* Appendix A. For example, CW-11 said that Amedisys intensely pressured nurses to keep patients on for at least five visits to avoid LUPAs. CW-11 was aware of nurses who discharged patients before they received their fifth visit, only to be informed that corporate was upset that "we have another LUPA," and had also seen nurses who wanted to discharge patients being told to find a way to get in a few more visits to avoid a LUPA. Early discharges and LUPAs were among the topics discussed every Wednesday at every branch office in the region during conference calls with the branch staff and, frequently, the Area Vice President of Operations, Maggie Suggs. CW-11 stated that it was well known how "corporate" expected staff to conduct operations (e.g., avoid LUPAs), and that Suggs's boss, Cheryl Lacey, was also aware of what the branches were being told.

F. Amedisys's Fraudulent Practices with Respect to Patient Recertifications

160. Defendants knowingly (or with reckless disregard for the truth) also caused Amedisys to fraudulently overcharge Medicare for unnecessary services by fraudulently certifying or recertifying patients for medically unnecessary 60-day treatment episodes, including (but by no means limited to) for participation in Balanced for Life, and certifying or recertifying patients who were no longer homebound. Numerous CWs, including CWs 3-4, 6, 10, 11, 12, 14-15, 17, 23, 27-28, 30-31, 37, 42, 43, 47-49, 52, 56-57, 60, 63, and 66, reported such misconduct. *See* Appendix A.

G. Amedisys's Fraudulent "Upcoding" Practices

161. In addition to providing medically unnecessary therapy visits, Amedisys engaged, on a widespread basis, in a form of Medicare fraud commonly known as "upcoding." Upcoding refers to entering codes (notably on a patient's OASIS form) that reflect a more severe illness or condition than the patient actually has, or that fraudulently attributes a patient's "primary diagnosis" to a medical condition other than the one giving rise to the need for therapy, in order to take advantage of higher billing rates associated with certain diagnoses, with certain conditions that carry charges for more expensive treatments than the services actually provided. Plaintiffs' CWs, including CWs 4, 6, 10, 11, 13, 15, 17, 19, 26, 29-31, 33, 41-43, and 52-54, discussed Amedisys's fraudulent upcoding practices. *See* Appendix A. For example:

(a) CW-30 described the involvement of QCCs in upcoding, over the objections of clinicians in the field. For example, Amedisys nurses were instructed to list every medical diagnosis that a patient may have in his medical record, and then QCC would extract the diagnoses that would result in the most Medicare revenue and reimbursement. Clinicians were pressed by QCCs to change the primary diagnosis on the OASIS form. Although the clinicians in the field were supposed to sign "correction" forms that QCC sent to them, CW-30 reported that there were "a lot" of times that the clinicians did not sign those forms but CW-30 observed QCCs edit and change the OASIS anyway using AMS2. Similarly, QCCs would work to upcode the OASIS characterization of a patient's functional abilities. QCCs called with lots of requested changes; it was a rarity if a nurse completed an OASIS and did not get a call. As CW-30 observed, "I think it was pretty obvious across the board that when they [the off-site QCC's] called you and requested that you make a change, it was because it was going to [increase] the reimbursement." Nurses had problems with the QCCs' suggestions, but there was absolutely pressure to agree to the QCCs' changes. For example, CW-30 would receive monthly reports from "corporate" on clinicians in the field who were not cooperating with the QCCs, and as branch Director of Operations CW-30 was expected to "address" such issues. If the branch Director's initial responses were not satisfactory, the Area VP would come to the branch, go over these monthly reports, and reiterate in person that the branch needed to "become more compliant with QCC recommendations." CW-30's Area VP also confided that "It's coming from above; I'm getting pressured; we've got to address this."

(b) CW-53 reported that during his/her tenure (even though s/he was on the sales side) s/he participated in several meetings and calls about having nurses "correct the OASIS forms," arising out of Amedisys's practice of asking nurses to backdate and change OASIS information in order to "capture reimbursement." CW-53 stated that the Regional Director would call the branch's DOOs and instruct him/her to have the

nurses change OASIS forms. CW-53 noted that it did not take a rocket scientist to figure out that the changes sought by corporate management were to increase reimbursement. CW-53 and the branch DOO tried unsuccessfully to push back against management, and both CW-53 and the branch director left the Company later that year because they were worried they would lose their licenses if stayed in such an environment, as instructions from the Regional Director to change documentation went against everything they knew.

(c) CW-54 described how Amedisys's Point-of-Care system prompted nurses filling out OASIS forms to answer certain questions in only a certain way so that to ensure a certain minimum number of therapy visits (such as 10). If the person entering patient data did not answer certain questions the way that Amedisys's software was designed to accept, the system would report an "error" and force the person to go back again and again until the questions were answered in the desired way (e.g., until they justified at least Amedisys's 10 physical therapy visits). The system also always demanded that one list every patient diagnosis, even if a diagnosis was not a reason that Amedisys was seeing that patient. In sum, CW-54 believed it was a bad computer system, but you could not tell that to anyone in corporate in charge of the system – they were always right. CW-54 would try to override the system to get accurate (but less remunerative) answers input over the objections of the computer, but would constantly get in trouble for trying to do so, as CW-54's branch was always on the hot seat" and under pressure from the boss of the QCC department (who would then call CW-54's Regional manager to complain) – but CW-54 was unwilling to "commit fraud."

(d) CW-17 said s/he felt certain that Medicare fraud was going on at Amedisys. CW-17 recalled being specifically instructed by a superior (who now holds a regional supervisory position at Amedisys) that s/he needed to code patient admissions to bring in the most possible money to Amedisys. CW-17 said that, after s/he had completed his/her assessment and OASIS form concerning a patient, a clinical manager would review it and then change the coding in a way that would allow Amedisys to obtain the most money – for example, by changing the order of the patient diagnoses that CW-17 had listed. Coding changes were done without CW-17's approval. CW-17 said s/he left Amedisys because s/he was "tired" of the Medicare fraud happening at Amedisys, and was unwilling to lose his/her license for Amedisys.

H. Amedisys Repeatedly Used "Data Fixes" to Bill Medicare for Non-Compliant 60-Day Episodes

162. Amedisys's AMS2 database is programmed to scrub patient data and identify cases, known as "date exceptions," that have not fulfilled the mandated requirements for 60-day treatment episodes. When AMS2 generates that list, the only way to "correct" the exception so that a reimbursement claim can be billed and paid by Medicare is for Amedisys to go into its own database and manually roll back the SOC (start of care) date, episode dates, or other dates to falsely appear in

compliance with Medicare guidelines and to prevent Medicare from denying the claim, which if billed accurately and truthfully, should have been denied as ineligible for reimbursement. Amedisys's changing of its billing data in this manner is known as a "data fix." CAF ¶167.

163. Because SOC dates are generated automatically by the Point-of-Care system when the field clinician logs in and begins to enter patient data at the initial visit, there is, no possibility that human error resulted in the input of an improper SOC date. CAF ¶173.

164. When AMS2 generates its error or exception report, it appears as a spreadsheet, an excerpt of which is reproduced below (CAF ¶168):

Feature	460	Cert period correctior	Cert Date Fix	Data Fixes
Feature	469	Cert period correctior	Cert Date Fix	Data Fixes
Feature	472	Cert period correctior	Cert Date Fix	Data Fixes
Feature	536	Cert period correctior	Cert Date Fix	Data Fixes
Feature	567	Cert period correctior	**Failed 60 day Integrity Check Covington, GA 3302. Patient PH1091469**	Data Fixes
Feature	598	Cert period correctior	Cert Date Fix - M1373975	Data Fixes
Feature	708	Cert period correctior	Needs SOC changed.	Data Fixes
Feature	727	Cert period correctior	Cert dates needing to be reverted back to the first episode on the pertinent dates screen.	Data Fixes
Feature	732	Cert period correctior	RDOO CAN'T CHANGE CERT DATES	Data Fixes
Feature	743	Cert period correctior	Cert dates need to be change for patient I1048004 W.Watson	Data Fixes
Feature	744	Cert period correctior	Cert Date need to be change for Patient is M1366049	Data Fixes

165. Each of the exceptions above indicates the changing of patient certification dates which directly affect the billing of an episode to Medicare. CAF ¶169.

166. Furthermore, the entry "Cert period correction . . . Failed 60 day Integrity Check Covington, GA 3302" indicates either that the patient's care exceeded the 60-day episode window, or that Amedisys missed visits during the episode. To correct that issue, Amedisys database analysts (DBAs) would go into the AMS2 source database and manually change dates back so that the episode and everything within the episode appeared to be in compliance with CMS regulations. Similarly, the excerpt above also indicates changes in the start of care dates (called "M0030" dates). CAF ¶170.

167. Changes to assessment dates, and efforts to conceal those changes, are also apparent in a March 11, 2008 email exchange between Tasha Mears and AMS2 lead programmer Brannon

Byrd. In that email, Mears condones changing several final assessment dates (called "M0090" dates) to within the CMS regulated 5-day window prior to the end of an episode. Mears then instructs Byrd, "We will need to ensure that date matches an actual visit date," again condoning changing dates to appear that the patient assessment was conducted in compliance with CMS regulations. CAF ¶171.

168. There are two ways to effectuate a data fix at Amedisys. First, if the information is still in the Point-of-Care laptop system and has not yet been uploaded to AMS2, upon receiving an integrity error message, the DOO can call the Amedisys help desk, which then provides a key code to override the automatically-generated dates in the POC. Second, if the Point-of-Care data have already been uploaded to AMS2. the database team or DBA, located at corporate headquarters, must make the correction based on instructions they receive. CAF ¶172.

169. A report generated by Amedisys employee Mark Little from the second quarter of 2007 through the second quarter of 2008 reflects 443 data fixes executed with the second highest number, 53, categorized as cert period corrections. CAF ¶174.

170. AMS2 data changes and data fixes were an accepted IT practice until 2008 when senior IT managers attempted to stop the practice. However, attempts to curtail the data changes and fixes were consistently met with resistance from Amedisys CIO Defendant Schwartz. CAF ¶175. Then, in July 2008, some minimal change management processes were permitted which, for the first time in Amedisys history, enabled changes to AMS2 data and programs to be tracked and accounted for. CAF ¶176.

171. Changes to AMS2 reimbursement data occurred at corporate headquarters through both "user overrides" and "data fixes," as well as so-called "manual adjustments" in the accounting department. Changes also occurred at the agency level through "user overrides." CAF ¶177.

I. Amedisys's Payments of Kickbacks to Physicians

172. Amedisys uses various forms of kickbacks to induce patient referrals both from

physicians and from hospitals, in violation of the federal Anti-Kickback Statute.

1. Mercury Doc

173. For example, since 2005 Amedisys has used a thinly-veiled kickback scheme known as "Mercury Doc" to entice physicians to refer patients to Amedisys with the promise of Care Plan Oversight ("CPO") billing. CPO reimbursement permits physicians to bill Medicare for their time overseeing patients who are under the care of a Medicare-certified home health agency. By the Company's own admission, in February 2009, the impact of Mercury Doc has been to increase physician referrals to the point that 16% of the referrals come through the Mercury Doc portal, a number that grew dramatically from 1% the year before. CAF ¶96.

174. In 2005, Amedisys launched an early paper-based version of the program later known as Mercury Doc in an effort to increase patient referrals by physicians. The program alerted physicians to revenue enhancement opportunities available by billing CMS for CPO reimbursement every time that they certified or recertified a patient. Amedisys provided physicians with a simple form, the "Care Plan Oversight Minute Log," to enable tracking and CPO billing. CAF ¶274.

175. To further increase referrals, in 2007, Amedisys rolled out Mercury Doc v2.0, a free "proprietary" web-based software program, which automated physician time tracking and invoice processing, making CPO profitable and virtually effortless for physicians. With that new web-based program, Amedisys account executives could market Mercury Doc to physicians as a way to earn "extra income," depending upon the number of patients referred to Amedisys. CAF ¶275.

176. Mercury Doc is a thinly-veiled kickback scheme in which the incentive is unwittingly paid by CMS. According to the Vice President of the National Association of Home Care ("NAHC"), Mercury Doc was determined to constitute a kickback after a complaint from a competitor of Amedisys's prompted a review by NAHC's General Counsel. CAF ¶276.

177. Amedisys's account executives entice physicians to refer patients by explaining that

they are leaving "$25,000 to $45,000" a year in CPO Medicare reimbursement "on the table." However, with Mercury Doc, the Amedisys account executives suggest, the doctors can reap those additional Medicare CPO billings without performing any additional services. CAF ¶277.

178. Account executives are trained to explain to physicians that when they (or anyone who has their login and password) opens Mercury Doc on their computer, they will be able to see all their Amedisys patients' files. In fact, as soon as the files are opened, an internal timer in Mercury Doc will record a continuous log accounting for every minute patient files remain open. At month's end, Mercury Doc generates an invoice for the time the patient files were opened that month, thereby allowing the physician to bill Medicare for services purported to be CPO. CAF ¶278.

179. CMS regulations allow physicians to bill for CPO services for time spent in oversight of complex cases often involving consultation with specialists. The minimum reimbursable unit of CPO services is 30 minutes. CAF ¶279.

180. At the Amedisys Physician Consultant conference held in 2008 at the Ritz Carlton in New Orleans, during their presentation on Mercury Doc, Amedisys's Dave Monic and Jim Young advised the physician attendees to "have your nurse log in for you." Despite the fact that CMS Conditions of Coverage do not permit the simple act of opening a computer file to qualify for reimbursement under CPO, statements such as this, coupled with the marketing efforts of Amedisys's account executives clearly demonstrate the concerted effort to use Mercury Doc to induce physician referrals by promoting what amounts to fraudulent CPO billing. CAF ¶280.

181. A former Amedisys Account Executive from Texas further confirmed that much of the CPO billing was done by physicians' office staff, stating, "The benefits, the money, is positive. And then there is being able to chart. But the truth is that once a patient goes home and is out of the acute phase of illness where he needed a doctor – well, the Docs just don't have the time to go checking files on Mercury Doc for a patient that is in home care. A couple might. Most don't. So it

winds up be[ing] the secretary or the office manager or a nurse that opens the files." CAF ¶281.

182. The more Amedisys patients that a physician has, the more potential files the physician has to view, the more minutes there are to log and the higher the potential CPO reimbursement for the physician. To facilitate referrals, Mercury Doc contains a link to the online Referral Section of the Amedisys web site, which allows physicians to make an online referral instead of having to phone the agency. CAF ¶284.

183. In April 2008, COO Graham requested, and received from the Amedisys IT department, a spreadsheet detailing Mercury Doc's unmitigated success at increasing referrals. The internal spreadsheet lists individual physicians and their respective account executives, with a "Before" and "After" Mercury Doc referral scorecard showing the increases. CAF ¶283.

184. Mercury Doc was and is in a constant state of development and revision, as evidenced by Amedisys's "Mercury Doc Enhancement Request Tracking Log." For example, CCO Defendant Jeter requested the ability to "Add Physician Consultant invoice capabilities" to Mercury Doc, which strongly suggests that the same physicians who are receiving unearned CPO reimbursement for referring patients via Mercury Doc, may also be receiving additional revenue or benefits as Amedisys Physician Consultants. CAF ¶286.

185. Amedisys has publicly claimed that Mercury Doc alone (which was rolled out mid-2005, and enhanced in 2007, and has been in place ever since) has resulted in 14% more physician referrals (i.e. episodes) than the national average. CAF ¶291.

2. Nurse Liaisons

186. Further, in violation of the Anti-Kickback Statute, to expedite and induce patient referrals by hospitals, Amedisys provides "Nurse Liaisons," or "Account Managers" – at no charge – to carry out intake services properly performed by the hospitals themselves. According to a June 1995 OIG Fraud Alert, home health companies that provide hospitals with discharge planners, home

health coordinators or home care liaisons to induce referrals can constitute a kickback. CAF ¶98.

3. Physician Advisory Council and Financial Incentives

187. Amedisys also improperly induced patient referrals by hiring physicians as "Physician Consultants" or "Medical Directors" for unspecified services or services not rendered. CAF ¶259. In addition, since at least 2004, Amedisys formed what it called the "Physician Advisory Council," which conducts annual retreats known as Physician Consultant Meetings consisting of 3-day all-expense paid trips to luxury hotels sponsored by Amedisys and offered to a handpicked group of Physician Consultants and their spouses, families and guests. CAF ¶97.

188. The Company has routinely provided lavish trips for its physician consultants who refer home health patients, including one to the "breathtaking" Ritz-Carlton Grande Lakes in Orlando, Florida in June 2004. The meetings include presentations by numerous Amedisys senior executives, including Defendant Schwartz, Amedisys Vice President of Disease Management Ann Frechette, Amedisys IT Manager Jim Young, and Amedisys Vice President of Quality Management and Analytics Tasha Mears. An article for the Company newsletter stated that, "Physician consultants learned valuable ways to enhance their practices in addition to getting the most out of referring patients to Amedisys for home health care." CAF ¶260.

189. Notably, spouses and children of the physician attendees were invited to attend these exotic and luxurious annual physician consultant "meetings," at Amedisys's expense. In addition to the free vacation, Amedisys sweetens the deal and further entices referrals by including rounds of golf, dinners and spa appointments for the consultants and their families. CAF ¶261.

190. Not only does Amedisys use free vacations to induce referrals, the Company also encourages buying off doctors. For example, at the 2008 Amedisys leadership conference in Orlando, Florida, a skit called "Late Night with Amedisys" presented doctors as zoo animals that could be trained by "a good counselor salesperson." In the skit, a trainer tempted a reluctant physician with

promises of golf outings as an inducement to bring the doctor into the Amedisys fold. CAF ¶262.

191. As corroborated by Plaintiffs' CWs, including CWs 4, 11, 22, 26, 32, 53, 57, and 63 (*see* Appendix A), Amedisys made improper payments to outside doctors, and outside doctors were retained on Amedisys's staff as directors or consultants because it violates Medicare regulations to compensate outside physicians for referring patients. But the same referring doctors were paid as directors or consultants, although their only or primary function was to refer patients to Amedisys. For example, according to CW-4, outside physicians were placed on Amedisys staff as medical directors and were paid a certain fee every month in exchange for sending a majority of their patients to Amedisys. CW-4 stated that Amedisys knew that doctors sending 100% of patients to Amedisys would be a red flag to Medicare (since doctors are required to offer patients a choice in home health care agencies). Therefore, according to CW-4, Amedisys would receive 85-90% of these referrals, with a small number going to other agencies. According to CW-4, Amedisys's goal was to have an outside doctor-medical director for every program offered (e.g., orthopedist for orthopedic program, cardiologist for heart program, etc.), with each Amedisys office having multiple medical directors willing to refer the bulk of the patients to Amedisys.

4. Amedisys Internal Financial Incentives to Meet Referral Goals

192. In addition, throughout the patient referral and admission process, Amedisys's employees are highly incentivized to meet corporate goals. For example, account executives receive bonuses for Medicare patient referrals but not for referrals of non-Medicare patients. CAF ¶268.

193. Amedisys Account Executives, Account Managers, DOOs, and Directors of Business Development who achieve at least 120% of referral goals for one quarter become members of the Amedisys President's Circle and are paid bonuses of $1,000, $3,000, or $5,000 depending upon how much they exceeded goals. Those who maintain a referral level of at least 120% for an entire year enter into the coveted Chairman's Club and receive an extra $3,000 on top of their quarterly bonuses.

In the third quarter of 2009 alone, 126 employees gained President's Circle recognition. CAF ¶269.

194. Both President's Circle and Chairman's Club members are rewarded with a lavish 4-day trip to a resort location complete with an awards dinner. Managers of those account executives are also invited on the trip and become eligible for the annual Leadership Conference held at resort locations such as Orlando, Florida and Montego Bay, Jamaica. CAF ¶270.

195. As with the Physician Consultant retreats, Amedisys paid not only for the President's Circle and Chairman's Club recipients to attend, it also paid for the spouses of those employees. In addition, at one such retreat held in 2008 at the Ritz Carlton in Montego Bay, Jamaica, upon checking in, attendees received $500 vouchers for use at the resort and spouses received an additional certificate in the amount of $250 to be used for "recreational activities" including the spa and golf. CAF ¶271.

196. DOOs at individual agencies are also eligible for financial bonuses if they achieve so-called "NIFO" (net income from operations) goals, and can be docked pay if they fail to meet goals according to a complex and dubious program of incentives and sanctions, known throughout Amedisys as "Care Math." According to Relator CAF, those performance-based rewards for employees in the field, and their families, appear to be designed to entice employees to meet and exceed their financial and Medicare admissions goals by whatever means necessary. CAF ¶¶272-73.

VI. THE TRUTH BEGINS TO EMERGE

197. On August 12, 2008, Citron Research published an online report, entitled "Seeking Healthy Returns in Amedisys? Better get a Second Opinion…," which raised material questions about the legitimacy of Amedisys's accounting and Medicare billing practices. The report stated that Citron had hired a private investigator to investigate the existence of possible accounting irregularities at the Company, and that certain former employees contacted by its investigator had reported, among other things, that:

- Amedisys pressured employees to manipulate OASIS scores in order to increase billings; [and]

- Local Amedisys offices would receive calls from the Company's headquarters that applied pressure on the Company's employees in the field to change the proposed scoring on Medicare patients (to justify higher billing).

As the Citron report also noted, its analysis left "plenty of reason to wonder just how Amedisys maintains gross profit margins that run way ahead of everyone else in the industry," and raised questions about whether Amedisys was complying with the Medicare laws and accounting standards. Citron emphasized in its report that "it is not yet concluding that Amedisys is committing Medicare fraud, but there are many indications that this inquiry needs deeper scrutiny. (Further documentation is anticipated.) Due to these concerns, Amedisys's near total dependence upon Medicare for its revenues has to be factored as a business risk."

198. On August 12, 2008, as a result of the negative and previously-undisclosed information in the Citron report, the price of Amedisys stock dropped a statistically significant 17.86%, down $11.80 from its closing price of $66.07 on August 11, to close at $54.27 on very heavy trading volume of 11.2 million shares (which was more than 11 times the prior day's volume). However, Amedisys's false reassurances to investors via statements to analysts, discussed below, artificially kept the Company's stock price from falling further than it did.

199. Citron's August 12, 2008 report, by its own terms, was therefore a partial disclosure, and did not fully reveal the truth concerning Amedisys's misconduct, and accordingly did not remove all of the artificial inflation in the price of Amedisys's common stock. Moreover, Amedisys senior management, in communicating with analysts at Oppenheimer, in an effort to diminish the impact of the Citron Report on the price of Amedisys stock, also falsely reassured financial markets that the accusations in the Citron report were "unfounded." As the August 12, 2008 Oppenheimer analyst report stated:

> We have reviewed a report on AMED by Citron Research. The report primarily questions the company's accounting for receivables and its ability to generate greater internal growth than its peers. After speaking to management and analyzing the

> supporting details of the report, we believe the report is irresponsible in its innuendos of an underlying problem at Amedisys. Furthermore, we believe the stock's reaction to the report is significantly overblown.
>
> First off, we believe the source of this report is suspect. Citron Research is a web-based investment research service. The legal disclaimer on the site says that the "principals of Citron Research most always hold a position in any securities profiled on the site." . . .
>
> We continue to have the utmost confidence in the current management team. In our experience, AMED has always been forthcoming and transparent with the details it provides around the business.
>
> After speaking to management and analyzing the supporting details of the report.... , we believe the accusations are unfounded. While clearly this will present an overhang in the short term, when the dust settles we believe the stock will offer a compelling buying opportunity.

In its August 12, 2008 report, Oppenheimer rated Amedisys stock (which was then trading at $54.27) as "Outperform" and projected a 12-18 month price target of $73.00.

200. In the wake of the August 12, 2008 Citron report, Amedisys senior management also spoke with analysts at BB&T Capital Markets to reiterate to the market the Company's confidence in its quarterly results and outlook and downplay the importance of the report. In an analyst report issued on August 13, 2008, BB&T Capital Markets echoed Oppenheimer's sentiments wherein they described the "18% drop" in Amedisys's share price as "an overreaction," and characterized the Citron report as "negatively biased." The BB&T report concluded: "We had the opportunity to speak with management yesterday and while they were deeply troubled by the reaction of their stock they reiterated confidence in their quarterly results, and their outlook for the company remains unchanged. In a nutshell, we believe that AMED's management has set forth appropriate operating procedures to enable more accurate coding and improve its overall Medicare reimbursement. As a result, we side with the company." At the time, BB&T rated Amedisys stock as "Hold."

201. Similarly, in an August 13, 2008 analyst report, Wachovia stated that "Recently published criticisms of the company's accounting, transparency and compliance appears to be

spurious at best, in our view, and in some instances inaccurate and illogical," and upgraded Amedisys stock from Market Perform to Outperform. Wachovia also expressed skepticism over Citron's suggestions that "Amedisys pressured employees to manipulate OASIS scores to increase billings." In the words of the Wachovia report: "Obviously we cannot evaluate the factual accuracy of this assertion. However, we can point out that the [Citron] note (or at least the portion we have seen) does not explain how many former employees were interviewed, when these employees worked for the company, [or] why these employees left the company."

202. As a result of the partial corrective disclosures contained in the August 12 Citron Report, Amedisys's common stock would never close again as high as it did on the day before the report was published (*i.e.*, Amedisys's stock price never again closed higher than its $66.07 price on August 11, 2008). Nonetheless, and in part due to Defendants' false denials of the Citron allegations, the fraud continued, and the price of Amedisys common stock continued to be materially inflated.

203. On September 3, 2009, Amedisys announced the abrupt resignations, effective that same day, of its President and COO, Defendant Graham (at age 49), and its CIO, Defendant Schwartz (at age 48). The Company's press release stated that these two executives were leaving to "pursue other interests." That day, in response to this unexpected news, the price of Amedisys stock dropped a statistically significant 21.68%, or $9.42, to close at $34.04, on extremely heavy trading volume of 22.6 million shares (which was more than 100 times the prior day's volume). However, the September 3, 2009 disclosure was only partial, and accordingly, Defendants' fraud continued.

204. Market participants viewed the news of these unexpected departures as a highly negative development, and one that indicated heightened risk that prior allegations of fraud concerning the Company were in fact well-founded. For example, in an October 14, 2009 report entitled "Amedisys: Caught between a RAC and a Hard Place," Citron focused on the abrupt nature of the departures of the two former executives (including Graham's highly suspicious stock sale in

the several weeks immediately preceding his departure), and described the departures as a "red flag" indicating the existence of fraud at the Company:

> In the month of July we see the President of the company, Larry Graham, who has worked there for over 10 years, sold most of his stock holdings in a single day – July 31 – a transaction that exceeded all of his prior stock sales combined. And just five weeks later, on September 3, he resigns – effective immediately, without any stated reason (beyond the ubiquitous "personal reasons") and without a succession plan in effect.
>
> This leaves a question both obvious and troubling: are those stock sales improper? Wasn't he the ultimate insider, with advance knowledge that he was planning to resign soon, with likely negative effect on the stock? Shouldn't he have resigned first, and sold later?
>
> The stock plunged sharply on the news, but recovered the loss within days as analysts (who spoke only with remaining management) reassured investors that Graham had resigned over a disagreement with the board regarding his ambition to be CEO.
>
> Compounding the mystery, on the same day, CIO Alice Schwartz, an employee of over eleven years standing, also abruptly resigns, also effectively immediately, and similarly absent an explanation or succession plan.
>
> Larry and Alice were the same people who were justifying Amedisys's higher than industry margins on a conference all in Q3 2008, explaining that they just treat "a sicker population" than their competitors. . . .
>
> Conversations and correspondence with a plethora of former employees from a variety of different offices has given Citron a deeper view into the underbelly of Amedisys's business. <u>As a result, it is our opinion that the abrupt executive departures aren't random circumstances, and are more likely a warning indicator of a more dangerous problem</u>. Citron challenges readers to cite a single other example where the resignation of top officers without notice or succession plan was not the harbinger of bad news.

205. The October 2009 Citron report also specifically focused on the departure of CIO Schwartz as a "red flag." As the report stated "Why is the departure of a Chief Information Officer relevant to Amedisys shareholders? For most companies, the CIO isn't even on investors' radar, so what's the deal here?" As Citron report further stated:

> <u>Former employees have consistently reported to Citron that the laptop-based Point Of Care program, in which every healthcare staffer records every patient visit, is specifically designed to prompt workers to skew their Oasis scoring for higher</u>

> reimbursement. It is Citron's opinion that this explains why Amedisys's margins are the highest in the industry, not that their patients are "sicker" than their competitors'.
>
> Numerous employees have told Citron that they feel pressured by the continuous automatic computer prompts in Amedisys's POC system to change their scores on the Oasis reports they submit.
>
> It is going to be interesting once auditors realize it is the POC system's rule-base which exerts influence on thousands of health-care practitioners, who are bound by onerous employee contracts and subject to being fired if they "cause trouble."
>
> So who knows the design and architecture of the rule-base better than anyone? Who oversaw its system specifications, development, implementation, training, scalability and all the "enhancements" over the last eleven years? That would be the Chief Information Officer, who resigned as described above. Considering the intensified fraud audits the company is now subjected to, investors should wonder: Is it just getting too hot in the kitchen? It should be noted that Alice Schwartz did not leave for a new job and her compensation at Amedisys was not of a scale to put her on the fast track to retirement.

206. Another "red flag" identified by the Citron report was the participation of Amedisys QCCs in modifying OASIS scoring for Amedisys patients. As Citron also reported on October 14, 2009:

> [P]atient records and billing data are . . . routed to Amedisys's Quality Care Coordinators (QCC). These 200 employees mainly work from home and review every Oasis record, ostensibly to verify that it is recorded correctly.
>
> Citron believes that each case that doesn't meet the optimum billing and reimbursement profile as defined by the POC system is kicked out for "special attention" by the QCC's. It is common practice for QCC's to send an OASIS correction form to the clinical manager, which requires the clinician to sign off on the revised re-coding. For fear of being labeled a "troublemaker" and losing their jobs, nurses routinely just sign off on these without even reading them.

207. On October 15, 2009, in response to the additional allegations in the October 2009 Citron report concerning the role of QCCs in modifying OASIS scores, the price of Amedisys stock dropped a statistically significant 6.94%, or $3.11, to close at $41.73 on heavy trading volume of 4.6 million shares (which was almost seven times the prior day's volume). However, the disclosures of October 14, 2009 were only partial, and accordingly the fraud continued.

208. Other analysts dismissed the latest concerns set forth in the October 14, 2009 Citron

report as unfounded. For example, in response to the October 14 Citron report, analysts at Baird commented as follows in their own October 15 report:

> We would buy AMED on today's sell-off. Not too surprising, Citron is attacking AMED, presumably with the impetus being recent management departures. It's only been a year since their last short report. We see little substance behind today's report, view it more of the same and a buying opportunity with AMED selling for 9x our 2011 EPS estimate, which assumed a 10% cut to Medicare over the next two years.

209. Similarly, in an October 15, 2009 report entitled "Absolute Citron Gives AMED Investors An Unnecessary Hangover," analysts at Jeffries & Company also voiced skepticism over the claims made in the Citron report:

> We are buyers especially on weakness today. We believe Citron's claims are unsubstantiated, Q309 results will be better-than-expected, healthcare reform will be less onerous to home nursing than many anticipate, and that AMED's valuation at less than 10x FY10 EPS is compelling particularly vs. its peers. . . .
>
> As we wrote in our AMED report dated 9/4/09, we believe the resignation of the former COO and CIO was due to a failed internal power struggle, not fear of an impending investigation as Citron alleges. . . .
>
> We remain skeptical that former nurses are reaching out to Citron to discuss personal AMED work experiences. We believe that any nurse with a legitimate concern would have already approached the Department of Justice where the opportunity for financial gain exists as part of a qui tam lawsuit.

210. On April 26, 2010, after the close of trading, the *WSJ* published an article online and then, on April 27, 2010, published the same article on its front page. The *WSJ* article questioned whether Amedisys was "taking advantage of the Medicare reimbursement system," particularly in light of the *WSJ*'s specially commissioned (and never before published) analysis by a Yale University professor[19] that showed that "the number of [Amedisys's] in-home therapy visits tracks Medicare

[19] Professor Dove's analysis of Medicare data in the April 26, 2010 *WSJ* article was new information to the market and investors were not previously aware of it. In addition, the data relied upon by Professor Dove for his analysis for the *WSJ* article were available only to certain government-approved researchers after a rigorous application process. That process requires the researcher to, among other things, (a) provide a detailed explanation of the research purpose for the data request; (b) identify and specify each data file sought; (c) satisfy CMS that the applicant is able to maintain the data on a secure data platform with safeguards to prevent unauthorized use or access; and (d) execute a strict confidentiality agreement that forbids the user from releasing the underlying data to anyone not named in the researcher's Data Use Agreement. Medicare

financial incentives." As the *WSJ* article reported:

> [A]n analysis by *The Wall Street Journal* of Medicare payments to home health-care companies in recent years raises questions about whether some companies—including the sector's largest, Amedisys Inc.—are taking advantage of the Medicare reimbursement system. The results show that the number of in-home therapy visits tracks Medicare financial incentives.
>
> Medicare reimbursements are determined in part by the number of at-home therapy visits each patient receives, with an extra fee kicking in as soon as a patient hits a certain number of visits. Between 2000 and 2007, Medicare paid companies a flat fee of about $2,200 for up to nine home therapy visits. It paid an additional reimbursement of roughly $2,200 if the therapy surpassed nine visits. . .
>
> Amedisys provided many of its patients just enough therapy visits to trigger the extra $2,200 payment. In 2005, 2006 and 2007, very few Amedisys patients received nine therapy visits while a much higher percentage got 10 visits or more. In 2007, for instance, only 2.88% of patients got nine visits, while 9.53% of patients got 10 visits.

The article also quoted a former Amedisys nurse, Tracy Trusler, as stating "I was told 'we have ten visits to get paid," and the article also reported that Ms. Trusler's supervisors asked her to (a) review patients who were just short of the ten-patient visit threshold, and (b) call the patients' therapists to remind them to make the extra appointment. Ms. Trusler was also quoted as stating that "[t]he tenth visit was not always medically necessary."

211. In addition, the *WSJ* article reported that after the reimbursement rules were modified in 2008, "the percentage of Amedisys patients getting 10 visits dropped by 50%, while the percentage that got six visits increased 8%. The percentage of patients getting 14 visits rose 33% and the percentage getting 20 visits increased 41%." Although the *WSJ* article also briefly discussed data relating to a handful of other home-health care companies, the overwhelming focus of the article was

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expressly prohibits public disclosure of documents produced pursuant to a request for data from CMS. In other words, even after researchers receive access to these data, they are prohibited from making the underlying Medicare data public. Further, accessing the data files costs up to hundreds or thousands of dollars for each specific file requested. Moreover, even if the raw Medicare data relied upon by the *WSJ*'s expert had been previously disseminated to the public (which it had not been), the complexity of the data and the need for specialized expertise to decipher, analyze and derive meaningful conclusions from the data further render the information "non-public" in the context of the financial markets. Here, the importance of the data as they relate to Amedisys would not have been understood absent Professor Dove's specialized expertise.

on Amedisys and the article was accompanied by a photograph of Defendant Borne and Amedisys-specific charts that focused specifically on Amedisys's practices.

212. The *WSJ* article, however, was only a partial disclosure of Defendants' misconduct, and the fraud continued. The article also quoted a Company representative as reassuring investors that Amedisys had done nothing wrong:

> [Amedisys spokesman Kevin LeBlanc said] the company didn't take advantage of the system and that the company's home visits "are in line with the industry trends." [LeBlanc] said Amedisys in general focuses on sicker patients than the industry average, and therefore patients that require more care. "Amedisys's clinical patterns are representative of the patient population we focus on, namely those patients suffering from complex, chronic and co-morbid medical issues," he said. . . .
>
> The Amedisys spokesman said any suggestion the company may have increased its number of therapy visits to receive higher reimbursements is "both incendiary and inaccurate." . . .
>
> Mr. LeBlanc said many factors contributed to Amedisys's rapid growth, including "our significant investment in the best and most innovative technologies, our strategic acquisitions of compatible companies, our expansion into other therapies and by providing the best quality care for our patients at a lower cost." He emphasized that the number of home therapy visits is driven not by the company but by doctors' orders.

213. On April 27, 2010, in response to the negative news in the *WSJ* article, Amedisys's stock price dropped a statistically significant 6.58%, or $3.98, to close at $56.52 on heavy trading volume of 2,865,100 shares (which was five times the prior day's volume). Amedisys's false reassurances to investors in the April 26, 2010 *WSJ* article, however, artificially kept the Company's stock price from falling further than it did.

214. Late in the evening on May 12, 2010, the *WSJ* reported that the Senate Finance Committee had launched an investigation into Amedisys to determine whether it "deliberately boosted the number of home therapy visits to trigger higher Medicare reimbursements." The *WSJ* quoted portions of Senator Max Baucus's public statement announcing the investigation, wherein he stated that companies "working with Medicare should not be allowed to target seniors or manipulate care simply to get higher reimbursement rates." The article also quoted Senator Charles Grassley's

statements in the same release, wherein Senator Grassley said, "It appears that either the home health care reimbursement policy is flawed, some companies are gaming the system, or both. We're working to figure out what's going on." Senator Baucus (D-Mont.) was the Chairman of the Senate Finance Committee, and Senator Grassley (R-Iowa) was its ranking minority member.

215. As part of their investigation, on May 12, 2010, Senators Baucus and Grassley sent a letter to Amedisys, in which they wrote that the home therapy numbers cited in the April 26, 2010 *WSJ* article "suggest home health agencies intentionally increased utilization for the purpose of triggering higher reimbursements." The May 12, 2010 letter also asked Amedisys's CEO, Defendant Borne, to provide information concerning Amedisys's therapy visits from 2006 through 2009 and its financial relationships with referring physicians. The Senators also asked Amedisys to provide information on its Balanced for Life falls-prevention program, and noted that "the referral form [for the Balanced for Life program] raises concerns that the program may be taking advantage of Medicare payments in order to improve company profits." As the *WSJ* reported, as of early 2010, more than 330 Amedisys locations offered Balanced for Life, which was up significantly from 33 locations in 2008. The May 12, 2010 Senate letter to Amedisys also requested documents, information and/or data from the Company.

216. The very next day, on May 13, 2010, Amedisys issued a public statement attempting to downplay the importance of the Senate Finance Committee investigation, to discredit the earlier April 26, 2010 *WSJ* article as "incomplete," and to otherwise reassure investors, stating:

> The letter of inquiry received from Senators Grassley and Baucus references an article published recently in The Wall Street Journal. The article told an incomplete story about the value of home health to patients, their families, and the overall healthcare system.
>
> . . .
>
> Amedisys provides home care to more than 35,000 elderly patients every day. We are proud to be an organization that leads by putting our patients first and are proud of the work we do on their behalf.

217. On May 13, 2010, in response to the negative news that the Senate Finance Committee was investigating Amedisys, the Company's stock price dropped a statistically significant 7.97%, or $4.48, to close at $51.73 on heavy trading volume of 3,142,900 shares (which was more than eight times the prior day's volume). Amedisys's false reassurances to investors in its May 13, 2010 public statement, however, artificially kept the Company's stock price from falling further than it did.

218. Even if the Individual Defendants were somehow unaware of the Medicare fraud that was rampant at Amedisys, they would have certainly learned of the fraud in researching the allegations in the Citron report, the *WSJ*, and the Senate Finance Committee letter request, and preparing the denial.

219. On June 30, 2010, Amedisys issued a press release, published by the *Business Wire* at 10:08 p.m. ET that day, announcing that it had received a notice of formal investigation from the SEC; and a subpoena for production of documents from the SEC relating to the same or similar matters as were under review by the Senate Finance Committee. However, the June 30, 2010 disclosure was only partial, and Defendants' fraud continued.

220. The next day, July 1, 2010, Amedisys filed with the SEC a Form 8-K attaching its June 30, 2010 press release and providing details concerning the ongoing Senate Finance Committee investigation. This disclosure made clear that the Senate Finance Committee investigation had not yet reached a resolution and was ongoing.

221. On July 1, 2010, in response to the negative news that the SEC had launched a formal investigation of Amedisys (in addition to the already ongoing Senate Finance committee investigation), Amedisys's stock price dropped a statistically significant 10.55%, or $4.64, to close at $39.34 on heavy trading volume of 4,534,200 shares (which was more than eight times the prior day's volume). Amedisys's false reassurances to investors during this time period, however, artificially kept the Company's stock price from falling further than it did.

222. Less than two weeks later, on July 12, 2010, Amedisys issued a press release announcing an earnings call for the next day. In his introductory comments on the July 13, 2010 earnings call, Defendant Borne stated, in relevant part:

> First, let me begin with an overview of our operating performance in the quarter. As Dale and Mike will explain in more detail, the decline in our volume of recertifications more than offset our growth in admissions for this quarter. This resulted in revenues much lower than we expected. . . . We are very disappointed with these results.

223. Amedisys's CFO, Defendant Dale Redman, continued:

> Volume in the second quarter came in significantly lower than we expected, both from a recert and an admit perspective, and our operating costs also affected the quarter. . . .
>
> Revenue for the quarter we estimate to be approximately $422 million. In comparison to the first quarter this number was a product of substantially lower volume of admits and recerts offset by higher completed episodes and higher revenue per episode. . . .
>
> Based on our second-quarter performance we are today suspending our previous annual guidance.

224. Amedisys COO Michael Snow added that:

> As you have heard, our operating performance in the second quarter was very disappointing driven primarily by earnings declines in the home care division. . . . [T]he results of this quarter are a bit of a wake-up call. . . .

225. Amedisys's second quarter operating results were substantially below expectations because, in the wake of the April 26 *WSJ* article and the Senate Finance Committee and SEC investigations, the Company was now under regulatory scrutiny and was forced to adopt much more conservative (and less lucrative) business practices.

226. On July 13, 2010, as a result of the negative news the previous day regarding the Company's drop in revenue and profit, Amedisys's stock price dropped a statistically significant 24.13%, or $8.45, to close at $26.57 on heavy trading volume of approximately 10.3 million shares (which was more than 15.7 times the prior day's volume). However, the July 12, 2010 disclosures were only partial, and accordingly Defendants' fraud continued.

227. During a 10:00 a.m. Amedisys conference call held on August 9, 2010 to discuss second quarter earnings, COO Michael Snow admitted that one of the factors in the decline in the recertification rates was related to "external factors" relating to the investigations that had been announced during the second quarter of 2010. Starting with this conference call, Amedisys began using the euphemism of "external factors" and "behavioral" to describe how Amedisys clinicians and employees were adopting more conservative (and less lucrative) business practices:

> And third, finally, we can't ignore the impact of external factors. These distractions contributed to our volume weakness, particularly in the utilization of therapy. And of course, if therapy utilization declines, our revenue per episode will be negatively impacted and it's unclear whether these factors will abate in the near-term.

228. Later in the same call, Defendant Borne responded to a question from analyst Sheryl Skolnick from CRT Capital Group asking for more detail on why there was such a steep decline in the recertification rate during the second quarter:

> Skolnick: I guess I'm worried about whether it's the behavior of the clinicians not seeking recerts, whether there was something in the compliance training you mentioned that might have scared them into doing something differently than they had done before and what, if anything, you're doing to address and determine those issues as opposed to just putting it in the basket of changes in behavior and outside influence and therefore not something the company can do anything about.
>
> Borne: Yeah, Sheryl. You got it. You nailed it. We have cut this result nine ways to Sunday and in the absence of other factual patterns, we have to put it under behavioral. And as much as we have gone out to provide assurances to our clinicians that we got to take care of patients because this outcome is unexplainable. And so we've gone out, as I said, do the right things for the patients every time, and so – but I cannot explain why we had the precipitous drop in June….

229. In a June 11, 2010 internal Amedisys email to his Regional Specialty Directors, Daniel Miller (Regional Director of Rehab Specialty Programs for the Georgia region) attempted to address what he perceived as a decrease in the number of therapy visits being performed as a result of the WSJ Article and the government inquiries. He noted that (Maffit ¶39):

> [y]ou know that there has been a large change in the number of recertifications across the company. There has also been an overall trend in therapy visit numbers decreasing.

> Any time there is a large shift in business patterns, we will try to drill down to determine what has caused that trend....
>
> There are some areas of concern that we want to make sure we can address right away, so I am asking you all to let me know if these issues are being noticed with your clinicians.
>
> Have you seen a trend of decreased visits scheduled due to recent audits? Have you seen a trend of decreased recerts due to recent audits, documentation reviews, etc?
>
> Have your clinicians expressed a fear of doing too many visits due to audits, documentation requirements, etc?
>
> Have you heard anyone express a desire to change practice patterns due to recent issues with the Senate inquiry?

230. The "overall trend in therapy visit numbers decreasing" referenced by Miller was a function of Amedisys therapists realizing that the number of therapy visits they had been performing in accordance with Amedisys's directions was unrelated to actual patient need. Miller's email to his RSDs was part of an effort to convince therapists to go back to their former patterns, and to perform visits in accordance with Amedisys policy, rather than in accordance with the therapists' professional judgment as to the patients' needs. Maffit ¶40.

231. On September 28, 2010, Amedisys issued a press release disclosing that it had received a civil investigative demand ("CID") from the U.S. Attorney's Office for the Northern District of Alabama "pursuant to the federal False Claims Act." The CID asked for a wide range of documents and information related to the Company's "clinical and business operations, including reimbursement and billing claims submitted to Medicare." As the *WSJ* noted when it reported on the announcement, if a company is found to have submitted a false claim to a federal agency, like Medicare, it could be liable for damages, plus $5,500 to $11,000 for each of the claims, and also lose its ability to do business with Medicare.

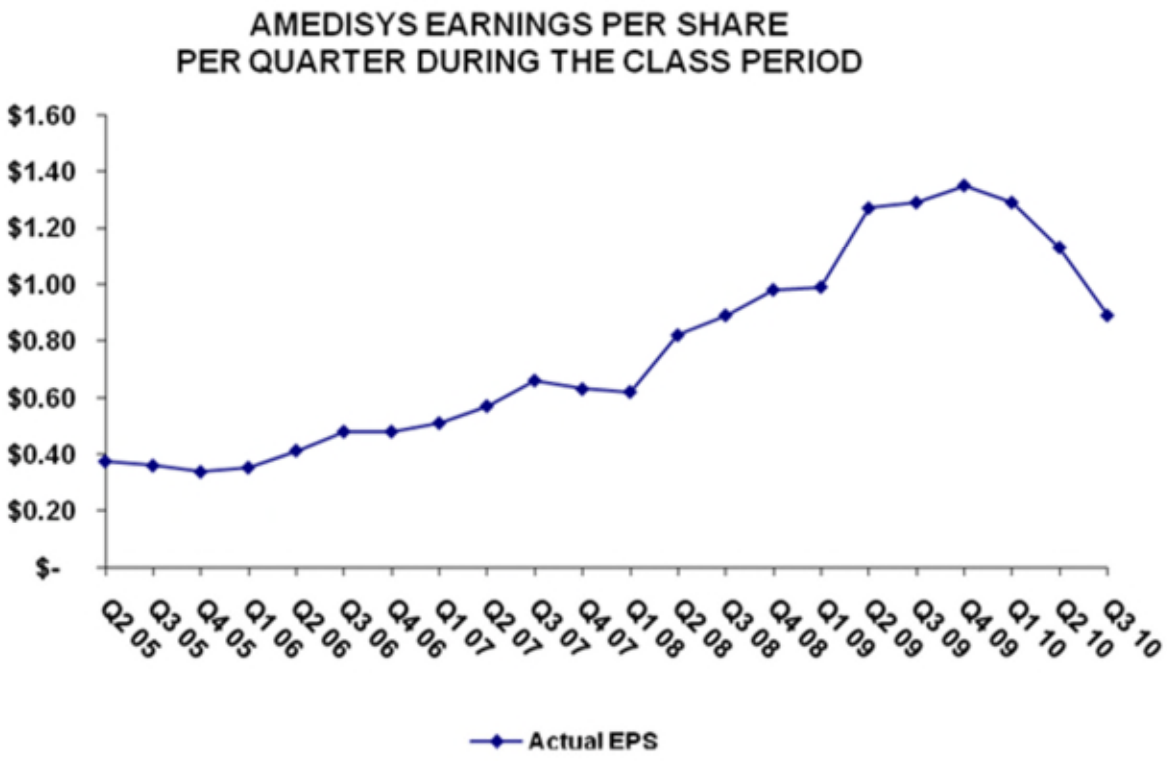
232. On September 28, 2010, as a result of the negative news regarding the DOJ's investigation of the Company, Amedisys's stock price dropped a statistically significant 15.51%, or

$4.41, to close at $24.02 on heavy trading volume of 3.36 million shares (which was more than 5.7 times the prior day's volume).

233. During the JPM Securities Healthcare Conference held on September 28, 2010, Defendant Borne addressed the decline in recertification rates that Amedisys had experienced in the second quarter, noting "we saw a lot of things that we couldn't explain except with Behavioral and some of that has to be the noise from Senate Finance Committee and SEC and *Wall Street Journal* articles and things like that."

234. On October 26, 2010, Amedisys released its operating results for the quarter ending September 30, 2010. Amedisys's results for 1Q10 revealed the extent to which Amedisys's adoption of more conservative business practices – in the wake of the events alleged above and in lieu of its past manipulative practices – adversely affected its reported revenue and earnings. That quarter was the first full quarter after publication of the *WSJ* article and the commencement of the Senate and SEC investigations. Given the increased public scrutiny and Amedisys's inability to continue to manipulate the Medicare payment system, Amedisys reported a 39.8% (or $14.3 million) reduction in net income for the third quarter of 2010 (compared to the third quarter of the prior year) to $21.6 million, and a 41% reduction in quarterly earnings per share from $1.29 to $0.76.

235. Moreover, the following graph shows the Company's reported earnings per share for each quarter of the Class Period, during which Amedisys reported record profits, until various partial disclosures concerning Amedisys's business operations began to enter the market in 2010:



236. On October 26, 2010 at 10:00 a.m., Amedisys hosted a conference call to discuss third quarter 2010 earnings. During the call, COO Michael Snow replied to a question from Whit Mayo with Robert Baird asking for additional insight into the recertification trends, noting that much of the change was "behavioral":

> Here is the long and short of it is as we went back and I think as we described in our calls earlier in the year, we tried to do analytics to try to get to the fundamentals of the change in research, and frankly where we kind of landed is primarily behavioral. So whether it's from external factors or a combination of some of the internal education we did, that just kind of laid in the lap of behavioral change.

237. Amedisys's use of the term "behavioral" as a euphemism for the behavior of the clinicians and their employees to no longer violate Medicare reimbursement regulations was not lost on the analysts. For example, later in the October 26, 2010 conference call, Sheryl Skolnick questioned why Amedisys employees would feel the need to change their behavior:

> But I am very concerned here. The number of visits per episode is up, okay. The acuity is down, and you're facing a significant price compression next year, which one

> of my colleagues I think adeptly pointed out gives you fewer arrows in the quiver to offset this. There is a behavioral change that's been undertaken by your clinicians, which – okay, that's an explanation, but why they felt the need to change their behavior is still a question. And where I am going with this is why should I not be worried that all of these changes in pattern, the drop in acuity, the drop in research, the change in behavior, the compression of price, why doesn't that add up to something that would make the DOJ ask questions?

238. In addition, on November 3, 2010, during the Oppenheimer Healthcare Conference, Defendant Borne again addressed the decline in recertification rates that Amedisys experienced, noting "But as we had this drop off which we think is behavioral, we hired an outside firm, OCS, to take a look at some of the dynamics around the drop off we saw at the end of the second quarter in recertifications, and [the] only thing we can attribute it to is actual behavioral response from some of the noise we had, from some of the investigations or inquiries that were open."

239. Because presumably Amedisys continued providing patients with medically appropriate care during 2010, the only plausible explanation for the Company's drop-off in earnings is that Amedisys ceased providing patients with medically *unnecessary* care.

240. On August 2, 2011, prior to the opening of trading on U.S. stock markets, Amedisys issued a press release reporting its operating results for the quarter ended June 30, 2011. Amedisys's results were a significant decline from the same period the prior year, and further revealed how government investigations, and changes in the regulatory environment, responding to Amedisys's manipulation of the Medicare system, had adversely affected Amedisys's reported and projected operating results.

241. For the three month period ended June 30, 2011, Amedisys reported net service revenue of $373.7 million compared to $422.3 million for the same period in 2010, a decrease of $48.6 million or 11.5%. Net income was reported for the quarter of $21.7 million compared to $32.2 million in 2010, a decrease of $10.5 or 32.7%.

242. The press release further reported that Amedisys had reduced its "net service revenue"

guidance for 2011 from a range of $1.6 billion to $1.65 billion (issued on February 22, 2011 and re-affirmed on April 26, 2011) to a range of $1.475 billion to $1.5 billion, and reduced Amedisys's 2011 diluted earnings per share guidance from a range of $3.00 to $3.30 per share to a range of $2.20 to $2.40 per share, based on an estimated 29.3 million shares outstanding.

243. Defendant Borne was quoted in the press release, stating "[r]egulatory changes mainly in our home health division have had a dampening impact on volume and pricing resulting in our downward adjustment to guidance for the year."

244. Amedisys's Form 10-Q for the Second Quarter of 2011 (signed by defendant Redman and certified by defendants Redman and Borne) further disclosed that Amedisys's revenue was "negatively impacted by the CMS face-to-face requirements, which became effective April 1, 2011."

245. The new regulations promulgated by CMS that impacted Amedisys's second quarter operations and projections were driven by the need to reduce fraud and abuse of the Medicare PPS, the very conduct Amedisys that was being investigated by the Senate Finance Committee. These new regulations required that Amedisys make assessments of patient progress on the thirteenth and nineteenth therapy visit and that physicians certify patient therapy needs in face-to-face meetings.

246. On August 2, 2011, as a result of the negative news regarding the Company's revenue and profit, Amedisys's stock price dropped $2.06, to close at $22.60 on heaving trading volume of approximately 2.95 million shares (which was almost five times the prior day's volume).

247. In the seven trading days starting on August 2, 2011 and extending through August 10, 2011, Amedisys's common shares fell in the aggregate by $8.65 per share (or approximately 35%) to close on August 10, 2011 at $16.01 per share, on higher than average trading volume of approximately 1.4 million shares.

248. On October 3, 2011, prior to the opening of the U.S. securities markets, the Senate Finance Committee released the Senate Report, which analyzed the business practices of Amedisys

and three other home health care companies (LHC Group, Gentiva and Almost Family). As stated in the Senate Report, the Senate Finance Committee has "the responsibility to monitor payments made by [CMS] for home health services in order to protect taxpayer dollars from waste, fraud, and abuse."

249. In a joint press release dated October 3, 2011 accompanying the Senate Report, Baucus and Grassley stated that the "staff report show[ed] tactics used by [the] major for-profit home health companies to game Medicare" and that "[i]nternal documents from [Amedisys] provided evidence of top-down strategies to game Medicare." As stated:

> "The gaming of Medicare represents serious abuse of the home health program," said Baucus. "Elderly patients in the Medicare system should not be used as pawns to increase a company's profits. Especially in these tough economic times, taxpayers simply cannot afford for their dollars to be wasted on unnecessary care. We are going to continue to crack down on these companies to ensure taxpayer dollars are used efficiently and Medicare patients are protected." "The reimbursement policy encourages gaming, and gaming is what's occurred. Companies are doing everything they can to make as much money as possible, whether the patients need the care or not.

250. The Senate Report also noted that the April 2010 *WSJ* article discussed above had previously raised serious concerns that home health companies "were taking advantage of the Medicare therapy payment system by providing medically unnecessary patient care," and that the Committee had initiated its inquiry into home health therapy practices at Amedisys, LHC Group, Gentiva, and Almost Family (the four largest publicly traded home health companies) as a result of the revelations contained in the *WSJ* article.

251. The Senate Report stated that it had reviewed documents provided by the various companies it had investigated, and concluded that "Amedisys, LHC Group, and Gentiva encouraged therapists to target the most profitable number of therapy visits, even when patient need alone may not have justified such patterns."

252. Further, the Senate Report stated that "[t]herapy visit records for each company showed concentrated numbers of therapy visits at or just above the point at which a 'bonus' payment

was triggered in the prospective payment system (PPS)." However, as with the *WSJ*'s earlier article, the Senate Report directed its most critical comments and concerns squarely at Amedisys. For example, the Senate Report devoted over six pages of text to its analysis of evidence indicative of improper billing practices at Amedisys, compared to less than a page on Almost Family. The Senate Report effectively exonerated Almost Family, finding that "none of the documents provided to the Committee by Almost Family show that [its] executives ever pushed therapists to target [Medicare visit] thresholds or pursue more profitable clinical regimens." Senate Report at 27. In sharp contrast, as to Amedisys, the Senate Report found (as further described in ¶ 76, *infra*), that:

> A review of internal documents and communications provided to the Committee by Amedisys shows that Amedisys management directed employees to adjust the number of home health therapy visits to maximize Medicare payout[s] to the company after the 2008 changes to the Medicare payment system. *Id*. at 9.

253. Confirming Lead Plaintiffs' allegations, the Senate Report found that "the home health therapy practices identified at Amedisys…at best represent abuses of the Medicare home health program. At worst, they may be examples of [Amedisys] defrauding the Medicare home health program at the expense of taxpayers." *Id*. at 2. The Senate Report reached similar conclusions regarding LHC Group and Gentiva – but not Almost Family.

254. Further, the Senate Report confirmed that, prior to the 2008 changes to the Medicare payment system, Amedisys grouped the number of therapy visits per episode at or slightly above 10 to maximize Medicare payout to the company. *Id*. at 9-10. Thus, in 2007, 9.1 percent of Amedisys's therapy episodes received 10 visits, while 2.9 percent of the therapy episodes received 9 visits. *Id*. at 10. According to Figure 11 of the Report, in 2007, 33% of Amedisys's episodes achieved 10-13 therapy visits, whereas in 2008, only 18.8% of episodes achieved 10-13 therapy visits, which further confirms Lead Plaintiffs' allegations set forth above.

255. The Senate Report also concluded that "[i]nternal documents from Amedisys show that, prior to the 2008 CMS therapy payment changes, managers were encouraged to meet the 10-

visit therapy threshold" (*id*. at 1), and that Amedisys's distribution of therapy visits prior to the 2008 changes to the Medicare payment system was not "not suprising given the employee training materials in circulation at the time." *Id*. at 11. For example, the Senate Report found that a 2006 PowerPoint presentation appended to the Report had instructed Amedisys' DOOs to "Look for patients that have 7, 8, 9 visits and try to get the 10 visits to make therapy threshold." *Id*. at 11, n. 21, and 46. The same presentation also "encouraged" DOOs to use an "Adjusted Revenue Report 'to identify patients that have had or will have revenue adjustments made to the expected payment amount…. This report gives you the best opportunity to convert or prevent [LUPA patients] and non therapy threshold patients.'" *Id*.

256. According to the Senate Report "Amedisys pressured therapists and regional managers to new clinical guidelines developed to maximize Medicare reimbursement" (*id*. at 1); "Amedisys's corporate management saw the proposed 2008 CMS PPS changes as an opportunity to increase its reimbursements from Medicare by altering internal clinical and marketing practices." *Id*. at 11. In fact, based upon documents and communications provided to the Senate Finance Committee, the Committee concluded that "Amedisys management directed employees to adjust the number of home health therapy visits to maximize Medicare payout to the company after the 2008 changes to the Medicare payment system." *Id*. at 9. The Senate Report referenced an internal Amedisys document entitled "Amedisys Strategic Planning, Executive Summary," presented to Amedisys's Board of Directors on July 24 and 25, 2007, that according to the Senate Report "outline[d] Amedisys CEO Bill Borne's strategic plan … that the proposed changes in the 2008 home health PPS system 'provides an opportunity for Amedisys to refine internal practices in order to enhance shareholder value despite the payment changes.'" *See id.* at 11, n.25, 166. Amedisys corporate management also set up an "A-Team" to "develop[] therapy programs after the release of the 2008 proposed PPS changes to target the most profitable Medicare therapy treatment patterns, including adding therapy

visits to clinical tracks that previously did not involve therapy." *Id.* at 1. Information concerning the A-Team's formation and purpose was reported to the Amedisys Board of Directors by Defendant Schwartz on July 24, 2007 (*id*. at 162) and October 25, 2007 (*id*. at 177 and 181-84). Defendants Borne, Redman, and Graham attended these Board meetings, and Defendant Jeter attended these Board meetings via teleconference. *Id*. at 158 and 174.

257. The Senate Report concluded that Amedisys created therapy based programs to boost Amedisys's revenue under the 2008 CMS PPS changes. *See id.* at 12-13. For example,

(a) talking points for a June 13, 2007 conference call "regarding the proposed PPS changes contained a strategy for 'Clinical Development,' which included 'Data Mining of most profitable/least profitable diagnoses and the financial impact….Develop an infrastructure to track monthly percentage growth in desirable cases…Recommendations of new programs with conceptual framework submitted based on analysis/data mining" (at 12, fn.27 and 185-190 at 189). The June 8, 2007 email distributing these talking points also included a document titled "Data Mining Strategies," which

> ranked medical diagnoses by average profit per episode. The document laid out a comprehensive strategy to increase therapy visits for certain therapy episodes that were beneath key thresholds, adding therapy visits into nontherapy episodes, and substituting physical therapy for skilled nursing visits. The document stated that a therapy based wound care program in which ''[physical therapy] replaces [skilled nursing] visits in wound care episodes w/o therapy'' would bring an "Added Revenue" of "$1,400,000."

Id. at 12 and fn.28, 185-190 at 187. The June 8, 2007 email distributing the talking points and the Data Mining Strategies document was received by Defendant Graham and Defendant Schwartz, and Amedisys Senior Vice President Jill Cannon (to whom Cheryl Lacey reported during the Class Period, and who reported to Graham and Borne during the Class Period). *Id.* at n.28, 186.

(b) An August 2007 Amedisys training document stated "[i]f we added only 6 Therapy visits to 3% of [congestive heart failure] patients who are F2F3 but received no therapy—8809 episodes, net to company almost half a million. Imagine what the revenue for the agencies will be!" *Id.* at 12. This training document was sent to Jill Cannon prior to its use. *Id.* at n.29, 192.

(c) A September 2007 "PowerPoint presentation introducing Amedisys's 'therapy wound care initiative,' which added physical therapy visits to home health episodes, noted that treating a wound care patient with 14 and 20 physical therapy visits would more than double the company's Medicare reimbursement for the episode in two examples. One example explained that the 2008 Medicare reimbursement without therapy services would be

$2,908.13, as opposed to $6,011.67 with 14 physical therapy visits under the new system." *Id.* at 12-13, n.32, 232-263.

(d) A document titled "Therapy Initiatives Update" was distributed for use on an August 31, 2007 A-Team Case Mix Committee conference call. "The document indicates that the average HHRG for Balanced for Life reimbursement was $4,100 in 2007. In 2008, the document noted a projected HHRG reimbursement increase to $4,700 because occupational therapy was added to the Balanced for Life program." *Id.* at 13. Defendant Schwartz's Administrative Assistant distributed the "Therapy Initiatives Update" to the A-Team group, including Defendants Borne, Schwartz, and Redman, as well as Jill Cannon, Cheryl Lacey. *Id.* at n.34, 286-288.

(e) An October 2007 Excel spreadsheet, which was "used to track tasks of the 'A-Team' committee," revealed that "Amedisys management decided, as part of its clinical strategy, to incorporate 'therapy into [the congestive heart failure] program' and institute 'Aggressive [Balanced for Life] and multi-disciplinary therapy program launches in 2008.'" *Id.* at 13, n.33, 264-285. This spreadsheet was distributed by Defendant Schwartz's executive assistant to a group including Defendant Schwartz, Cheryl Lacey, Jill Cannon, and Tasha Mears. *Id.* at n.33, 265.

258. The Senate Report also concluded that Amedisys altered patient care guidelines to hit the 2008 therapy thresholds. "Amedisys altered its clinical recommendations for the number of therapy visits, known as ''clinical tracks,'' as a result of the CMS payment changes in 2008. The new clinical tracks correspond to the new payment thresholds." *Id.* at 13. For example, prior to the 2008 changes, Amedisys's "'Better Balance At Home' and 'Better Strength At Home' programs had a recommended 3 to 12 therapy visits." *Id.* However, Amedisys's clinical recommendations changed after CMS implemented its payment changes in 2008. "Instead of the number of visits being in the 3 to 12 range, the new visit range for 'Rehabilitation @ Home' became 8, 16, or 22 visits. All 3 of these visit tracks were 2 visits above each therapy payment threshold. *Id.* Further, the Senate Report concluded that "Amedisys excutives pressured employees to reach specific therapy payment threholds" *Id.*

259. In support of its conclusions, the Senate Report referred to numerous documents and instances in which Amedisys senior executives pushed therapists to target payment thresholds or pursue more profitable clinical regimens, confirming the allegations of Plaintiffs' CWs. *See, e.g.*,

Senate Report at 12-15. The Senate Report was the first time investors and stock analysts were exposed to internal documents that demonstrated that Amedisys was "gaming" the health care system.

260. As analysts and investors obtained, reviewed and interpreted the Senate Report and the Company's responses to it, investors began to react to the revelations in the Senate Finance Committee Press Release and Senate Report concerning this further news about Amedisys. For example, an analyst from CRT Capital Group issued a report concluding that Amedisys (as well as LHC Group) might well face criminal liability. The same CRT report downgraded Amedisys to "sell" from "fairly valued," with a price target of only $8.00 per share. The analyst from CRT Group was quoted in a news report saying that "the 670-page report from the Senate committee offered a mountain of evidence in the form of emails and other documents" showing Amedisys and two other companies did participate in the practice originally exposed by the *WSJ* on April 26, 2010. Deutsche Bank also downgraded Amedisys to "hold" from "buy," with a price target of $15 (down from $28).

261. In reaction to the release of the Senate Report, the price of Amedisys's common stock also plunged by roughly 10% on October 3, 2011 falling to $13.40 a share on heavy trading volume. On October 4, 2011, Amedisys's stock price fell precipitously again to hit an 8-year low, falling an additional 14% to close at $11.53 – this time on even heavier trading volume than the October 3 stock price drop. The declines on both dates were statistically significant.

262. In contrast, Almost Family, which was exonerated of wrongdoing in the Senate Report, saw its stock price initially fall on October 3, 2011 but then quickly rebounded on October 4, 2011 to close at $16.77 a share – $0.14 a share ***above*** its closing price on Friday, September 30, 2012.

263. On November 1, 2011, less than one month after release of the Senate Report, Amedisys announced that COO Michael Snow was leaving the Company, and that Defendant (and CFO at the time) Dale Redman would transition to the role of Executive Vice President and Treasurer in anticipation of his retirement in the first quarter of 2012.

VII. DEFENDANTS' MATERIALLY FALSE AND MISLEADING STATEMENTS MADE DURING THE CLASS PERIOD

264. During the Class Period, Defendants made a series of materially false and misleading statements that concealed Defendants' improper practices and artificially inflated the value of Amedisys's publicly-traded securities. Among other things, Defendants made statements concerning Amedisys's financial results, including *inter alia* the Company's income, revenue, retained earnings and earnings per share, which were materially false and misleading due to Defendants' scheme to improperly manipulate the Medicare reimbursement system, as alleged herein. These misstatements were particularly material to investors given that the Company's revenue is tied almost exclusively to Medicare reimbursements – indeed, according to Amedisys's public filings, Medicare payments represented approximately 93%, 93%, 89%, 87%, 88%, and 86% of the Company's revenue in 2005, 2006, 2007, 2008, 2009, and 2010, respectively. Amedisys would swiftly cease to operate if the Company were unable to receive Medicare reimbursements. Defendants also made statements during the Class Period concerning the Company's compliance with federal, state and local laws and regulations, which were materially false and misleading due to Defendants' scheme to improperly manipulate the Medicare reimbursement system. Defendants' materially false and misleading statements are discussed in greater detail below.

A. Second Quarter 2005

265. On August 2, 2005 (the first day of the Class Period), at 7:00 a.m., Amedisys issued a press release, signed by Defendant Browne, announcing record earnings and revenue for the second quarter of 2005.[21] Defendants stated in the press release:

> For the quarter ended June 30, 2005, the Company reported net income of $7.9 million, or $0.50 per diluted share, on record net service revenue of $80.1 million. Net service

[21] Quarterly financial results are announced retrospectively – so a company's second quarter financial results are announced in the third quarter, third quarter results are announced in the fourth quarter, and so on.

> revenue increased by 41% when compared with the $56.9 million reported for the comparable period in the prior year.

In this press release, Defendant Borne also touted Amedisys's record financial results:

> "Our continued commitment to both organic growth and selective acquisitions has resulted in the achievement of record quarterly revenue and earnings per share, as well as a significant increase in net income," noted William F. Borne, Chief Executive Officer of Amedisys.

266. Also on August 2, 2005, Amedisys held a conference call discussing its earnings for the second quarter of 2005. During the conference call, Defendant Graham repeated the above information concerning Amedisys's second quarter 2005 financial results.

267. On August 9, 2005, Amedisys issued its Form 10-Q for the second quarter of 2005 (the "2Q05 10-Q"), signed by Defendant Browne, which repeated the above information concerning Amedisys's second quarter 2005 financial results. Amedisys's 2Q0510-Q also reported the Company's retained earnings of $31,491,000.

268. Further, the 2Q05 10-Q included certifications from Defendants Borne and Browne who both certified, among other things, that:

- [the 2Q05 10-Q] does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this quarterly report.

- the financial statements, and other financial information included in [the 2Q05 10-Q], fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this quarterly report;

Defendants Borne and Browne also certified that they had disclosed to the Company's auditors and its audit committee, "[a]ll significant deficiencies and material weaknesses in the design or operation of internal controls over financial reporting…" and "[a]ny fraud, whether or not material, that involves management or other employees who have a significant role in [Amedisys's] internal control over financial reporting." Further, Defendants Borne and Browne certified that the 2Q05 10-Q

complied with the Exchange Act and that "[t]he information contained in the [2Q05 10-Q] fairly presents, in all material respects, the financial condition and result of operations of the Company.

269. The above statements were materially false and misleading when made because, among other things:

(a) the statements concerning Amedisys's financial results, including revenue, income, earnings per share and retained earnings, and the purported reasons behind those increases, failed to disclose that they were materially and artificially inflated as a result of Defendants' improper manipulations of the Medicare reimbursement system, as described herein; and

(b) when signing the above-described certifications, Defendants Borne and Browne knew about or recklessly disregarded, and failed to disclose, Defendants' fraudulent scheme to improperly manipulate the Medicare reimbursement system, as described herein.

B. Third Quarter 2005

270. At 8:01 a.m. on November 1, 2005, Amedisys issued a press release, signed by Defendant Browne, reporting its financial results for the third quarter of 2005. In this press release, the Company emphasized its "record quarterly revenue," stating:

> For the quarter ended September 30, 2005, the Company reported net income of $7.8 million, or $0.48 per diluted share, on record net service revenue of $112.2 million. Net service revenue increased by 92 percent when compared with the $58.5 million reported for the comparable period in the prior year. […]

271. Also on November 1, 2005, beginning at or about 10:00 a.m., Amedisys held a conference call discussing its earnings for the third quarter of 2005. During the conference call, Defendant Browne repeated the above information concerning Amedisys's third quarter 2005 financial results.

272. On November 7, 2005, Amedisys filed a Form 8-K with the SEC to which was attached an investor presentation, signed by Defendant Browne, touting Amedisys's "increasing revenue," "expanded margins," and "EPS growth." Further, the investor presentation, among other things, repeated Amedisys's 2005 third quarter financial results, as described above.

273. On November 9, 2005, Amedisys filed its Form 10-Q for the third quarter ended September 30, 2005 (the "3Q05 10-Q"), signed by Defendant Browne, which again repeated the above information concerning Amedisys's third quarter 2005 financial results. Amedisys's 3Q05 10-Q also reported the Company's retained earnings of $39,251,000. Further, Defendants Borne and Browne provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 3Q05 10-Q.

274. On February 13, 2006, Amedisys filed a Form 8-K with the SEC to which was attached an investor presentation touting Amedisys's "increasing revenue," "expanded margins," and "EPS growth." Further, the investor presentation, among other things, repeated Amedisys's 2005 third quarter financial results, as described above.

275. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269.

C. Fourth Quarter and Year-End 2005

276. At 6:00 p.m. on February 22, 2006, Amedisys reported its fourth quarter 2005 and 2005 year-end financial results. In the earnings release, signed by Defendant Borne, Amedisys announced:

> For the year ended December 31, 2005, the Company reported net income of $30.1 million, or $1.88 per diluted share, on net service revenue of $381.6 million. […] For the quarter ended December 31, 2005, the Company reported net income of $7.3 million, or $0.45 per diluted share, on record net service revenue of $118.9 million. Net service revenue increased 85 percent when compared with the $64.4 million reported for the comparable period in the prior year.

In this earnings release, Defendant Borne stated that "fiscal 2005 represented the strongest net income and service revenue in Amedisys' history" and further touted Amedisys's performance by stating:

> Our results, both for the quarter and the full year, are indicative of Amedisys' continued solid top-line growth, which has been a critical driver in the Company's ability to deliver strong earnings growth over the last three years […] Amedisys reported an increase for the year ended December 31, 2005 in net service revenue of 68 percent, and in net income of approximately 47 percent, when compared with the prior year. Our results are due, in part, to the continued strong internal growth of Medicare admissions. This growth rate was approximately 16 percent for the fourth quarter, and 18 percent for the year, and reflects the significant efforts made by all of our field staff towards further enhancing the clinical reputation of the Company.

277. At 10:00 a.m., on February 23, 2006, Amedisys held a conference call to discuss the Company's fourth quarter and year end 2005 earnings. During this conference call, Defendant Borne stated that the Company's "…revenue growth was 68 percent for the past year, our net income grew by 50 percent, and our earnings per share grew by 25 percent." Also on the conference call, Defendant Browne repeated the above information concerning Amedisys's fourth quarter and year end 2005 earnings and elaborated on those financial results, stating:

> Our revenues of 183.9 million represent an increase of 85% on 2004, and reflect continued strong internal growth… […] For the year, our revenues of 380 [*i.e.*, million] …, the 1.6 million [sic], represents an increase of 154.4 million or 68 percent on the previous year. […] Our net income for the quarter of 7.3 million or 45 cents per diluted share, compares with 6.1 million or 39 cents per share in the fourth quarter of 2004. And for the 12 months ended December our net income was 30.1 million, an increase of 47 percent when compared with the 20.5 million recorded in 2004.

278. On March 1, 2006, Amedisys filed a Form 8-K with the SEC, signed by Defendant Browne, to which was attached an investor presentation touting Amedisys's "increasing revenue," "expanded margins," and "EPS growth." Further, the investor presentation, among other things, repeated Amedisys's fourth quarter and year-end 2005 financial results, as described above.

279. On March 16, 2006, Amedisys filed its Form 10-K for the year ended December 31, 2005 (the "2005 10-K"), signed by Defendants Borne and Browne, which repeated the above information concerning Amedisys's fourth quarter and year-end 2005 financial results and also reported retained earnings of $46,552,000. Amedisys's 2005 10-K also incorporated the investor presentation slides filed with Amedisys's Form 8-Ks filed on March 1, 2006, February 13, 2006 and

November 7, 2005 (described above).

280. In addition, Defendants Borne and Browne provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2005 10-K.

281. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269.

D. First Quarter 2006

282. On May 2, 2006, at 8:01 a.m., Amedisys issued a press release, signed by Defendant Browne, announcing record earnings for the first quarter of 2006. The Company's press release stated:

> For the quarter ended March 31, 2006, the Company reported quarterly net income of $7.3 million, or $0.45 per diluted share, on record quarterly net service revenue of $127.2 million. Net service revenue increased by 81 percent when compared with the $70.4 million reported for the comparable period in the prior year.

In the press release, Defendant Borne also touted the Company's "record quarterly revenue" as being "indicative of … the continued significant demand for our services." Further, Defendant Borne stated "[i]n particular, we have continued to deliver strong internal growth in Medicare admissions."

283. Also on May 2, 2006, beginning at 10:00 a.m., Amedisys held a conference call discussing the Company's first quarter 2006 earnings. During this conference call, Defendant Borne touted the Company's "top line revenue growth" and "strong compliance program." In addition, on the call, Defendant Browne repeated the above information concerning Amedisy's first quarter 2006 financial results. Further, Defendant Browne stated that Amedisys "recorded revenue per episode of $2,649 in the first quarter, an increase of approximately 2.3 percent over the first quarter of 2005 of $2,587."

284. Also on May 2, 2006, Amedisys filed its Form 10-Q for the first quarter ended March

31, 2006 (the "1Q06 10-Q"), signed by Defendant Browne, which repeated the above information concerning Amedisys's first quarter 2006 financial results. Amedisys's 1Q06 10-Q also reported retained earnings of $53,836,000. Further, Defendants Borne and Browne provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 1Q06 10-Q.

285. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269. Moreover, the statements concerning Amedisys's earnings per share and retained earnings increases, and the purported reasons behind those increases, including "significant demand for our services" and a "strong compliance program," failed to disclose that Amedisys's financial results were materially and artificially inflated as a result of Defendants' improper manipulations of the Medicare reimbursement system, and that Amedisys lacked adequate compliance controls.

E. Second Quarter 2006

286. On August 1, 2006 at 8:01 a.m., Amedisys issued its earnings release for the second quarter of 2006. In this press release, the Company emphasized its "record quarterly net income," stating:

> For the quarter ended June 30, 2006, the Company reported record quarterly net income of $9.1 million, or $0.55 per diluted share, on record quarterly net service revenue of $132.9 million. Net service revenue increased by 66 percent when compared with the $80.1 million reported for the comparable period in the prior year.

In this press release, Defendant Borne also touted the Company's "strong revenue growth."

287. Also on August 1, 2006, starting at around 10:00 a.m., Amedisys hosted a conference call concerning its "record second quarter results." During the conference call, Amedisys's Principal Accounting Officer and Treasurer Donald Loverich, Jr., repeated the above financial information concerning Amedisys's second quarter 2006 financial results.

288. Also on August 1, 2006, Amedisys issued its Form 10-Q for the second quarter of

2006 (the "2Q06 10-Q"), which again repeated the above financial information concerning Amedisys's second quarter 2006 financial results. Amedisys's 2Q06 10-Q also reported the Company's retained earnings of $62,889,000. Further, Defendant Borne and Amedisys's Principal Accounting Officer and Treasurer Donald Loverich, Jr., provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2Q06 10-Q.

289. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269.

F. Third Quarter 2006

290. On October 25, 2006, at 8:00 a.m., Amedisys issued its earnings release for the third quarter of 2006. In this press release, the Company again broadcast its "record quarterly net income," stating:

> For the quarter ended September 30, 2006, the Company reported record quarterly net income of $10.6 million, or $0.64 per diluted share, a 33 percent increase in earnings per share over the same quarter last year. These earnings were achieved on record quarterly net service revenue of $137.0 million. Net service revenue increased by 22 percent when compared with the $112.2 million reported for the comparable period in the prior year. […]

In the press release Defendant Borne touted the Company's "improved operating results" and "continuing strong internal growth" among other things to "drive earnings and enhance shareholder returns."

291. Also on October 25, 2006, starting at 10:00 a.m., Amedisys hosted a conference call discussing its earnings for the third quarter of 2006. During the conference call, Amedisys's Principal Accounting Officer and Treasurer Donald Loverich Jr. repeated the above information concerning Amedisys's third quarter 2006 financial results. Further, during the call Defendant Borne discussed the Company's new "Point-of-Care" system noting that it would "enhance [the Company's] compliance efforts by mandating and standardizing documentation while validating clinical necessity

for all care provided."

292. Also on October 25, 2006, Amedisys filed its Form 10-Q for the third quarter of 2006 (the "3Q06 10-Q"), which again repeated the above information concerning Amedisys's third quarter 2006 financial results. Amedisys's 3Q06 10-Q also reported the Company's retained earnings of $73,448,000. Further, Defendant Borne and Amedisys's Principal Accounting Officer and Treasurer provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 3Q06 10-Q.

293. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269. Moreover, the statements concerning Amedisys's "continuing strong internal growth," failed to disclose that Amedisys's earnings were materially and artificially inflated as a result of Defendants' improper manipulations of the Medicare reimbursement system, as described herein, rather than "continuing strong internal growth." In addition, the Point-of-Care system did not enhance the Company's compliance efforts or validate "clinical necessity for all care provided," and Amedisys lacked adequate compliance controls.

G. Fourth Quarter and Year-End 2006

294. On February 20, 2007, at 7:00 a.m., Amedisys issued its earnings release for the fourth quarter and year end 2006. The press release stated:

> For the year ended December 31, 2006, the Company reported record net income of $38.3 million, or $1.72 per diluted share, on record net service revenue of $541.1 million. […]
>
> For the quarter ended December 31, 2006, the Company reported record quarterly net income of $11.4 million, or $0.48 per diluted share, on record quarterly net service revenue of $144.0 million.

In this press release, Defendant Borne touted "yet another year of record revenues and record net income." Defendant Borne also highlighted to investors that the Company's "earnings per share have

grown over 20 percent in each of the past four years." In this press release, the Company also announced the resignation of Defendant Giblin after only four short months of working at the Company.

295. Also on February 20, 2007, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's financial results for the fourth quarter and year end of 2006. In commenting on the record results for the year Defendant Borne touted the Company's accomplishments, stating:

> We posted record revenues and record earnings per share for 2006… Our revenues doubled in the past 24 months as a result of both internal growth and acquisitions, and our net income has nearly doubled over the same period.

Defendant Giblin repeated the above information concerning Amedisys's financial results for the fourth quarter and year end of 2006 and offered the following statements elaborating on that financial information:

> Our fourth quarter revenues grew nearly 21% over the 2005 fourth quarter to a quarterly record $144 million on a 29% increase in completed episodes of Care. […]
>
> Revenue per episode totaled [$]2,612 in the current quarter, up 1.7% from $2,569 in last year's fourth quarter. […]
>
> Net income totaled $11.4 million this quarter or $0.48 per diluted share, a new quarterly record, increasing 56% from the 7.3 million or $0.34 per diluted share reported for last year's fourth quarter. […] For the full-year 2006, we grew our net service revenue by 42% over the 2005 period to a record $541.1 million on a 43% increase in complete episodes of Care… Revenue per episode totaled $2,634 in 2006, up 2.6% from 2,567 in 2005.

296. Also on February 20, 2007, Amedisys filed its Form 10-K for the year ended December 31, 2006 (the "2006 10-K"), signed by Defendant Borne, which again reiterated the above information concerning Amedisys's financial results for the fourth quarter and year end of 2006. Amedisys's 2006 10-K also reported the Company's retained earnings of $84,807,000. Further, the 2006 10-K touted extensively Amedisys's purported compliance program and practices and, in particular, its supposed billing-related compliance training practices:

> **Compliance and Quality Improvement**

> … We develop, implement and maintain comprehensive compliance and quality improvement programs as a component of the centralized corporate services provided to our home health and hospice agencies. Our compliance program includes … a process for reporting regulatory or ethical concerns to our Chief Compliance Officer, including a toll-free telephone hotline. We have a Compliance Committee, which is chaired by the Chief Compliance Officer and is comprised of our Chief Executive Officer, Chief Operating Officer, the Senior Vice President of Clinical Operations and the Senior Vice President of Human Resources. This Corporate Compliance Committee reviews and recommends appropriate courses of action for handling compliance issues….
>
> We conduct periodic compliance surveys of all of our agencies, which include audits of patient charts and documentation to ensure compliance with Medicare regulations. Audit findings and corresponding action plans are routed to both the Chief Compliance Officer and the Senior Vice President of Operations.

Further, Defendants Borne and Giblin provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2006 10-K.

297. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269. Moreover, the statements concerning Amedisys's purported "comprehensive compliance and quality improvement programs" misrepresented Amedisys's compliance program and failed to disclose Defendants' improper manipulations of the Medicare reimbursement system, as described herein.

298. In addition, when signing the above-described certifications, Defendants Borne and Giblin knew about or recklessly disregarded, and failed to disclose, Defendants' fraudulent scheme to improperly manipulate the Medicare reimbursement system, as described herein.

H. First Quarter 2007

299. On May 1, 2007, at 7:00 a.m., Amedisys issued its earnings release for the first quarter of 2007 and announced yet another quarter of "record first quarter revenues and earnings." According to the Company's press release:

- Net service revenues were $153.6 million, up 21% compared to $127.2 million reported for the first quarter of 2006.

- Net income was $13.3 million, or $0.51 per diluted share, compared to $7.3 million, or $0.34 per diluted share, for the first quarter of 2006.

In the press release, Defendant Borne touted the Company's "record quarterly revenues and record net income." Defendant Borne also stated that Amedisys's "diluted earnings per share increased 50% from the first quarter of 2006 to the first quarter of 2007." In addition, the Company disclosed that its revenue per episode for the first quarter of 2007 was $2,644.

300. Also on May 1, 2007, starting at 10:00 a.m., Amedisys held a conference call discussing its first quarter 2007 financial results. During the call, Defendant Borne touted the Company's "record revenues" and repeated the above information concerning Amedisys's first quarter 2007 earnings. Defendant Redman also touted Amedisys's "outstanding quarter," noting that the Company "set a number of records" and repeated the above information concerning Amedisys's first quarter 2007 earnings.

301. Also on May 1, 2007, Amedisys issued its Form 10-Q for the first quarter of 2007 (the "1Q07 10-Q"), signed by Defendant Redman, which repeated the above information concerning Amedisys's first quarter 2007 earnings. Amedisys's 1Q07 10-Q also reported the Company's retained earnings of $97,722,000. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 1Q07 10-Q.

302. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269.

I. Second Quarter 2007

303. On July 31, 2007, at 7:00 a.m., Amedisys issued its earnings release for the second quarter of 2007, announcing yet another quarter of record revenues and income. The Company's press release stated:

Three-Month Periods Ended June 30, 2007 and 2006

- Net service revenue was $169.5 million, up 27.5% compared to $132.9 million reported for the second quarter of 2006.
- Net income was $14.9 million, up 64.8% compared to $9.1 million for the second quarter of 2006, with diluted earnings per share of $0.57 for the second quarter of 2007, up 35.7% from $0.42 per diluted share for the second quarter of 2006.
- Earnings before interest, taxes, depreciation and amortization ("EBITDA") was $26.3 million, up 44.6% compared to $18.2 million during the second quarter of 2006.

In this press release, Defendant Borne touted "another exceptional quarter for us, with record revenues and record earnings." Further, the Company disclosed its revenue per episode of $2,671 and $2,658 for the three-month and six-month periods ended June 30, 2007, respectively.

304. Also on July 31, 2007, starting at 10:00 a.m., Amedisys hosted a conference call concerning its earnings release for the second quarter of 2007. On the call, Defendant Borne touted Amedisys's "record revenues of $169 million and record earnings of $0.57 per share." Defendant Redman also spoke on the conference call and repeated the above information concerning Amedisys's second quarter 2007 financial results.

305. Also on July 31, 2007, Amedisys issued its Form 10-Q for the second quarter of 2007 (the "2Q07 10-Q"), signed by Defendant Redman, which again repeated the above information concerning Amedisys's second quarter 2007 financial results. Amedisys's 2Q07 10-Q also reported the Company's retained earnings of $112,639,000. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2Q07 10-Q.

306. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269.

J. Third Quarter 2007

307. On October 30, 2007, at 7:00 a.m., Amedisys issued an earnings release announcing

that the Company had set yet another record with its earnings for the third quarter of 2007. Amedisys's press release stated:

> Three-Month Periods Ended September 30, 2007 and 2006
>
> - Net service revenue was $180.9 million, up 32.0% compared to $137.0 million reported for the third quarter of 2006.
> - Net income was $20.2 million or $0.77 per diluted share, inclusive of $4.2 million related to Alliance or $0.16 per diluted share. Excluding the Alliance gain, net income was $16.0 million, up 51.6% compared to $10.6 million for the third quarter of 2006, with diluted earnings per share of $0.61 for the third quarter of 2007, up 27.1% from $0.48 per diluted share for the third quarter of 2006.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA"), excluding Alliance was $29.5 million, up 44.5% compared to $20.4 million during the third quarter of 2006.
>
> Nine-Month Periods Ended September 30, 2007 and 2006
>
> - Net service revenue was $503.9 million, up 26.9% compared to $397.1 million reported for 2006.
> - Net income was $48.4 million or $1.85 per diluted share, inclusive of $4.2 million related to Alliance or $0.16 per diluted share. Excluding the Alliance gain, net income was $44.2 million, up 64.3% compared to $26.9 million for 2006, with diluted earnings per share of $1.69 for the nine-month period ended September 30, 2007, up 37.4% from $1.23 per diluted share for 2006.
> - EBITDA, excluding Alliance was $79.3 million, up 47.6% compared to $53.8 million during 2006.

In this press release, Defendant Borne touted the Company's "record revenues and earnings." Further, the Company disclosed its revenue per episode of $2,679 and $2,666 for the three-month and nine-month periods ended September 30, 2007, respectively.

308. The October 30, 2007 press release also reported that, notwithstanding the institution of the new CMS guidelines that eliminated bonus payments at the 10+ visit threshold, Amedisys had established new methodologies, including the Point-of-Care system, to minimize any revenue reduction.

309. Also on October 30, 2007, starting at 10:00 a.m., Amedisys hosted a conference call to discuss its third quarter 2007 earnings. On the call, Defendant Borne touted Amedisys's "record revenues of $181 million and record earnings of $0.61 per diluted share excluding the Alliance

matter." Defendant Redman also spoke on the conference call and repeated the above information concerning Amedisys's third quarter 2007 financial results. Defendant Graham spoke about how the new Point-of-Care system had been designed to enhance the Company's "compliance controls":

> It is very important to us as we continue to grow that we stay focused on three very important areas, our care coordination abilities, our clinical outcomes and most importantly, our compliance controls. The design of our point-of-care system was very purposeful in order to further enhance these areas. […]

310. Further, during the question and answer portion of the October 30, 2007 conference call, Defendant Redman emphasized the Company's Point-of-Care system as a means to enhance the Company's compliance with the CMS regulations:

> We have benefited from a system-wide roll-out of our point-of-care system, which has enabled our clinical assessment data to become more consistent when compared with a paper-based environment. […] So, these care consistency reminders that Larry referred to earlier, they enhance our care coordination, they enhance our documentation, ultimately, our compliance. . .

311. Also on October 30, 2007, Amedisys issued its Form 10-Q for the third quarter of 2007 (the "3Q07 10-Q"), signed by Defendant Redman, which again repeated the above information concerning Amedisys's third quarter 2007 financial results. Amedisys's 3Q07 10-Q also reported the Company's retained earnings of $132,855,000. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 3Q07 10-Q.

312. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269. Further, the statements that Amedisys's Point-of-Care system was designed to enhance the Company's "compliance controls" and "compliance" misrepresented Amedisys's compliance program and failed to disclose how Point-of-Care was used to improperly manipulate the Medicare reimbursement system, as described herein.

313. As a result of Defendants' fraudulent October 30, 2007 press release, conference call

and Form 10-Q, the price of Amedisys' common stock rose on October 30, 2007 by $6.75 (or 18.4%) to close on October 30, 2007 at $43.40 per share.

K. Fourth Quarter and Year-End 2007

314. On February 27, 2008, at 7:00 a.m., Amedisys issued its earnings release for the fourth quarter and year ended December 31, 2007. Amedisys's press release stated:

> Three-Month Periods Ended December 31, 2007 and 2006
> - Net service revenue for the fourth quarter of 2007 increased 34.7% to $194.0 million compared to $144.0 million in the fourth quarter of 2006.
> - Net income increased 47.2% to $16.7 million compared to $11.4 million in the fourth quarter of 2006.
> - Diluted earnings per share increased 31.3% to $0.63 compared to $0.48 per diluted share in the fourth quarter of 2006.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 38.8% to $30.4 million compared to $21.9 million in the fourth quarter of 2006.
>
> Years Ended December 31, 2007 and 2006
> - Net service revenue for the full-year period in 2007 increased 29.0% to $697.9 million compared to $541.1 million in 2006.
> - Net income increased to $65.1 million, or $2.48 per diluted share (inclusive of a $4.2 million gain related to Alliance* or $0.16 per diluted share). Excluding the gain on release of Alliance's net liabilities, net income increased 59.2% to $60.9 million compared to $38.3 million in 2006.
> - Diluted earnings per share (excluding Alliance) increased 34.9% to $2.32 compared to $1.72 per diluted share in 2006.
> - EBITDA (excluding Alliance) increased 45.0% to $109.8 million compared to $75.7 million in 2006.

In this press release, Defendant Borne touted the Company's "record revenues and net income results" and highlighted that "[i]n addition to achieving strong double-digit growth in net service revenue and net income, this was the fifth consecutive year that earnings per share growth has exceeded 20 percent." Further, the Company disclosed its revenue per episode of $2,666 and $2,666 for the three-month and twelve-month periods ended Decmber 30, 2007, respectively.

315. Also on February 27, 2008, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's earnings for the fourth quarter and year ended December 31, 2007. On the

call, Defendant Borne touted Amedisys's financial results stating "[f]or the fourth quarter, we recorded net revenue of $194 million and earnings per share of $0.63, growth of 35% and 31% respectively over the fourth quarter of 2006." Further, Defendant Borne stated "[f]or the full year we recorded net revenue of $698 million and earnings per share of $2.32, growth of 29% and 35% respectively." Defendant Redman also spoke on the conference call and repeated the above information concerning Amedisys's financial results for the fourth quarter and year ended December 31, 2007.

316. Also on February 27, 2008, Amedisys issued its Form 10-K for the year ended December 31, 2007 (the "2007 10-K"), which again repeated the above information concerning Amedisys's financial results for the fourth quarter and year ended December 31, 2007. Amedisys's 2007 10-K also reported the Company's retained earnings of $149,570,000. The 2007 10-K also repeated the Company's statements contained in the 2006 10-K, described above, touting Amedisys's purported compliance program and practices and, in particular, its billing-related compliance training practices. The 2007 10-K was signed by Defendants Borne and Redman. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2007 10-K.

317. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269. The statements covering Amedisys's compliance program misrepresented Amedisys's compliance program and failed to disclose Defendants' improper manipulations of the Medicare reimbursement system, as described herein.

L. First Quarter 2008

318. On April 30, 2008, at 6:00 a.m., Amedisys issued its earnings release for the first quarter of 2008. Amedisys's press release stated:

Three-Month Periods Ended March 31, 2008 and 2007

- Net service revenue for the first quarter of 2008 increased 38.7% to $213.1 million compared to $153.6 million in 2007.
- Net income increased 24.1% to $16.5 million compared to $13.3 million in 2007.
- Diluted earnings per share increased 21.6% to $0.62 compared to $0.51 per diluted share in 2007.
- Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 37.0% to $32.3 million compared to $23.6 million in 2007.

In this press release, Defendant Borne touted the Company's "record revenue." Further, the Company disclosed its revenue per episode of $2,680 for the three-month period ended March 31, 2008.

319. Also on April 30, 2008, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's earnings for the first quarter of 2008. On the call, Defendant Borne touted Amedisys's financial results stating "[w]e had excellent results for the first quarter, recording net revenue of $213 million and earnings per share of $0.62 … [t]his represents growth of 39% and 22%, respectively, over the first quarter of '07." Defendant Redman also spoke on the conference call and repeated the above information concerning Amedisys's financial results for the first quarter of 2008.

320. Also on April 30, 2008, Amedisys issued its Form 10-Q for the quarter ended March 31, 2008 (the "1Q08 10-Q"), which again repeated the above information concerning Amedisys's financial results for the first quarter 2008. Amedisys's 1Q08 10-Q also reported the Company's retained earnings of $166,034,000. The 1Q08 10-Q was signed by Defendant Redman. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 1Q08 10-Q.

321. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269.

M. Second Quarter 2008

322. On the morning of July 29, 2008, at 6:00 a.m., Amedisys issued its earnings release

for the second quarter of 2008. Amedisys's press release stated:

> Three-Month Periods Ended June 30, 2008 and 2007
>
> - Net service revenue increased 84.5% to $312.7 million compared to $169.5 million in 2007.
> - Net income increased 36.6% to $20.4 million compared to $14.9 million in 2007.
> - Diluted earnings per share increased 33.3% to $0.76 compared to $0.57 per diluted share in 2007.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 68.7% to $44.3 million compared to $26.3 million in 2007.
>
> Further, the Company disclosed its average revenue per episode of $2,852 and $2,782 for the three-month and six-month periods ended June 30, 2008, respectively.

323. Also on July 29, 2008, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's earnings for the second quarter of 2008. On the call, Defendant Borne touted Amedisys's financial results stating "[w]e had outstanding results for the second quarter, recording net service revenue of $313 million and earnings per share of $0.82 after adjusting for certain TLC integration costs … [t]his represents growth of 85% and 44%, respectively, over the second quarter of '07." Defendant Redman also spoke on the conference call and repeated the above information concerning Amedisys's financial results for the second quarter of 2008.

324. Also on July 29, 2008, Amedisys issued its Form 10-Q for the quarter ended June 30, 2008 (the "2Q08 10-Q"), which again repeated the above information concerning Amedisys's financial results for the second quarter 2008. Amedisys's 2Q08 10-Q also reported the Company's retained earnings of $186,418,000. The 2Q08 10-Q was signed by Defendant Redman. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2Q08 10-Q.

325. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269.

N. Third Quarter 2008

326. On October 28, 2008, at 6:00 a.m., Amedisys issued its earnings release for the third quarter of 2008. Amedisys's press release stated:

> Three-Month Periods Ended September 30, 2008 and 2007
> - Net service revenue increased 77.7% to $321.6 million compared to $180.9 million in 2007.
> - Net income increased 16.2% to $23.5 million compared to $20.2 million in 2007.
> - Diluted earnings per share increased 13.0% to $0.87 compared to $0.77 per diluted share in 2007.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 46.4% to $49.4 million compared to $33.7 million in 2007.

Further, the Company disclosed its average episode-based revenue per completed episode of $2,868 and $2,808 for the three-month and six-month periods ended September 30, 2008, respectively.

327. Also on October 28, 2008, starting at 10:00 a.m., Amedisys hosted a conference call to discuss its 2008 third quarter earnings. In his opening remarks, Defendant Borne repeated certain information concerning the Company's third quarter earnings outlined above, including the Company's "net revenue of $322 million and adjusted earnings per share of $0.89…[representing] growth of 78% and 46%, respectively, over the third quarter of 2007." Defendant Borne also touted the Company's results for the nine-month period ended September 30, 2008, as described above. Defendant Borne also emphasized the importance of compliance to Amedisys, stating that "compliance is central to everything we do as a company."

328. Also during this conference call Defendant Redman repeated the above information concerning Amedisys's financial results for the third quarter of 2008.

329. Further, during the October 28, 2008 conference call, Defendant Graham noted an increase in recertifications over the prior year:

> For the quarter, our internal growth rate over last year in episodic-based admissions was 14%. Our internal recertification growth over prior year was 23%. The increase in our recertifications are the result of our admission growth, our startup initiative, and our agencies acquired over the past two years that have transitioned into our base

> agencies. As an agency opens, we first develop our census by obtaining patient admissions. However, as time progresses, these patients may require an additional episode of care and thus cause our recertification rate to increase. […]
>
> To summarize this, our internal episodic-based revenue growth rate in dollars grew 28%, which consists of volume growth of 19%. As a reminder, volume growth is total episodic growth, which is admit plus recert growth.

330. Defendant Graham also touted Amedisys's ability to service sicker, higher-risk patients:

> Amedisys is a clear example of a home-health provider with a higher distribution of patients on the high end of the risk scale. More than one half of all patients admitted by Amedisys agencies are predicted to be of high or very high risk of hospitalization compared to just one third of patients nationwide. Conversely, only 10% of the Amedisys patients are assessed as low or very low risk compared to 23% of patients nationally.
>
> Another indicator of overall patient severity is length of stay, with higher-severity patients requiring more days of service, as a general rule. As patient length of stay increases, hospitalization rates also increase, and many measures of patient outcomes typically decrease. The higher severity of Amedisys patients is also shown by longer length of stay than the national benchmarks, based on 2008 data.
>
> The average Medicare patient requires approximately 1.55 episodes of care. The average Amedisys Medicare patient receives about 1.85 episodes of care. The logical result of a high-risk patient population is overall lower quality outcome scores. Yet despite caring for a population that is considerably higher risk and requires a longer length of stay than the national norm, Amedisys has shown consistently higher overall quality of care, as measured by the OCS Standardized Outcome Index, referred to as SOI, a proprietary measure that offers a single number representative of overall quality.
>
> In conclusion, Amedisys excels in a complicated care-management environment, as evidenced by a patient population with higher than national risk characteristics requiring a longer length of care and yet producing quality patient outcomes.

331. During the October 28, 2008 earnings call, Defendant Schwartz, CIO and Senior Vice President of Clinical Operations, reinforced and elaborated upon Defendant Graham's statements regarding the quality of care delivered by Amedisys – despite the purported higher chronicity and clinical acuity of Amedisys patients.

> Clinical acuity, meaning how sick or debilitated a patient is, is expressed in home care by what is known as a case-mix weight. […] … Amedisys' case-mix weight is higher

> than both national and regional norms. […] We service a sicker population requiring greater resource needs.
>
> With a trend of sicker patients receiving services each year, our approach has been to continue to develop our care management systems and evidence based clinical programs, with a focus on better servicing our senior population that has multiple clinical needs.

332. Defendant Schwartz also highlighted the purported merits of Amedisys's compliance practices:

> We have 461 home care locations that are all connected via a wide area network. All of our full time and consistent PRN employees in home care have laptops and are using those to input clinical visit information in the patient's home. We had three goals when developing this system -- enhanced standardization with consistency and compliance control...

333. Defendant Jeter, CCO/Corporate Counsel, also spoke during the October 28, 2008 conference call, touting the compliance functions in place at Amedisys, including concerning its billing-related compliance programs:

> Our compliance program features a multi-layer and recurrent approach designed to ensure the propriety of both our services and our billings.

334. Defendant Jeter also discussed centrality of the Point-of-Care system to the Company's compliance practices:

> Additionally, our point-of-care system represents a fundamental compliance control and is the sort of technology that helps us improve not only what we do in terms of clinical care but how we do it in terms of our adherence to Medicare rules and regulations.
>
> One simply cannot overemphasize the importance of this technology as a means for strengthening our compliance with the law.
>
> * * *
>
> Amedisys' point-of-care system elevates the quality of our documentation, which goes hand-in-hand with better compliance. […]

335. Defendant Jeter further touted the purported quality of Amedisys's compliance practices, including reassuring investors of the Company's compliance practices with specific reference to certain of the fraudulent practices at issue here:

> Beginning in early 2005, we identified three key areas to which any home healthcare agency maybe susceptible because of the inherent revenue impacts of each. These are first, excessive therapy, where a high number of therapy visits are conducted, which results in increased reimbursement and may be potentially suggestive of fabricated or unnecessary visits just to increase reimbursement.
>
> Second, LUPA exaggeration, which is where an agency has an exceptionally low number of Low Utilization Payment Adjustments, otherwise known as LUPAs, which may be suggestive of potentially fabricated or unnecessary visits so as to avoid having reimbursement automatically reduced by the government.
>
> And third, up-coded case mixes, where an agency has a higher-than-average case-mix weight that may be suggestive of possible manipulation of coding occasioned by scoring patients as sicker than they actually are. These are big-bang-for-the-buck kinds of risk areas for fraud.
>
> Since 2005, one of the primary functions that my compliance auditors have performed is the proactive review of agencies that perform well in each of these areas. We have focused on those Amedisys agencies performing very well with respect to having a higher percentage of high profitability therapy episodes and having a lower incidence of low reimbursement LUPAs and in having overall higher-reimbursement case-mix scores.
>
> Now, it should be noted that just because an agency has a high percentage of high profitability therapy or a lower occurrence of LUPAs or a higher case mix does not necessarily mean that there is something improper or untoward occurring. In each instance, there may well be wholly appropriate justifications for each risk category. However, because of the revenue implications of each, there exists a potential for improprieties, which we feel warrants a compliance review.
>
> Since 2005, my staff has audited those agencies that stand out based on these high-revenue audit-focus areas. […]
>
> We are also continuously refining our audit processes and risk controls.

336. Defendant Jeter further highlighted Amedisys's purported deterrents to fraud, stating: "Amedisys has long had stiff enforcement policies for compliance violations" and the "compliance plan articulates a zero tolerance police for healthcare fraud and abuse."

337. Also on October 28, 2008, Amedisys issued its Form 10-Q for the third quarter of 2008 (the "3Q08 10-Q"), which again repeated the above information concerning Amedisys's financial results for the third quarter of 2008. Amedisys's 3Q08 10-Q also reported the Company's retained earnings of $209,911,000. The 3Q08 10-Q was signed by Defendant Redman. Further, Defendants

Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 3Q08 10-Q.

338. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269. In addition: (1) when making the material misstatements concerning Amedisys's rate of recertification, Defendants knew or recklessly disregarded at the time, and failed to disclose, that they were engaged in a fraudulent scheme to improperly manipulate the Medicare reimbursement system, including through improper recertification of patients, as described herein; (2) when making the material misstatements concerning the purported higher chronicity and clinical acuity of Amedisys's patients, Defendants knew or recklessly disregarded, and failed to disclose, at the time that they were engaged in a fraudulent scheme to improperly manipulate the Medicare reimbursement system, which among other things, included the provision of additional, unnecessary therapy visits, "upcoding" patient diagnoses, and improper recertification, as described herein; and (3) the statements concerning Amedisys's compliance program misrepresented Amedisys's compliance program and failed to disclose Defendants' improper manipulations of the Medicare reimbursement system, as described herein.

O. Fourth Quarter and Year-End 2008

339. On February 17, 2009, at 7:00 a.m., Amedisys issued its earnings release for the fourth quarter and year-ended December 31, 200. Amedisys's press release stated:

> Three-Month Periods Ended December 31, 2008 and 2007
> - Net service revenue increased 75.3% to $340.1 million compared to $194.0 million in 2007
> - Net income increased 57.6% to $26.3 million compared to $16.7 million in 2007.
> - Diluted earnings per share increased 54.0% to $0.97 compared to $0.63 per diluted share in 2007.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 68.8% to $51.4 million compared to $30.4 million in 2007.

Years Ended December 31, 2008 and 2007

- Net service revenue increased 70.1% to $1,187.4 million compared to $697.9 million in 2007.
- Net income increased 33.1% to $86.7 million compared to $65.1 million in 2007.
- Diluted earnings per share increased 29.8% to $3.22 compared to $2.48 per diluted share in 2007.
- EBITDA increased 55.6% to $177.4 million compared to $114.0 million in 2007.

In this press release, Defendant Borne touted the Company's "record revenues and earnings for both the fourth quarter and full year." Defendant Borne highlighted that "[t]his marks the sixth consecutive year that earnings per share growth has exceeded 20%." Further, the Company disclosed its average episodic-based revenue per completed episode of $2,972 and $2,854 for the three-month and twelve-month periods ended December 31, 2007, respectively.

340. Also on February 17, 2009, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's earnings for the fourth quarter and year-end of 2008. In his opening remarks, Defendant Borne repeated certain information concerning the Company's fourth quarter 2008 earnings outlined above, including the Company's "net revenue of $340 million and adjusted earnings per share of $0.98…[representing] growth of 75[%] and 56%, respectively over the fourth quarter of '07." Defendant Borne also touted the Company's year-end 2008 results, as described above. Defendant Redman also highlighted the Company's "tremendous year," repeating the above information concerning Amedisys's financial results for the fourth quarter and year-end of 2009.

341. In addition, during this conference call, Larry Graham discussed episodic based revenue and recertifications, stating:

> For the quarter, our internal episodic-based revenue growth rate was 30% with 16% related to volume and 14% related to rate. For the full year, our internal episodic-based revenue growth rate was 28% with 19% related to volume and 9% related to rate. The volume increase during the quarter and full year related to increases in the total number of admissions and re-certifications with internal-based episodic admissions growing 11% for both periods and internal episodic-based re-certifications growing 20% in the quarter four, and 25% for the full year.

342. Also on February 17, 2009, Amedisys issued its Form 10-K for the fourth quarter and

year end of 2008 (the "2008 10-K"), signed by Defendants Borne, Redman and Graham, which again repeated the above information concerning Amedisys's financial results for the fourth quarter and year end of 2008. Amedisys's 2008 10-K also reported the Company's retained earnings of $236,252,000.

343. Amedisys's 2008 10-K also discussed Amedisys's purported controls in place to ensure compliance with Federal, state and local laws regarding coding, clinical operations, billing for Medicare reimbursements, patients recertification and compliance. In this regard, the 2008 10-K made the following materially false and misleading claims:

> We establish and maintain processes and controls over coding, clinical operations, billing, compliance and patient recertifications to help ensure that we are compliant with Medicare requirements.
>
> Coding
>
> Specified diagnosis codes are assigned to each of our patients based on their particular health condition and ailment (such as diabetes, coronary artery disease or congestive heart failure). Because coding regulations are complex and are subject to frequent change, we maintain controls surrounding our coding process. In order to reduce associated risk, we provide coding training for new agency directors and clinical managers; provide annual coding update training for agency directors and clinical managers; provide coding training during orientation for new employees; provide monthly specialized coding education; circulate a clinical operations quality newsletter; obtain outside expert coding instruction; utilize coding software in our POC system; and have automated coding edits based on pre-defined compliance metrics in our POC system.
>
> Clinical Operations
>
> . . . In order to help ensure our agencies are following applicable regulatory requirements, we complete audits of patient charts (locally, by line management regional staff, for Sarbanes-Oxley compliance and by Direct line supervisors); we use risk forecasting methodologies; we utilize regulatory "turnaround teams" when problems are identified; we administer survey guideline education; we hold recurrent homecare regulatory education; we utilize outside expert regulatory services; and we have a toll-free hotline to offer additional assistance.
>
> Billing
>
> We maintain comprehensive controls over our billing processes to help ensure accurate and complete billing. We have company-wide annual billing compliance

> testing; use formalized billing attestations; limit access to billing systems; use risk forecasting methodologies; perform direct line supervisor audits; hold weekly operational meetings; use automated daily billing operational indicators; deploy operational "turnaround teams" when problems are identified; and terminate employees who knowingly fail to follow our billing policies and procedures in accordance with a well publicized "Zero Tolerance Policy".
>
> Patient Recertification
>
> In order to be recertified for an additional episode of care, a patient must be diagnosed with a continuing medical need. This could take the form of a continuing skilled clinical need or could be caused by changes to the patient's medical regimen or by modified care protocols within the episode of care. As with the initial episode of care, a recertification requires approval of the patient's physician. Before any employee recommends recertification to a physician, we conduct an agency level, multidisciplinary care conference. We also use centralized automated compliance recertification indicators to identify and monitor agencies that have relatively high recertification levels.
>
> Compliance
>
> . . . We develop, implement and maintain comprehensive ethics, compliance and quality improvement programs as a component of the centralized corporate services provided to our home health and hospice agencies. . . . We promote a culture of compliance within our company through persistent messages from our senior leadership concerning the necessity of strict compliance with legal requirements and company policies and procedures, and through publicizing and enforcing our Zero Tolerance Policy. We also employ a comprehensive compliance training program . . .

344. Further, Amedisys's 2008 10-K included certifications from Defendants Borne and Redman that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2008 10-K.

345. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269, including that Defendants knew or recklessly disregarded, and failed to disclose, at the time that they were engaged in a fraudulent scheme to improperly manipulate the Medicare reimbursement system, and that Amedisys lacked adequate processes and controls over coding, clinical operations, billing, compliance and patient

recertifications to comply with Medicare requirements.

P. First Quarter 2009

346. On April 28, 2009, at 6:00 a.m., Amedisys issued its earnings release for the first quarter of 2009. Amedisys's press release stated:

> Three-Month Periods Ended March 31, 2009 and 2008
>
> - Net service revenue increased $128.7 million or 60.4% to $341.8 million compared to $213.1 million in 2008…
> - Net income attributable to Amedisys, Inc. increased $10.5 million or 64.1% to $27.0 million compared to $16.5 million in 2008
> - Diluted earnings per share increased 59.7% to $0.99 compared to $0.62 per diluted share in 2008.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 67.0% to $54.0 million compared to $32.3 million in 2008.

In this press release, Defendant Borne touted the Company's "record revenue and earnings." Further, the Company disclosed its revenue per episode of $3,033 for the three-month period ended March 31, 2009.

347. Also on April 28, 2009, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's 2009 first quarter earnings. In his opening remarks, Defendant Borne repeated certain information concerning the Company's first quarter 2009 earnings outlined above, including the Company's "net revenue of $341 million and earnings per share of $0.99…[representing] growth of 60% and 59%, respectively over the first quarter of 2008." Defendant Redman also repeated the above information concerning Amedisys's financial results for the first quarter of 2009.

348. Defendant Graham commented on the growth in episodic revenue during the April 28, 2009, conference call pointing out that recertifications had increased by 15% during the first quarter:

> For the quarter, our internal episodic-based revenue growth rate was 23%, with 10% related to volume and 13% related to rate. The volume increase during the quarter related to increases in the total number of admissions and re-certifications with internal

> episodic-based admissions growing 8% and internal episodic-based re-certifications growing 15% in the first quarter. The rate increase was primarily due to our continued deployment of our specialty programs to more of our home health agencies.

349. Also on April 28, 2009, Amedisys issued its Form 10-Q for the quarter ended March 31, 2009 (the "1Q09 10-Q"), signed by Defendant Redman, which again repeated the above information concerning Amedisys's financial results for the first quarter 2009. Amedisys's 1Q09 10-Q also reported the Company's retained earnings of $263,274,000. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 1Q09 10-Q.

350. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269. In addition, the above statements concerning the purported reasons behind Amedisys's earnings increases, including strong internal growth and the deployment of "specialty programs," failed to disclose that they were materially and artificially inflated as a result of Defendants' improper manipulations of the Medicare reimbursement system, as described herein.

351. Defendant Schwartz further spoke on behalf of Amedisys at a Jefferies Healthcare Conference conducted on June 18, 2009. Defendant Schwartz represented at the Conference, among other things, that for the first quarter of 2009, Amedisys was able to grow revenue internally at a 23% rate based on "the admissions that we bring in," "how many recertifications, how many patients went into another episode," and "the revenue per episode of those admissions and recertifications."

352. Defendant Schwartz also promoted Amedisys's "specialty division [Balanced for Life] that focuses on providing therapy for balance impairments related to dizziness and falls."

353. The above statements were materially false and misleading when made because, among other things: (1) the statements concerning Amedisys's internal growth rate, and the purported

reasons behind those increases, including its certification and recertification rates, and revenue per episode, failed to disclose that they were materially and artificially inflated as a result of Defendants' improper manipulations of the Medicare reimbursement system, as described herein; and (2) when making the material misstatements concerning Amedisys's Balanced for Life program, Schwartz knew or recklessly disregarded at the time, and failed to disclose, that the Balanced for Life program was an artifice to provide services to patients that were medically unnecessary.

Q. Second Quarter 2009

354. On July 28, 2009, at 7:00 a.m., Amedisys issued its earnings release for the second quarter 2009. Amedisys's press release stated:

> Three-Month Periods Ended June 30, 2009 and 2008
>
> - Net service revenue increased $65.2 million or 20.9% to $377.9 million compared to $312.7 million in 2008…
> - Net income attributable to Amedisys, Inc. increased $14.7 million or 72.1% to $35.1 million compared to $20.4 million in 2008.
> - Diluted earnings per share increased 67.1% to $1.27 compared to $0.76 per diluted share in 2008.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 52.0% to $67.4 million compared to $44.3 million in 2008.

In this press release, Defendant Borne touted the Company's "three-prong business strategy of providing superior clinical services, growing our business aggressively and becoming as operationally efficient" and "high-quality outcome driven care to the…chronically ill Medicare patient population for the lowest cost." Further, the Company disclosed its average episodic-based revenue per completed episode of $3,166 and $3,102 for the three-month and six-month periods ended June 30, 2009.

355. Also on July 28, 2009, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's 2009 second quarter earnings. In his opening remarks, Defendant Borne repeated certain information concerning the Company's second quarter 2009 earnings outlined above,

including the Company's "net revenue of [$]378 million and earnings per share of $1.27…[representing] growth of 21[%] and 67%, respectively over the second quarter of '08." Defendant Redman also repeated the above information concerning Amedisys's financial results for the second quarter of 2009.

356. Also during the call, Defendant Graham addressed the internal episodic growth rate for the second quarter of 2009:

> For the quarter, our internal episodic-based revenue growth rate was 19%. With 7% related to volume and 12% related to rate. For the six months, our internal episodic-based revenue growth rate was 21%. The volume increased during the second quarter related to increases in the total number of admissions and re-certifications, with these internal episodic-based admissions growing 4% and internal episodic-based re-certifications growing 10% in the second quarter. The rate increase was primarily due to our continued deployment of our specialty programs to more of our home health agencies, which resulted in an increase in our average revenue – episodic-based revenue per episode of $325.

357. Also on July 28, 2009, Amedisys also issued its Form 10-Q for the second quarter of 2009 (the "2Q09 10-Q"), signed by Defendant Redman, which again repeated the above information concerning Amedisys's financial results for the second quarter of 2009. Amedisys's 2Q09 10-Q also reported the Company's retained earnings of $298,357,000. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2Q09 10-Q.

358. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269.

R. Third Quarter 2009

359. On October 27, 2009, at 7:00 a.m., Amedisys issued its earnings release for the third quarter 2009. Amedisys's press release stated:

Three-Month Periods Ended September, 2009 and 2008

- Net service revenue increased $66.7 million or 20.7% to $388.3 million compared to $321.6 million in 2008…
- Net income attributable to Amedisys, Inc. increased $12.4 million or 53.0% to $35.9 million compared to $23.5 million in 2008.
- Diluted earnings per share increased 48.3% to $1.29 compared to $0.87 per diluted share in 2008.
- Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 40.0% to $69.1 million compared to $49.4 million in 2008.

In this press release, the Company disclosed its average episodic-based revenue per completed episode of $3,189 and $3,132 for the three-month and nine-month periods ended September 30, 2009.

360. Also on October 27, 2009, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's third quarter 2009 financial results. During the conference call, Defendant Borne repeated the above information concerning the Company's third quarter 2009 earnings, including the Company's "net revenue of [$]388 million and earnings per diluted share of $1.29…[representing] growth of 21[%] and 48%, respectively over the third quarter of '08." Defendant Redman also repeated the above information concerning Amedisys's financial results for the third quarter of 2009.

361. Also during the conference call, Defendant Borne touted the Company's "quality management and compliant processes." Further, Defendant Borne pointed out that there was an increase of 8% in the volume of recertifications during the third quarter:

> For the quarter, our internal episodic-based revenue growth was 18%, with 6% related to volume and 12% related to rate. The volume increase during the quarter was comprised of 12% in internal episodic-based admissions of 4% and 8% recertifications. For the year-to-date period, our internal episodic-based revenue growth was 20%, with 8% related to volume and 12% related to rate. The volume increase during the quarter was comprised of growth in internal episodic-based admissions of 5% and recertifications of 10%.

362. Also on October 27, 2009, Amedisys also issued its Form 10-Q for the third quarter of 2009 (the "309 10-Q"), signed by Defendant Redman, which again repeated the above information

concerning Amedisys's financial results for the third quarter of 2009. Amedisys's 3Q09 10-Q also reported the Company's retained earnings of $334,296,000. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 3Q09 10-Q.

363. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269, and for failing to disclose that Amedisys lacked aequate compliance controls.

S. Fourth Quarter and Year-End 2009

364. On February 23, 2010, at 7:00 a.m., Amedisys issued its earnings release for the fourth quarter and year-ended December 31, 2009. Amedisys's press release stated:

> Three-Month Periods Ended December 31, 2009 and 2008
>
> - Net service revenue increased $65.4 million or 19.2% to $405.5 million compared to $340.1 million in 2008…
> - Net income attributable to Amedisys, Inc. increased $11.5 million or 43.5% to $37.8 million compared to $26.3 million in 2008.
> - Diluted earnings per share increased 39.2% to $1.35 compared to $0.97 per diluted share in 2008.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 38.8% to $71.3 million compared to $51.4 million in 2008.
>
> Years Ended December 31, 2009 and 2008
>
> - Net service revenue increased $326.1 million or 27.5% to $1.5 billion compared to $1.2 billion in 2008…
> - Net income attributable to Amedisys, Inc. increased $49.1 million or 56.7% to $135.8 million compared to $86.7 million in 2008.
> - Diluted earnings per share increased 51.9% to $4.89 compared to $3.22 per diluted share in 2008.
> - EBITDA increased 47.5% to $261.8 million compared to $177.4 million in 2008.

In this press release, Defendant Borne highlighted that "[t]his marks the seventh consecutive year in which we have increased our earnings per share in excess of 20%." Further, the Company disclosed

its average episodic-based revenue per completed episode of $3,260 and $3,166 for the three-month and twelve-month periods ended December 31, 2009, respectively

365. Also on February 23, 2010, starting at 10:00 a.m., Amedisys hosted a conference call to discuss the Company's financial results for fourth quarter and year end 2009. In his opening remarks, Defendant Borne repeated certain information concerning the Company's fourth quarter 2009 earnings outlined above, including the Company's "net revenue of $405 million and earnings per share of $1.35…[representing] growth of 19[%] and 39%, respectively over the fourth quarter of 2008." Defendant Borne also touted the Company's year-end 2009 results, as described above. Defendant Redman also repeated the above information concerning Amedisys's financial results for the fourth quarter and year-end of 2009.

366. In discussing the internal growth rate for the fourth quarter of 2008, Defendant Borne disclosed:

> For the quarter, our internal-based revenue growth was 15%, with 5% related to volume and 10% related to rate. The volume increase during the quarter was comprised of growth and internal episodic-based admissions of 7% and recertifications of 2%. […] For the year-to-date period, our internal episodic-based revenue growth was 18%, with 7% related to volume and 11% related to rates. The volume increase during the year was comprised of growth in internal episodic-based admissions of 6% and recertifications of 8%.
>
> The increase in our rate, both the quarter and the year-to-date, is driven by our focus on higher acuity patients, many of whom are benefiting from our state-of-the-art disease management programs, such as our Balance for Life program. At quarter-end, we had launched our BFL program in 332 locations, representing 64% of our total home health locations.

367. Also on February 23, 2010, Amedisys issued its Form 10-K for the fourth quarter and year end of 2009 (the "2009 10-K"), signed by Defendants Borne and Redman, which again repeated the above information concerning Amedisys's financial results for the fourth quarter and year end of 2009. Amedisys's 2009 10-K also reported the Company's retained earnings of $372,089,000. The 2009 Form 10-K was certified as complying with the Exchange Act by Defendants Borne and

Redman.

368. Amedisys's 2009 10-K also discussed Amedisys's controls in place to ensure compliance with Federal, state and local laws regarding coding, clinical operations, billing for Medicare reimbursements, patients recertification and compliance. In this regard, the 2009 10-K made the following materially false and misleading claims:

> We establish and maintain processes and controls over coding, clinical operations, billing, patient recertifications and compliance to help monitor and promote compliance with Medicare requirements.
>
> Coding—Specified diagnosis codes are assigned to each of our patients based on their particular health condition and ailment (such as diabetes, coronary artery disease or congestive heart failure). Because coding regulations are complex and are subject to frequent change, we maintain controls surrounding our coding process. In order to reduce associated risk, we provide coding training for new agency directors and clinical managers; provide annual coding update training for agency directors and clinical managers; provide coding training during orientation for new employees; provide monthly specialized coding education; circulate a clinical operations quality newsletter; obtain outside expert coding instruction; utilize coding software in our POC system; and have automated coding edits based on pre-defined compliance metrics in our POC system.
>
> Clinical Operations— . . . In order to help monitor and promote compliance with regulatory requirements, we complete audits of patient charts; we use risk forecasting methodologies; we administer survey guideline education; we hold recurrent homecare regulatory education; we utilize outside expert regulatory services; and we have a toll-free hotline to offer additional assistance.
>
> Billing—We maintain controls over our billing processes to help promote accurate and complete billing. In order to promote the accuracy and completeness of our billing, we have annual billing compliance testing; use formalized billing attestations; limit access to billing systems; use risk forecasting methodologies; perform direct line supervisor audits; hold weekly operational meetings; use automated daily billing operational indicators; and take prompt corrective action with employees who knowingly fail to follow our billing policies and procedures in accordance with a well publicized "Zero Tolerance Policy".
>
> Patient Recertification—In order to be recertified for an additional episode of care, a patient must be diagnosed with a continuing medical need. This could take the form of a continuing skilled clinical need or could be caused by changes to the patient's medical regimen or by modified care protocols within the episode of care. As with the initial episode of care, a recertification requires approval of the patient's physician. Before any employee recommends recertification to a physician, we conduct an agency level, multidisciplinary care team conference. We also monitor centralized

> automated compliance recertification metrics to identify, monitor, and where appropriate audit, agencies that have relatively high recertification levels.
>
> Compliance—. . . We develop, implement and maintain ethics, compliance and quality improvement programs as a component of the centralized corporate services provided to our home health and hospice agencies. . . . We promote a culture of compliance within our company through persistent messages from our senior leadership concerning the necessity of strict compliance with legal requirements and company policies and procedures, and through publicizing and enforcing our Zero Tolerance Policy. We also employ a comprehensive compliance training program . . .

369. Further, Amedisys's 2009 10-K included certifications from Defendants Borne and Redman that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2009 10-K.

370. The above statements were materially false and misleading when made for, among other reasons, the reasons discussed in ¶269, including that Defendants knew or recklessly disregarded, and failed to disclose, at the time that they were engaged in a fraudulent scheme to improperly manipulate the Medicare reimbursement system, and that Amedisys lacked adequate processes and controls over coding, clinical operations, billing, compliance and patient recertifications to comply with Medicare requirements.

T. First Quarter 2010

371. As previously discussed, on April 26, 2010, the *WSJ* article was published. As quoted in the *WSJ* article, Amedisys was already seeking to falsely reassure investors that Amedisys had done nothing wrong:

> [Amedisys spokesman Kevin LeBlanc said] the company didn't take advantage of the system and that the company's home visits "are in line with the industry trends." [LeBlanc] said Amedisys in general focuses on sicker patients than the industry average, and therefore patients that require more care. "Amedisys' clinical patterns are representative of the patient population we focus on, namely those patients suffering from complex, chronic and co-morbid medical issues," he said.

> The Amedisys spokesman said any suggestion the company may have increased its number of therapy visits to receive higher reimbursements is "both incendiary and inaccurate." . . .
>
> Mr. LeBlanc said many factors contributed to Amedisys's rapid growth, including "our significant investment in the best and most innovative technologies, our strategic acquisitions of compatible companies, our expansion into other therapies and by providing the best quality care for our patients at a lower cost." He emphasized that, the number of home therapy visits is driven not by the company but by doctors orders. "The final decision as to how much care the patient needs ultimately is authorized by the physician, not the home health-care provider," he said in an email.

372. On April 27, 2010, at 7:00 a.m., Amedisys issued its earnings release for the first quarter 2010. Amedisys's press release stated:

> Three-Month Periods Ended March 31, 2010 and 2009
>
> - Net service revenue increased $71.2 million or 20.8% to $413.0 million compared to $341.8 million in 2009.
> - Net income attributable to Amedisys, Inc. increased $9.6 million or 35.6% to $36.6 million compared to $27.0 million in 2009
> - Diluted earnings per share increased 30.3% to $1.29 compared to $0.99 per diluted share in 2009.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") increased 31.0% to $70.7 million compared to $54.0 million in 2009.

In this press release, the Company disclosed its average episodic-based revenue per completed episode of $3,282 for the three-month period ended March 31, 2010.

373. Also on April 27, 2010, starting at 10:00 a.m., Amedisys hosted a conference call confirming the Company's first quarter 2009 earnings. During the conference call, Defendant Redman and Amedisys's COO repeated the above information concerning Amedisys's financial results for the first quarter of 2010.

374. Also during the call, Defendant Borne stated:

> The *WSJ* article clearly states that treating sick patients in their homes rather than paying for costly hospitalizations can help save billions of dollars. In the era of a growing elderly population, this is exactly the role Amedisys serves in the healthcare industry.

* * *

> [CMS] has designed Medicare reimbursement to incentivize the transformation of healthcare from expensive facility-based care to more innovative, less expensive and more effective homecare. And Amedisys is accomplishing this transformation.

375. Later in the conference call, Amedisys's Director of Investor Relations sought to discredit the *WSJ* article:

> Basically in reference to the [WSJ] article, there was not a whole lot of new news that we haven't discussed in volumes in different reports. …Well, you know the reality is when a therapist or a nurse goes out and assesses the patient, we look at what is called frequency which is the level and the amount of business that we will provide each week and the frequency of that. That is embedded in the care plan and the care protocol that the physician has to review and sign off on. If there is indeed a change, even a one visit change in their protocol we have to go back to the physician and address the reason why we make that change. So it is probably not unusual for some of those schedulers from time to time to call and chat with the therapists or nurses and making sure that they are online with the care curriculum that we set for the patient at the initiation of calls.
>
> When we did discover, you know, that sound bite during our communications with the Wall Street Journal reporter, again as I mentioned, it was a good reporter. You know, we reached out to that agency. Our compliance did an audit. We talked to the active PT, physical therapist, as well as the physical therapy assistant. Asked them if they've ever done a visit that they felt that they were inappropriate or that they were ever pressured to do a visit that was unnecessary. And there was a resounding no. They were very comfortable with the care they were providing to the patient. So I think that balanced side of it maybe could have been mentioned. But besides that, as far as the trends and changes in trends and the information that came out, and I did like the piece that the reporter did recognize -- that home care is really the solution for a complex situation. And some of the trends that you've seen is really a trend as a result of reimbursement change to the hospitals and DRGs, the 75% rule with inpatient rehab facilities. Those patients had to naturally migrate somewhere. And our belief is that CMS prepared and positioned for it and created an environment to let the Home Health industry care for those patients. So, overall, I was pretty pleased with the results of the article.

376. During the same earnings call, analyst Sheryl Skolnick of PRC Capital Group asked:

> … [T]here's a question mark here at to just how Amedisys can be so efficient at picking patients at billing so correctly so many times at generating such high degree of consistency about optimizing Medicare reimbursements under a specific rule. And then I guess what is new news here in the article that I found a bit disquieting is that the data showing that once the rules change, you were able to do that again with the new system.
>
> . . . I think that that is the issue that is troubling people and making it not go away. That the data shows this very significant pattern for LHC, for yourselves, for [Gentiva]

> to perhaps – and maybe [American Family], to perhaps a greater extent than it does for others in the industry. So that is why it is not going away and I guess what my question here is, first, to make that point; second to say, just how are you doing it so well and, third, to ask a question what happens when physicians who I believe may even be medical directors in some of your units are quoted in the Wall Street Journal as saying "Well, I let the therapists do their thing." How are you ensuring that the doctors actually, being the gatekeeper especially under the new reimbursement rule that will require face-to-face visits with doctors and patients?

Defendant Borne responded:

> In reference to how we focus on that, we are very specific with care algorithms and I'll use clinical tracks as a better term and the evidence base, and we have a prescription of care for specific patient conditions. They are about 70 of those clinical tracks that we have. And although the [therapists] always and the nurses always have discretion in what to do, we help to prescribe what we feel in a defined protocol, the care that is delivered to achieve the best results that are out there. And that is – those are called frequency to visits.
>
> So with the fact that we have technology and we can track and monitor. And we can use our point of care system to help direct what we feel is a more comprehensive assessment. Because with any assessment too which is an OASIS assessment. It is about 40 pages. We actually have particular systems inside that were pop-ups that if a nurse answers some particular questions in the OASIS that we feel more explanation is needed, it helps the nurses, the therapists, whomever is doing the assessment to be more comprehensive and consistent.

377. Also on April 27, 2010, Amedisys issued its Form 10-Q for the first quarter of 2010 (the "1Q10 10-Q"), signed by Defendant Redman, which again repeated the above information concerning Amedisys's financial results for the first quarter 2010. Amedisys's 1Q10 10-Q also reported the Company's retained earnings of $408,735,000. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which, among other things, attested to the accuracy and completeness of the information contained in Amedisys's 1Q10 10-Q.

378. On May 12, 2010, the Senate Finance Committee Investigation was announced. On May 13, 2010, Amedisys issued a public statement attempting to downplay the importance of the Senate Finance Committee investigation, and further discredit the earlier April 26, 2010 *WSJ* article as "incomplete." Amedisy's statement read, in part:

> Amedisys, Inc. (NASDAQ: AMED), one of America's leading home health and hospice companies, issued the following statement in response to a letter of inquiry received on May 12, 2010, from the Senate Committee on Finance.
>
> "We will cooperate with the Committee's inquiry. We also look forward to discussing with the Senators the many benefits and advantages home health care provides for the millions of Americans our industry serves," said William F. Borne, Amedisys chief executive officer.
>
> The letter of inquiry received from Senators Grassley and Baucus references an article published recently in The Wall Street Journal. The article told an incomplete story about the value of home health to patients, their families, and the overall healthcare system.

379. The above statements were materially false and misleading when made because, among other things: (1) the statements concerning Amedisys's financial results, including revenue, income, earnings per share and retained earnings, and the purported reasons behind those increases, failed to disclose that they were materially and artificially inflated as a result of Defendants' improper manipulations of the Medicare reimbursement system, as described herein; (2) when making the material misstatements concerning the April 26, 2010 *WSJ* article and the Senate Finance Committee investigation, Defendants knew or recklessly disregarded at the time, and failed to disclose, that they were engaged in a fraudulent scheme to improperly manipulate the Medicare reimbursement system, as described herein; and (3) when signing the above-described certifications, Defendants Borne and Redman knew about or recklessly disregarded, and failed to disclose, Defendants' fraudulent scheme to improperly manipulate the Medicare reimbursement system.

U. Second Quarter 2010

380. On July 1, 2010, Amedisys issued a press release indicating that it had received "notice of a formal investigation from the Securities and Exchange Commission (SEC) pertaining to the company, and received a subpoena for documents relating to the matters under review by the Senate Finance Committee." Amedisys sought to downplay the impact of the SEC investigation and allay investors concerns by indicating that the Company intended "to cooperate with the SEC with respect

to this investigation." Amedisys also stated that it understood that "the SEC is also investigating others in the home health industry regarding matters being examined by the Senate Finance Committee."

381. On July 12, 2010, Amedisys issued a press release announcing an investor conference call for the next day. That release stated:

> We currently believe that our second quarter net income will be approximately $1.12 per share. These results include nonrecurring costs of 17 cents per share primarily associated with realignment of operations, and the Senate Finance Committee and SEC investigations; $3.5 million or 7 cents per share we received from CMS under their pay for performance demonstration program and a reversal of the first quarter corporate bonus accrual which amounted to 7 cents per share. The net effect of these items on reported earnings per share was a reduction of approximately 3 cents per share.

382. On July 13, 2010, starting at 9:00 a.m., Amedisys hosted a conference call. During the conference call, Defendant Borne sought to discredit the *WSJ* article, stating, in part:

> The article in the Wall Street Journal published in late April is cited in the Senate Finance Committee's inquiry and the shareholder suits, and it seems appears to have received the attention of the SEC as well. We believe this article has shown a lack of understanding about our industry and overlooked some important facts. We shared quite a bit of information with the Wall Street Journal reporter explaining how the home health industry works, highlighting our business model, innovations, clinical outcomes, and our focus on quality.
>
> In fact, we provided the reporter with an opportunity to meet with our patients, visit our offices, and speak with our staff. After countless hours of correspondence with this reporter we were disappointed that she presented what we believe to be an unbalanced story, excluding much of the data that we shared with her in the spirit of full cooperation.

383. On July 15, 2010, Amedisys published an "Open Letter to Shareholders," signed by Defendant Borne (the "Open Letter"). In the Open Letter, Amedisys sought to alleviate investor concerns about the Company arising from the April 26, 2010 *WSJ* article, the Senate Finance Committee Investigation and the SEC Investigation by providing purported innocent explanations for the fraudulent conduct alleged herein, touting the Company's compliance policies and practices, expressing the Company's intent to cooperate with the SEC and Senate Finance Committee

investigations and seeking to again discredit the April 26, 2010 *WSJ* article. The Open Letter made the following materially false and misleading claims:

> Our therapy visits track patient acuity. Sicker, more complex, patients generally require higher levels of therapy than healthier patients. Our therapy distribution tracks the acuity (or sickness) of our patients, with sicker patients receiving more therapy than their healthier counterparts.
>
> . . . [W]e simply deliver the care patients need and their doctors prescribe.
>
> . . . Our policies respect that recommending and ordering therapy are strictly clinical responsibilities, and prohibit our business people from improperly interfering or attempt to influence these matters.
>
> Our physician consultants are <u>not</u> compensated for referrals. . . .
>
> Wall Street Journal Article: . . . We believe the WSJ article is based upon an inaccurate understanding of a very complex industry and the ever-changing population that we serve, and that it overlooked some important facts. . . For example, the WSJ article focused on the change in therapy utilization in the home health industry from 2007 to 2008, appearing to suggest that providers in the industry changed their therapy utilization to take advantage of the new Medicare reimbursement methodology that CMS implemented in 2008, without giving proper consideration to whether patients needed the care.
>
> However, the WSJ story appeared to assume a static patient population when in fact the needs of the patients under our care in 2008 were quite different from those of the patients under our care in 2007, including a more diverse distribution of patients based upon primary diagnoses and acuity mix. The key factors impacting our shifting patient population include the trend that Amedisys has been taking care of patients who are increasingly sicker and debilitated, and therefore who need more therapy visits. At the same time, other factors have resulted in Amedisys also taking care of more lower acuity patients who require relatively fewer visits. . . .
>
> Under our policies, employee compensation is not computed based upon any therapist or agency reaching any of the past or present Medicare reimbursement thresholds for therapy. In fact, under our policies, therapists and other employees are compensated regardless of whether Amedisys receives any reimbursement from Medicare for the therapy they perform. . . .
>
> Our compliance program includes all elements recommended by the Office of Inspector General of the Department of Health and Human Services, and is run by a seasoned former state Medicaid fraud and abuse prosecutor, Jeffrey Jeter. We have a Zero Tolerance Policy for fraud and abuse, and manipulation of therapy thresholds is and has been an express violation of our compliance policies. We routinely audit agencies that have high therapy utilization, and conduct hundreds of clinical audits each quarter. We maintain a compliance hotline for reporting

concerns.

384. On August 9, 2010, at 7:01 a.m., Amedisys issued its earnings release for the second quarter of 2010. The press release stated:

> Three-Month Periods Ended June 30, 2010 and 2009
>
> - Net service revenue increased $44.4 million or 11.8% to $422.3 million compared to $377.9 million in 2009…
> - Net income attributable to Amedisys, Inc. decreased $2.9 million or 8.2% to $32.2 million compared to $35.1 million in 2009.
> - Diluted earnings per share decreased 11.0% to $1.13 compared to $1.27 per diluted share in 2009.
> - Earnings before interest, taxes, depreciation and amortization ("EBITDA") decreased 5.9% to $63.4 million compared to $67.4 million in 2009.

385. Also on August 9, 2010, at 10:00 a.m., Amedisys hosted a conference call concerning the Company's second quarter 2010 earnings results set out above. During the conference call Defendant Borne repeated certain information concerning the Company's second quarter 2010 earnings outlined above, including the Company's delivery of "revenue growth of 12%, recording net revenue of $422 million, net income of $32 million, which represents a decline of 8% over the second quarter of 2009." Defendant Redman also repeated the above information concerning Amedisys's financial results for the second quarter of 2010.

386. During the earnings call, Michael Snow, COO, sought to reassure investors as to the decline in recertification rates that the Company experienced in the second quarter of 2010:

> As I mentioned in our July call, the primary drag on volume growth in the second quarter was the deterioration of recertifications, particularly late in the quarter. From what we've seen of others in the industry, this is not unique to Amedisys, but the recert rate in June was so pronounced that it significantly reduced our active census leading into third quarter, which will require a number of months to rebuild.
>
> …
>
> And third, finally, we can't ignore the impact of external factors. These distractions contributed to our volume weakness, particularly in the utilization of therapy. And of course, if therapy utilization declines, our revenue per episode will be negatively impacted and it's unclear whether these factors will abate in the near-term.

387. During the question and answer portion of the call, analyst Sheryl Skolnick of CRT Capital asked for more detail on why there was such a steep decline in the recertification rate during the second quarter. In response, Defendant Borne sought to marginalize the decline, falsely suggesting that it was due to physicians' reactions and merely bringing Amedisys's in line with the industry average.

> <Q - Sheryl Skolnick>: Good morning and thank you very much for letting me ask a question on this call. I want to focus on the recertification pattern because to me this is really a key not only to what"s happening here in the near term but also over the much longer term. And that is you said on the last conference call that re-certs declined much more steeply in the last half of June. So really don't want to put words in your mouth, but giving us a sense of falling off the cliff in the last half of June. And I guess I'm at a loss to understand how a slow progression of re-cert decline like attributable to the orthopedic growth, as well which presumably is also your Balance for Life program would also be attributed to a compression of case mix. And I get all of that part, so that part's all negative, but it just still doesn't make sense that all of a sudden you should have such a steep decline. I mean if you were to have had that same decline over the whole period for the company as a whole, you would have had a 50% decline in re-certs in the quarter.
>
> So this is non-trivial, and I guess I'm worried about whether it's the behavior of the clinicians not seeking re-certs, whether there was something in the compliance training you mentioned that might have scared them into doing something differently than they had done before and what, if anything, you're doing to address and determine those issues as opposed to just putting it in the basket of changes in behavior and outside influence and therefore not something the company can do anything about.
>
> <A - William F. Borne, Chief Executive Officer and Chairman>: Yeah, Sheryl. You got it. You nailed it. We have cut this result nine ways to Sunday and in the absence of other factual patterns, we have to put it under behavioral. And as much as we have gone out to provide assurances to our clinicians that we've got to take care of patients because this outcome is unexplainable. And so we''ve gone out, as I said, do the right things for the patients every time, and so – but I cannot explain why we had the precipitous drop in June.

388. Amedisys also filed its Form 10-Q for the second quarter of 2010 on August 9, 2010 (the "2Q10 10-Q"), signed by Defendant Redman, which again repeated the above information concerning Amedisys's financial results for the second quarter of 2010. Amedisys's 2Q10 10-Q also reported the Company's retained earnings of $440,937,000. Further, Defendants Borne and Redman provided certifications that were substantially the same as the certifications described above which,

among other things, attested to the accuracy and completeness of the information contained in Amedisys's 2Q10 10-Q.

389. In the 2Q10 10-Q, Amedisys also disclosed that it had experienced a decrease in its recertification rate during the second quarter of 2010: "Our internal episodic-based recertification growth has decreased from 10% in the second quarter of 2009 to a negative 9% for the second quarter of 2010."

390. The above statements were materially false and misleading when made because, among other things: (1) the statements concerning Amedisys's financial results, including revenue, income, earnings per share and retained earnings, and the purported reasons behind those increases, failed to disclose that they were materially and artificially inflated as a result of Defendants' improper manipulations of the Medicare reimbursement system, as described herein; (2) when making the material misstatements concerning the *WSJ* Article and the Senate Finance Committee investigation, Defendants knew or recklessly disregarded at the time, and failed to disclose, that they were engaged in a fraudulent scheme to improperly manipulate the Medicare reimbursement system, as described herein; (3) when making the material misstatements concerning Amedisys's extensive compliance practices, Defendants knew or recklessly disregarded at the time, and failed to disclose, that they were engaged in a fraudulent scheme to improperly manipulate the Medicare reimbursement system, as described herein; (4) when making the material misstatements concerning Amedisys's rate of recertification, Defendants knew or recklessly disregarded at the time, and failed to disclose that they were engaged in a fraudulent scheme to improperly manipulate the Medicare reimbursement system, including through improper recertification of patients, as described herein; and (5) when signing the above-described certifications, Defendants Borne and Redman knew about or recklessly disregarded, and failed to disclose, Defendants' fraudulent scheme to improperly manipulate the Medicare reimbursement system, as described herein.

* * *

391. All of the foregoing false and misleading statements were also false and misleading for their failure to disclose material, non-public facts whose non-disclosure rendered the Defendants' statements materially misleading. During the Class Period, Defendants failed to disclose the material adverse facts below that were in existence at the time each of the foregoing materially false and misleading statements was made, the disclosure of which would have led to a sharp decline in the price of Amedisys's common stock:

a. Amedisys provided medically unnecessary treatment visits to patients in violation of Medicare law;

b. Amedisys certified (and recertified) patients for medically unnecessary 60-day treatment episodes;

c. Amedisys implemented corporate-wide practices that were expressly designed to ensure that the Company would hit highly-lucrative Medicare reimbursement triggers, regardless of whether those triggers were justified under Medicare regulations;

d. Amedisys overcharged Medicare by implementing fraudulent "clinical tracks," such as its "Balanced for Life" and wound care programs, that automatically resulted in the provision of a pre-set number of therapy visits for patients in those programs irrespective of their genuine medical need;

e. Amedisys engaged in rampant improper upcoding, including by using its computer systems and QCCs to command nurses or therapists completing the OASIS form to select the therapy that would lead to the highest reimbursement for Amedisys – without regard to genuine medical need;

f. Amedisys paid improper and illegal remuneration to doctors to solicit the certification of profitable Medicare patients and facilitate improper patient recertifications;

g. Amedisys lacked processes and controls over coding, clinical operations, billing, patient recertifications and compliance to adequately monitor and ensure compliance with Medicare requirements; and

h. Amedisys lacked internal controls over financial reporting to ensure that Amedisys operated in compliance with Medicare regulations and that the Company's reported financial results accurately reported the Company's true finanicial state.

VIII. ADDITIONAL ALLEGATIONS SUPPORTING A STRONG INFERENCE OF SCIENTER

392. As alleged herein, Defendants acted with scienter in that they knew, or recklessly disregarded, that the public documents and statements issued or disseminated in the name of the Company were materially false and misleading; knew or recklessly disregarded that such statements or documents would be issued or disseminated to the investing public; and knowingly and substantially participated or acquiesced in the issuance or dissemination of such statements or documents as primary violators of the federal securities laws.

A. Defendant Amedisys and the Individual Defendants

393. The additional allegations below strongly support a finding that Amedisys and the Individual Defendants acted with scienter. In addition to the Individual Defendants, Amedisys acted through additional members of senior management, including Cheryl Lacey, who had knowledge of the fraud and who facilitated the provision of materially false and misleading information that was disseminated to public shareholders:

(a) Home Health Care Reimbursed by Medicare Is Amedisys's Primary Business. That home health care was both the core business and critically important to Amedisys supports a strong inference of scienter. Medicare-reimbursed home health care services's tremendous importance to Amedisys is indisputable, and Defendants made numerous materially false and misleading public statement about the core operations of the Company. As Amedisys acknowledges in its public filings, at all material times the Company has been (and remains) critically dependent on Medicare reimbursement payments as its primary source of revenue. Medicare payments consistently represented roughly 90% of the Company's net service revenue during the 2005-2009 time period. Given the critical importance of Medicare-reimbursed home health care to Amedisys, it is simply not plausible that Amedisys's most senior management, including the Individual Defendants, including those directly responsible for overseeing, managing and reporting on its financial state, were not privy to the internally known adverse facts about it.

(b) Defendants Were Aware During the Class Period of the Strict Medicare Reimbursement Requirements of Medical Necessity and Homebound Status. As a recipient of Medicare reimbursement, Amedisys executives understood that their provision of care to patients needed to comply with Medicare rules and regulations, including the requirements that medical care be medically necessary and that patients were homebound at the time of care.

(c) Defendants Established Financial Incentives and Quotas for Its Employees to Hit Medicare Reimbursement Thresholds. As discussed above, Amedisys established financial quotas and incentives for its employees to hit the Medicare reimbursement thresholds rather than medical necessity.

(d) Amedisys's Compliance Committee. During the Class Period, Amedisys had a Compliance Committee, which oversaw and was responsible for compliance practices and initiatives at Amedisys, including reviewing and handling all compliance issues faced by the Company. Defendants Borne and Jeter served on the Compliance Committee at all relevant times during 2006, 2007, and 2008; and at various times from 2006 to 2008, Defendants Graham, Redman, and Schwartz served on it as well. In their capacity as members of the Compliance Committee, these Defendants were responsible for and had access to all relevant information concerning purported Amedisys's legal and regulatory compliance, including purported compliance with Medicare regulations, and would have learned of the Company's violations of the law as set forth herein.

(e) Defendants Have Been on Notice of *Qui Tam* Suits and Governmental Investigations of the Company for Years, Including the DOJ's Requests for Documents and Testimony. Amedisys and the Individual Defendants received numerous CIDs (civil investigative demands) from the DOJ that put the Company on notice of the government's close scrutiny of its business practices. On September 28, 2010, Amedisys issued a press release disclosing that it had received a CID from the U.S. Attorney's Office for the Northern District of Alabama "pursuant to the federal False Claims Act." The CID asked for a wide range of documents and information related to the Company's "clinical and business operations, including reimbursement and billing claims submitted to Medicare." In addition, on April 26, 2011, Amedisys received another related CID requiring the production of additional documents. As Amedisys disclosed in its Form 10-Q dated May 9, 2012 for the quarter ended March 31, 2012 (the "1Q12 10-Q"), the second CID "related to the CID issued in September 2010, [and] generally covers the same time period as the previous CID and requires the production of additional documents." The 1Q12 10-Q also stated that the "CIDs are often associated with previously filed *qui tam* actions, or lawsuits filed under seal under the False Claims Act, 31 U.S.C. §3729 et seq." The 1Q12 10-Q added that "[s]ubsequent[to the receipt of the second CID], the Company and certain current and former employees have received CIDs for testimony."

(f) Amedisys's Recertification Rate Declined in the Wake of the April 2010 *WSJ* Article and Announcement of the Senate Investigation. The Senate Finance Committee, as part of its investigation, requested documents identifying physicians who gave the highest number of referrals to Amedisys in each state. Shortly after the announcement of the Senate Finance Committee's investigation into Amedisys's relationship with doctors, and the publication of the April 2010 *WSJ* article calling into question Amedisys's Medicare billing practices, the amount of the Company's re-certifications declined significantly. In fact, in the 2Q10 10-Q Amedisys admitted that its "internal episodic-based recertification growth has decreased from 10% in the second quarter of 2009 to a negative 9% for the second quarter of 2010." In the Form 10-Q for the third quarter of 2010, Amedisys again admitted a decline in recertifications, stating:

"We have continued to experience a decline in the number of recertifications over 2009 and expect the trend to continue into the fourth quarter." During the conference call held on August 9, 2010, discussing the results of the second quarter 2010, when asked "whether it's the behavior of the clinicians not seeking recerts" that was causing the decline in recertifications, Defendant Borne admitted that "we have to put it under behavioral."

(g) The October 2011 Senate Report Uncovered Improprieties at Amedisys. The Senate Finance Committee concluded in its Report that "[t]he home health therapy practices identified at Amedisys," including those alleged in this Complaint, "at best represent abuses of the Medicare home health program" and "[a]t worst, they may be examples of for-profit companies defrauding the Medicare home health program at the expense of taxpayers." The Senate Finance Committee also found that:

- "Internal documents from Amedisys show that, prior to the 2008 CMS therapy payment changes, managers were encouraged to meet the 10-visit therapy threshold;"
- "An 'A-Team' set up by Amedisys corporate management [including Defendants Schwartz] developed therapy programs after the release of the 2008 proposed PPS changes to target the most profitable Medicare therapy treatment patterns, including adding therapy visits to clinical tracks that previously did not involve therapy;"
- "Amedisys pressured therapists and regional managers to adhere to new clinical guidelines developed to maximize Medicare reimbursements;" and
- "Amedisys management directed employees to adjust the number of home health therapy visits to maximize Medicare payout to the company after the 2008 changes to the Medicare payment system."

As stated in the Senate Report, members of Amedisys's senior management reported these programs intended to inflate revenuws to the Amedisys Board of Directors including Defendant Borne and other of the Individual Defendants.

(h) Amedisys Self-reported Non-compliance with the Stark Law, which Prohibits Improper Payments to Doctors for Patient Referrals. In the 1Q12 10-Q, Amedisys revealed that it had made disclosures to CMS under the agency's Stark Law Self-Referral Disclosure Protocol relating to certain services agreements between a subsidiary of the Company and a large physician group.[22] In the 1Q12 10-Q, Amedisys admitted that, "[d]uring some period of time since December 2007, [the

[22] The Stark Law (i) prohibits physicians from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies, (ii) prohibits the entity from presenting or causing to be presented claims to Medicare (or billing another individual, entity, or third party payer) for those referred services, and (iii) establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse. 42 U.S.C. §1395nn.

Company's] arrangements appear ***not to have complied*** in certain respects with an applicable exemption to the Stark Law referral prohibition."

(i) Amedisys Entered Into the September 2013 Settlement of the Related Derivative Action. On September 5, 2013, the Court approved the settlement of the related derivative action arising out of the same set of operative facts as this case. Amedisys and other defendants (including Defendants Borne, Redman, Jeter, Browne, Graham, and Schwartz) agreed to adopt and maintain certain corporate governance reforms, and that the derivative action was a substantial factor in the decision to adopt the corporate governance reforms. The corporate reforms included establishment of a Compliance and Ethics Committee of the Board of Directors to oversee the CCO (Defendant Jeter) and to raise material compliance issues with the entire Board, outside review of Amedisys's compliance and ethics program, and maintenance, for at least three years, of certain governance and internal controls. As described by the derivative plaintiffs in their motion for preliminary approval of the settlement, the "[s]ettlement guarantees Amedisys and its shareholders the substantial, immediate, and lasting benefit of governance and oversight reforms that directly address the alleged internal control and compliance failures that led to the allegedly fraudulent Medicare billing scheme, and the related alleged deficiencies in the Company's disclosures to shareholders."

(j) Amedisys Settled the DOJ's Claims Against the Company for $150 Million. On November 12, 2013, Amedisys issued a press release, which announced that the Company had "recorded an accrual of $150 million related to the tentative settlement of both the DOJ investigation and the Stark Law Self-Referral matter" (the "DOJ Settlement"). The reference to the Stark Law corroborates Plaintiffs' allegations that Amedisys hired outside doctors as directors or consultants, though their primary, or only, role was to refer patients to Amedisys for home care, and that physicians routinely deferred to Amedisys in prescribing patients' courses of treatment. The November 12, 2013 press release further disclosed that "in connection with the tentative settlement, [the Company] expect[s] to enter into a corporate integrity agreement with the OIG – HHS."

By order of magnitude, Amedisys's $150 million cash payment is equivalent to approximately the aggregate of Amedisys's 2007 and 2008 profits. It far exceeds the settlement amounts that the government obtained in its comparable settlements with other home health companies that were mentioned, along with Amedisys, in the April 2010 *WSJ* article and the Senate Report. Specifically, the settlement amount is more than two times the amount of the government's $65 million settlement with LHC,[23] and six times the government's $25 million settlement with Gentiva.[24]

[23] *See* September 30, 2011 DOJ release, "Louisiana-Based LHC Group Inc. Agrees to Pay U.S. $65 Million to Resolve False Claims Act Allegations," available at http://www.justice.gov/opa/pr/2011/September/11-civ-1299.html, last visited January 13, 2015.

[24] *See* March 1, 2012 DOJ release, "Hospice Provider Odyssey Healthcare Agrees to Pay $25 Million to Resolve False Claims Act Allegations," available at http://www.justice.gov/opa/pr/2012/March/12-civ-272.html, last visited January 13, 2015.

(k) Defendant Borne, Amedisys Founder, Former CEO and Chairman of the Board, Resigned Shortly After Announcement of the DOJ Settlement. On February 24, 2014, Defendant Borne resigned suddenly from Amedisys, after 33 years with the Company that he personally founded. Kevin Kingsbury noted on *Dow Jones Newswire* on February 24, 2014 that there is "no comment in the struggling home-health firm's statement from Borne, further highlighting the board pushed [Amedisys's] founder out." According to a Credit Suisse research report of that same date, "[w]hile the announcement was somewhat sudden, a push for change was not entirely unexpected given years of operational underperformance and government investigations."

(l) The DOJ's April 23, 2014 Press Release Announcing the Completion of the $150 Million Settlement with Amedisys Provided Additional Details of the Allegations that the Settlement Resolved. The press release stated in relevant part:

"It is critical that scarce Medicare home health dollars flow only to those who provide qualified services," said Stuart F. Delery, Assistant Attorney General for the Civil Division. "This settlement demonstrates the department's commitment to ensuring that home health providers, like other providers, comply with the rules and don't misuse taxpayer dollars."

The settlement announced today resolves allegations that, between 2008 and 2010, certain Amedisys offices improperly billed Medicare for ineligible patients and services. Amedisys allegedly billed Medicare for nursing and therapy services that were medically unnecessary or provided to patients who were not homebound, and otherwise misrepresented patients' conditions to increase its Medicare payments. These billing violations were the alleged result of management pressure on nurses and therapists to provide care based on the financial benefits to Amedisys, rather than the needs of patients.

Additionally, this settlement resolves certain allegations that Amedisys maintained improper financial relationships with referring physicians. The Anti-Kickback Statute and the Stark Statute restrict the financial relationships that home healthcare providers may have with doctors who refer patients to them. The United States alleged that Amedisys' financial relationship with a private oncology practice in Georgia – whereby Amedisys employees provided patient care coordination services to the oncology practice at below-market prices – violated statutory requirements...

This settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by Attorney General Eric Holder and Secretary of Health and Human Services Kathleen Sebelius. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered a total of more than $19.2 billion through

False Claims Act cases, with more than $13.6 billion of that amount recovered in cases involving fraud against federal health care programs.[25]

(m) Amedisys's Corporate Integrity Agreement Reflects the Poor State of the Company's Internal Controls During the Class Period. The DOJ's April 23, 2014 press release also announced that Amedisys would be subject to a Corporate Integrity Agreement with the OIG of the HHS ("Corporate Integrity Agreement" or "CIA") that "requires the companies to implement compliance measures designed to avoid or promptly detect conduct similar to that which gave rise to the settlement."[26] Amedisys's April 24, 2014 Form 8-K announced details of the CIA:

> On April 23, 2014, the Company entered into a Corporate Integrity Agreement … with the OIG-HHS… Among other things, the Corporate Integrity Agreement requires the Company to maintain its existing compliance program and compliance committee; provide certain compliance training; continue screening new and current employees against certain lists to ensure they are not ineligible to participate in federal health care programs; engage an independent review organization to perform certain auditing and reviews and prepare certain reports regarding the Company's compliance with federal health care programs, the Company's billing submissions to federal health care programs and the Company's compliance and risk mitigation programs; and provide certain reports and management certifications to OIG-HHS. Upon breach of the Corporate Integrity Agreement, the Company could become liable for payment of certain stipulated penalties, or could be excluded from participation in federal health care programs.

(n) Under the CIA, Amedisys Must Undertake Significant Compliance Reforms, including the following:

- Administrators of Amedisys home health care centers (i.e., DOOs), are required to execute yearly certifications stating that "To the best of my knowledge . . . , the [insert name of care center] is in material compliance with applicable Federal health care program requirements and the obligations of the CIA."

[25] On April 24, 2014, Amedisys filed a Form 8-K with the SEC that announced that the Company had entered into the DOJ Settlement in order to release the Company from "(a) claims involving home health services rendered by certain of the Company's care centers from January 1, 2008 through December 31, 2010 that the United States contended were (i) provided to patients who were not homebound, (ii) provided to patients lacking a need for skilled nursing and/or skilled therapy services, (iii) provided to patients without regard to medical necessity, or (iv) overbilled by upcoding patients' diagnoses, and (b) claims arising from the Company's billings to the Medicare program during the period from April 1, 2008 through April 30, 2012 for home health services referred by a particular physician practice group while the Company was providing such practice group remuneration that was not consistent with fair market value in the form of patient care coordination services performed by Company employees."

[26] A corporate integrity agreement customarily "aris[es] under a variety of civil false claims statutes. Providers or entities agree to the obligations, and in exchange, OIG agrees not to seek their exclusion from participation in Medicare, Medicaid, or other Federal health care programs." http://oig.hhs.gov/compliance/corporate-integrity-agreements/index.asp, last visited April 2, 2015.

- Amedisys, within 90 days of the CIA, was required to distribute its Code of Conduct to all Covered Persons,[27] including statements that Amedisys requires they comply with all federal health care program requirements, that they are expected to report to Amedisys's Compliance Officer any suspected violations of those requirements, and Amedisys's commitment to non-retaliation and to maintain the confidentiality and anonymity of these reports.

- Amedisys, within 90 days of the CIA, was required to provide training to Covered Persons and Relevant Covered Persons.[28] Amedisys's training to Relevant Covered Persons was required to include a discussion of "(a) the Federal health care program requirements regarding the accurate coding and submission of home health claims; (b) policies, procedures, and other requirements applicable to the documentation of medical records; (c) the personal obligation of each individual involved in the claims submission process to ensure that such claims are accurate; (d) applicable reimbursement statutes, regulations, and program requirements and directives; (e) the legal sanctions for violations of the Federal health care program requirements; and (f) examples of proper and improper claims submission practices." In addition, each Amedisys Board member must also receive the same training as other Amedisys employees within 90 days of the CIA, and also receive an additional two hours of training on the responsibilities of Board members and corporate governance.

- Amedisys, within six months of the CIA, was required to develop "an internal Risk Evaluation and Mitigation Program (REM Program) that shall contain, at a minimum, the following elements: (a) an identification of the material Medicare compliance risk areas for Amedisys's home health services, based upon internal compliance audits, matters submitted to Amedisys's Disclosure Program, IRO reviews, and other appropriate internal risk assessments (Risk Evaluation); (b) a risk mitigation plan that outlines risk mitigation activities that will be performed and tracked for each risk identified in the Risk Evaluation (Risk Mitigation Plan); and (c) a system that monitors and tracks the implementation of the Risk Mitigation Plan (Monitoring System) to confirm that the specified mitigation activities are implemented and the results are reported to the Compliance Officer."

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[27] Covered Persons are "(a) all owners of Amedisys who are natural persons (other than shareholders who: (1) have an ownership interest of less than 5% and (2) acquired the ownership interest through public trading), officers, directors, and employees of Amedisys; and (b) all contractors, subcontractors, agents, and other persons who provide patient care items or patient care services or who perform billing or coding functions on behalf of Amedisys, excluding vendors whose sole connection with Amedisys is selling or otherwise providing medical supplies or equipment to Amedisys and who do not bill the Federal health care programs for such medical supplies or equipment."

[28] Relevant Covered Persons "includes Covered Persons involved in the delivery of patient care items or services to patients receiving home health benefits, the preparation or submission of such claims for reimbursement from any Federal health care program, and/or the internal review or auditing of such claims submitted to any Federal health care program."

- Amedisys, within 90 days of the CIA, was required to hire an Independent Review Organization that will review the REM Program, and "Amedisys's home health coding, billing, and claims submission to the Medicare program and the reimbursement received (Claims Review)."

- Amedisys, within 120 days of the CIA, and yearly thereafter, was required to provide a report detailing its compliance with the CIA.

(o) Statements by U.S. Attorneys Involved in the Investigation into Amedisys Characterized Amedisys's Misconduct as Medicare Fraud. For example:

- Joyce White Vance, the U.S. Attorney for the Northern District of Alabama, stated: "Amedisys made false Medicare claims, depriving the American taxpayer of millions of dollars and unlawfully enriching Amedisys. The vigorous enforcement work by assistant U.S. attorneys in my office, along with their colleagues in North Georgia, Eastern Pennsylvania, Eastern Kentucky and the Civil Division of the Justice Department, has secured the return of $150 million to the taxpayers and stands as a warning to future wrongdoers that we will aggressively pursue them."

- Zane David Memeger, the U.S. Attorney for the Eastern District of Pennsylvania, stated: "Combating Medicare fraud and overbilling is a priority for my office, other components of the Department of Justice, and United States Attorneys' Offices across the country. We have recovered billions of dollars in federal health care funds from schemes such as the one alleged in this case. Those are health care dollars that should be spent on legitimate medical needs."

- Kerry B. Harvey, the U.S. Attorney for the Eastern District of Kentucky, stated: "This settlement represents a significant recovery of public funds and an important victory for the taxpayers. Fighting health care fraud and recovering taxpayer dollars that fund our vital health care programs is one of the highest priorities for our district."

- Sally Quillian Yates, the U.S. Attorney for the Northern District of Georgia stated: "Home health services are a large and growing part of our federal health care system. Health care dollars must be reserved to pay for services needed by patients, not to enrich providers who are bilking the system."

- Daniel R. Levinson, the Inspector General for HHS, was also quoted in the DOJ press release, and characterized Amedisys's actions as fraud: "Improper financial relationships and false billing, as alleged in this case, can shortchange taxpayers and patients. Our compliance agreement with Amedisys contains strong monitoring and reporting provisions to help ensure that people in Federal health programs will be protected."

(p) DOJ Intervention in and Settlement of the *Qui Tam* Litigations Reflects the Strength of Those Allegations. On April 22, 2014, the DOJ filed a Notice of Election to

Intervene in Part and Declination in Part in the CAF, Brown, Umberhandt, Lewis, Maffit, and Ognen actions, in which the United States "[n]otifie[d] the Court of its election to intervene in part for settlement purposes against the following defendants - Amedisys, Inc.; Amedisys Holding, LLC; Amedisys Home Health, Inc. of Alabama; Amedisys Georgia, LLC; Amedisys Hospice, LLC; and Amedisys Northwest, LLC (collectively, "Amedisys") -- as to allegations that [certain identified] Amedisys care centers[29] . . . improperly billed and failed to refund overpayments for Medicare home health care services that Amedisys: (a) provided to non-homebound patients, (b) provided to patients lacking a need for skilled nursing and/or skilled therapy services, (c) provided to patients without regard to medical necessity, and (d) overbilled by upcoding patients' diagnoses, during the period from January 1, 2008 through December 31, 2010. The United States declines to intervene as to all other allegations and defendants."[30]

The fact that the DOJ intervened in the *qui tam* litigations is significant, and speaks to the merits of the claims alleged. According to a memorandum published by the DOJ titled "False Claim Act Cases: Government Intervention in *Qui Tam* (Whistelblower) Suits,"[31] intervention by the DOJ is relatively rare: "Fewer than 25% of filed *qui tam* actions result in an intervention on any count by the Department of Justice." Further, "Intervention by the Department of Justice in a qui tam case is not undertaken lightly" and "Intervention usually requires approval by the Department in Washington."

(q) The *Qui Tam* Relators Received Significant Whistleblower Awards and the Payment of Attorneys' Fees. The DOJ's April 23, 2014 press release announced that the DOJ Settlement also resolved the seven *qui tam* lawsuits filed against Amedisys, and that the relators would collectively receive over $26 million in whistleblower awards. As part of the DOJ Settlement, Relator Brown received $6,564,386.69, plus interest; Relator CAF Partners received $18,692,067.21, plus interest; Relator Umberhandt received $208,360.85, plus interest; and Relators Raven and Curtis each received

[29] The list of Amedisys care centers included nine centers in Alabama (Ozark, Tuscaloosa, Fayette, Brent, Gadsden, Anniston, Sylacauga, Roanoke, and Citronelle), seven centers in Florida (Jacksonville, Brandon, Palatka, Gainesville, Lake City, Ocala, and Chiefland), six centers in Georgia (Rome, Cartersville, Cedartown, Covington, Monroe, and Athens), two centers in Louisiana (Lafayette and Opelousas), four centers in Mississippi (Collins, Laurel, Hattiesburg, and Magee), seven centers in Oklahoma (Oklahoma City, Stroud, Seminole, Enid, McAlester, Yukon, and Ardmore), two centers in Pennsylvania (King of Prussia and Allentown), six centers in South Carolina (Lexington, Orangeburg, Sumter, Newberry, Greenville, and Clinton), eleven centers in Tennessee (Lebanon, Nashville, Gallatin, Clarksville, Dickson, Jamestown, Livingston, Crossville, Oneida, Cookeville, and Bartlett), and three centers in Virginia (Abingdon, Duffield, and Clintwood).

[30] On April 22, 2014, the U.S. District Court for the Eastern District of Pennsylvania (where the *qui tam* actions were consolidated, except for the *United States ex rel. Raven and Curtis* action) issued an order that provided for the operative *qui tam* complaints by Relators CAF, Brown, Umberhandt, Lewis, Maffit, and Ognen be unsealed once the DOJ filed a Notice of Settlement and attached the fully executed settlement. The Order also provided that the Notice of Intervention in part and Declination in Part, the unsealing order, and all papers filed after the Notice of Settlement would also be unsealed. All other documents remained sealed.

[31] Available at http://www.justice.gov/sites/default/files/usao-edpa/legacy/2011/04/18/Internet%20Whistleblower%20update_0.pdf (last visited January 13, 2015)

$467,844.47, plus interest. In its April 24, 2014 Form 8-K, Amedisys also announced that it would pay the relators' attorneys $3.9 million in fees and expenses.

(r) Amedisys Entered Into the July 2014 Settlement of the Related ERISA Action. On July 24, 2014, the Court approved the settlement of the class action lawsuits alleging violations of the Employee Retirement Income Security Act of 1974 ("ERISA"). Amedisys and other Defendants (including Defendants Borne, Graham, Redman, Browne, and Schwartz) agreed to pay $1.2 million and provide additional non-monetary benefits to 401(k) Plan participants. The non-monetary relief, to be provided at Amedisys's cost, includes annual training by outside counsel in fiduciary duties and best practices for existing ERISA plan fiduciaries, training for each new ERISA plan fiduciary, and Amedisys's participation in education campaigns regarding benefits of diversification of investments, the availability and potential benefits of age-targeted investments, and the evaluation of risks and potential benefits of different investment options.

(s) Amedisys Senior Managers Knowingly Provided Information for Use in Forming False and Misleading Statements by the Company. Cheryl Lacey is, and throughout the Class Period was, a senior-level employee in operations at Amedisys. Lacey was a key link between Amedisys's senior managers, including the Individual Defendants, and Amedisys's agencies and lower level employees. Prior to 2009, Amedisys Senior Vice President Jill Cannon, to whom Lacey reported, reported directly to COO Defendant Graham. After 2009, when Graham and CIO Defendant Schwartz left the Company, Cannon reported directly to Defendant Borne. Both Lacey and Cannon were recipients of emails and documents cited by the Senate Report, including documents related to data mining for most profitable diagnoses and ranking diagnoses by average profit per episode, adding therapy visits to congestive heart failure diagnoses to increase revenue, using Balanced for Life to increase revenue, and A-Team activities. In fact, both Cannon and Lacey were recipients of the Therapy Initiatives Update email distributed to the A-Team Case Mix Committee, evidencing that both of them were members of the A-Team run by Defendant Schwartz. According to CW-11, during the Class Period, the Oklahoma-based Lacey was initially a Vice President of Operations, and was later promoted to Senior Vice President of Operations.[32] According to CWs 5, 7, 11, 33, and 46 (*see* Appendix A), Lacey directed regional executives and employees to engage in practices that defrauded Medicare

- CW-11 reported that Lacey was responsible for ensuring (i) that Amedisys's agencies maintained high censuses (i.e., a high volume of patients receiving treatment); (ii) that 100% of treated individuals were covered by Medicare which reimbursed Amedisys at higher rates than private insurance providers;

[32] According to her *Bloomberg Business* profile, Lacey is currently "the Senior Vice President of Operations for [the] Home Care Division of Amedisys Inc. Ms. Lacey is responsible for half of [] Amedisys's operational functions and procedures within the home care division. . . . She joined Amedisys with its first acquisition in 1998, and has held positions including Administrator, Regional Administrator and, most recently, Vice President of Operations." http://www.bloomberg.com/research/stocks/people/person.asp?personId=106581078&ticker=AMED

(iii) that the agencies kept patients on as long as possible; and (iv) that the agencies avoid LUPAs. CW-11 also stated that Lacey was responsible for gathering information on total census, revenue per agency, average length of stay, numbers of LUPAs, new admissions, and discharges, and that Lacey then forwarded that information to her supervisor Jill Cannon – the Senior Vice President to whom Lacey reported. Lacey in turn supervised and gave direction to Maggie Suggs and CW-11, who then passed along directions to their subordinates.

- CW-11 further reported that Lacey pressured the agencies to ensure that patients received as many physical therapy visits as possible. Amedisys would "push the envelope" and, as a result Lacey held a conference call in 2006 or 2007 issuing a companywide directive to urge the agencies to more closely monitor physical therapy visits because many of those visits were in violation of the law. That call included all of Amedisys's area Vice Presidents of Business Development (such as CW-11), all of the Company's area Vice Presidents of Operations (such as Maggie Suggs), and all of the Directors of Nursing. On that call, Lacey indicated that the Company was being watched for compliance and it was clear that the Company was going to be looked at, although CW-11 did not know how the company learned they were being watched. Lacey directed each regional Vice President to communicate throughout his or her region that the agencies should back off of physical therapy visits.

- CW-11 further described Lacey as enforcing the rule that Amedisys employees were to reach the goal of 10 visits every time – whether the patient needed them or not. CW-11 reported being in attendance at meetings where this practice was discussed, and also reported having discussions with Maggie Suggs, who reported to Lacey, about having case conferences with physical therapists in her region about how they needed to keep their patients on longer. According to CW-11, Suggs said that she would visit Amedisys branches that were having operational issues – and that not doing 10 visits was an operational issue.

- CW-11 also reported that Lacey suggested, during that same call, that the agencies see patients under different diagnoses than those under which they were initially admitted in order to prolong relationships with patients.

- In addition, CW-11 stated that Lacey held weekly calls with the area Vice Presidents of Business Development, the area Vice Presidents of Operations, and the Directors of Nursing, during which she would discuss the numbers of LUPAs and stress the need to avoid LUPAs because it meant the company was losing money. On those calls, Lacey would also discuss the numbers of Medicare admissions, the average length of patient stays, the numbers of discharges, and anticipated referrals.

- CW-5 had significant contact with Lacey during weekly conference calls, and received the directive from Lacey that "you will have 10 PT [physical therapy]

visits." CW-5 also described Lacey as quite bad with respect to the aggressive steps that Amedisys management took to maximize the number of Amedisys patients who hit (or just slightly exceeded) the 10-therapy visit threshold.

- CW-7 confirmed that Lacey, on behalf of senior management, delivered the directive to employees to ensure that patients received 10 therapy visits or else the employees would be in trouble, and that these instructions came down in regular conference calls with branch directors of operations. Lacey also instructed employees to make sure that, if a patient was going out of town and would not be available for 10 physical therapy visits on a three-times-a-week schedule, as was normal, the patient would receive physical therapy every day for 10 days. CW-7 further confirmed that Lacey and Suggs led those calls.

- CW-33, who served as a Regional Administrator whose territory gradually expanded until being promoted to Vice President of Operations (at which point she began to report to Lacey), described "struggling" when CW-33 started reporting to Lacey. According to CW-33, Lacey directed CW-33 to do "things that went against my grain" as an ethical person. Those actions included promoting the Balanced for Life program and order for patients to fall into certain CMS therapy "buckets" just as it became known that Medicare was going to implement the revised therapy visit payment reimbursement scheme in 2008. CW-33 stated that it seemed that if certain patients needed a certain level of care under the new regulations, then they would have needed the same level of care prior to those new regulations.

- CW-46 also confirmed that Lacey actively enforced management's directives to maximize Medicare reimbursements regardless of medical necessity. According to CW-46, for both referrals and recertifications, when a nurse would "dig their heels in" and refused to admit or recertify patients because they did not qualify, the case would be kicked up to one among a group of executives – including Lacey, Suggs, and Cannon for review – which often resulted in a different clinician being sent out to evaluate the patient (or prospective patient). According to CW-46, these executives were sending out a different clinician to get a different answer on the patient, and reiterated that the push for admissions and recertifications was extreme.

- Based on information that Lacey communicated during the phone calls described above with area Vice Presidents and Directors, Amedisys employees throughout the Company's regions and agencies knew and came to understand that the Company's senior management, including the Individual Defendants, expected employees to maintain high patient censuses, provide treatment to patients for as long as possible even when not necessary, do whatever possible to avoid LUPAs even when not necessary, and otherwise maximize Medicare reimbursements even if it meant providing services that were not medically necessary.

- Lacey fraudulently manipulated the number of therapy visits provided to Amedisys patients, and directed the provision of medically unnecessary visits

> to Amedisys patients, with scienter. This information was then included in Amedisys's and the Individual Defendants false and misleading public statements. Lacey, as the key link between Amedisys's senior managers, including the Individual Defendants, and Amedisys's agencies and lower level employees, ordered or approved the making or issuance of these statements, or furnished the information for inclusion within these statements, with scienter.

B. The Individual Defendants

394. The Defendants named herein were the officers primarily responsible for speaking on behalf of Amedisys to the investing public (and in certain instances also signatories of the Company's annual and quarterly SEC filings during the Class Period). The Defendants had ultimate control over Amedisys's public statements, and personally made numerous materially false and misleading statements concerning Amedisys's home health care operations during the Class Period. Each of the Individual Defendants held key positions and responsibilities within the Company such that they would have been knowledgeable about Amedisys's core business. The additional allegations below support a strong inference that the Individual Defendants acted with scienter:

1. Defendant Borne

395. According to the employment agreement between Amedisys and Defendant Borne dated January 1, 1999, Borne was ultimately responsible for, and exercised control over, the Company:

> BORNE shall perform such duties as are usually performed by a Chairman/Chief Executive Officer of a business similar in size and scope as the Company and such other reasonable additional duties as may be prescribed from time to time by the Company's board of directors which are reasonable and consistent with the Company's operations, taking into account BORNE's expertise and job responsibilities…

As was the case with Borne, the CEO is typically the highest-ranking member of the executive team and is responsible for managing the company's operations and resources. Defendant Borne was the Founder, CEO, and Chairman of Amedisys since its inception in 1982 and was knowledgeable about its core business practices. Borne was the officer primarily responsible for speaking on behalf of

Amedisys to the investing public, and made numerous materially false and misleading statements to the investing public during the Class Period. This included certifying pursuant to the Sarbanes-Oxley Act that the information in Company reports "fairly presents, in all material respects, the financial condition and result of operations of the Company." In short, Borne had ultimate control over Amedisys's business and public statements.

396. CW-5 recalled attending an Amedisys management meeting in Orlando, Florida during the early spring of 2006, which was also attended by other Amedisys Directors of Operations and certain other managers from around the country. At the meeting, CW-5 described how Defendant Borne went on a "tirade" about an unspecified investigation concerning Amedisys, and cautioned the managers against cooperating in the investigation. According to CW-5, he wanted all the branch managers at the meeting to know that, as managers, they were going to be sitting right there by him at the defendants' table, and that "I am going to hold you underwater if I go down." CW-53 also attended the same 2006 meeting in Florida, and corroborated CW-5's recollection of that meeting. For example, CW-53 similarly recalled Borne telling them that an unspecified government investigation of Amedisys was going on, and how "if he [Borne] was sinking in the ocean, he would step on our heads, hold our heads underwater, and take our last breath of air and come up above water." Borne also told attendees, in substance, that they would be sitting beside him in the courtroom "if it came to that." Borne's staff immediately tried to get him away from the microphone and a break was called before the meeting continued; when Borne returned he changed subjects and said nothing further about any investigations. Defendant Borne's statements at this meeting support a strong inference of scienter and that he was personally aware of the fraudulent practices alleged herein. They also confirm the intimidating and domineering role of management at Amedisys, which is described by numerous confidential witnesses herein. *See* Appendix A.

397. As discussed above, on February 20, 2014, shortly after the November 2013

announcement of Amedisys's $150 million settlement with the DOJ, and two months before the DOJ Settlement was finalized and announced, Defendant Borne stepped down from his position as CEO, Chairman, and member of the Board of Directors of Amedisys.

398. Defendant Borne was clearly aware of the opportunity for Amedisys to game PPS and increase revenue after the 2008 PPS changes – he specifically told the Board of Directors it was an opportunity to "enhance shareholder value despite the payment changes." Senate Report at 11 n.25.

399. Defendant Borne was at the July and October 2007 Board meetings where Defendant Schwartz presented on the A-Team and the Case Mix Refinement Plan.

400. Defendant Borne was a recipient of the A-Team "Therapy Initiatives Update" document discussing using Balanced for Life to increase revenue and reimbursement. Senate Report at 13 n.24, 287-88.

401. Defendant Borne was also on the Amedisys Compliance Committee, and was a settling defendant in the related ERISA and Derivative Actions. Defendant Borne further made false and misleading statements, among other things, in April and July 2010 in response to the *WSJ* Article. Once he chose to speak, he was obligated to ensure he spoke fully and accurately.

2. Defendant Schwartz

402. Defendant Schwartz was Amedisys's CIO from September 2004 through September 3, 2009, and this case largely concerns the Company's manipulation of its Medicare billing technology. Schwartz, as CIO, was responsible for the OASIS information management system through which Amedisys was able to upcode the severity of its patients' therapy needs. According to the employment agreement between Amedisys and Defendant Schwartz dated October 26, 2006, she was responsible for and had control over the Company's information systems, including compliance with policies, regulations, and laws:

> [Schwartz] shall perform such duties as are usually performed by the chief information officer of a publicly-traded company similar in size and scope to the Company.

> [Schwartz] shall also perform such other reasonable additional duties as may be prescribed from time to time by the Company's Board of Directors (the "Board"), the Company's Chief Operating Officer and President or the Company's Chief Executive Officer, consistent with the expectation of the Company and the Company's operations and taking into account [Schwartz]'s expertise and job responsibilities, including but not limited to adherence to internal compliance policies, regulatory agency rules and regulations and applicable Federal and State laws. [Schwartz] shall have the title of Chief Information Officer and shall report directly to the Company's Chief Operating Officer and President (or his designee) and indirectly to the Company's Chief Executive Officer.

Defendant Schwartz had control over Amedisys's information systems, including but not limited to ultimate control over AMS2 and the Point-of-Care computer systems, and was primarily responsible for speaking on behalf of Amedisys to the investing public concerning matters relating to Amedisys's information system and other matters, and in fact made at least one false and misleading public statement during the Class Period as evidenced herein. Defendant Schwartz directly reported to Amedisys's COO (which, during her tenure was Defendant Graham) and indirectly to Defendant Borne, and Schwartz shared control over Amedisys's business and public statements. As the senior officer primarily responsible for Amedisys's information systems, including the OASIS system, Defendant Schwartz provided information that was incorporated into public statements that she knew or recklessly disregarded were false and misleading.

403. Defendant Schwartz was in charge of the A-Team, set up by Amedisys corporate management after the release of the 2008 PPS changes to "target the most profitable Medicare therapy treatment patterns, including adding therapy visits to clinical tracks that previously did not involve therapy." Senate Report at 1. Defendant Schwartz's administrative and executive assistants also distributed A-Team documents discussing using Balanced for Life to increase revenue and incorporating therapy into congestive heart failure treatment, and Defendant Schwartz was herself a recipient of those documents.

404. Defendant Schwartz was a recipient of the June 8, 2007 Data Mining Strategies documents discussing using data mining to target the most profitable diagnoses and ranked medical

diagnoses by average profit per episode. Senate Report at 186-90.

405. Schwartz also attended the July 2007 and October 2007 Amedisys Board meetings to discuss how the 2008 changes to the PPS would be impacting Amedisys's revenues and how Amedisys could change its business model to adapt to them and preserve and increase Amedisys's revenue, including through the manipulation of the OASIS system and the provision of the medically unnecessary wound care and balanced for life clinical tracks.

406. On July 24, 2007, Schwartz reported to the Amedisys Board on the formation and purpose of Amedisys's "A-Team," whose purpose was to "develop strategic clinical programs and cost-current efficiency measures to address the proposed case mix reference."

407. Schwartz's assistant distributed to Schwartz and other Defendants the "Therapy Initiatives Update" for use on an August 31, 2007 A-Team Case Mix Committee conference call. The document indicates that the average Balanced for Life reimbursement was $4,100 in 2007, and in 2008, the document noted a projected reimbursement increase to $4,700 because occupational therapy was added to the Balanced for Life program. Senate Report at 13 n.34, 287-88.

408. During a staff meeting in September 2007, Defendant Schwartz tasked the Vice President of Information Services, Dana Voss, to develop a Case Mix Project Plan to plan for the necessary programming changes to AMS2. During the same meeting, CIO Schwartz directed the IT Compliance Manager to engage outside consultants to perform a certification and review of the data collected through the Case Mix Project created by Voss and advised that third party validation was necessary to appease Amedisys's Board of Directors. Schwartz was project sponsor of Amedisys's Case Mix Project Plan version 1.0, whose purpose was to "address the Prospective Payment System and Case Mix changes occurring in 2008," and which "identifies AMS code changes that must be made in order to comply with the new 2008 refinements to PPS calculations and case mix." CAF ¶¶200-02.

409. Defendant Schwartz received the October 2007 Excel spreadsheet, which was "used to track tasks of the 'A-Team' committee," and revealed that "Amedisys management decided, as part of its clinical strategy, to incorporate 'therapy into [the congestive heart failure] program' and institute 'Aggressive [Balanced for Life] and multi-disciplinary therapy program launches in 2008.'" Senate Report at 13 n.33, 264-85.

410. In March 2008, Defendant Schwartz attended the Amedisys leadership conference in Orlando, Florida, at which Defendant Borne stated that Amedisys had developed programs to obtain the higher reimbursement rates under the new Medicare regime.

411. In 2008 and 2009, as a member of Amedisys's "Rehab Team," Defendant Schwartz was responsible for gaining academic support for, and substantiating Amedisys's claims regarding, Balanced for Life, and was unsuccessful in gaining the support of institutions including Yale, Johns Hopkins, and Emory University. CAF ¶160.

412. According to Relator CAF, Defendant Schwartz resisted attempts by Amedisys's IT department to curtail improper AMS2 data changes and data fixes. CAF ¶175.

413. Defendant Schwartz gave presentations to physician consultants during lavish trips to exotic locations. CAF ¶¶260-61.

414. Evidence of Defendant Schwartz's and Jeter's failure to ensure that Amedisys complied with governing laws is demonstrated by how they treated an improper breach of confidential patient information during the Class Period. In or around August 9, 2008, an Amedisys partner, Outcome Concept Systems ("OCS") mistakenly sent Amedisys agency reports containing protected health information of 4,084 Amedisys patients (including patient names, start of care and discharge dates) to 7 home health care entities outside of Amedisys in direct violation of HIPAA regulations. CAF ¶195.

415. Although OCS and Amedisys were obligated to report these HIPAA violations to the

government, Defendant Schwartz, after consulting with Defendant Jeter, made the decision to not report the security breach and instead just "let it die" and to "move on." Defendant Schwartz's stated reason for overlooking OCS's serious breach of HIPAA was because at that time, OCS was working on "major projects" for Amedisys and she did not want this issue obstructing the progress of those projects. CAF ¶196.

416. On September 3, 2009, Amedisys announced the abrupt resignations of Defendant Schwartz as CIO and Defendant Graham as President and COO.[33] Amedisys's 2008 10-K identified both Schwartz and Graham as key members of Amedisys's senior management team, whose loss would have a "material adverse effect" on the Company's business:

> Our success depends upon the continued employment of members of our senior management team, including our Chairman and Chief Executive Officer, William F. Borne, our President and Chief Operating Officer, Larry R. Graham, our Chief Financial Officer, Dale E. Redman, our Chief Information Officer and Senior Vice President of Clinical Operations, Alice A. Schwartz, and our Chief Compliance Officer, Jeffrey D. Jeter. The loss or departure of any one of these executive officers could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

417. Market participants viewed these abrupt resignations as a significant negative development for the Company and a "red flag."

3. Defendant Graham

418. Defendant Graham was the COO for Amedisys from January 1999 through September 3, 2009. According to the employment agreement between Amedisys and Graham dated February 1, 2000, he was responsible for and had control over the Company's operations:

> GRAHAM shall perform such duties as are usually performed by the Chief Operations Officer of health care companies of a business similar in size and scope as the Company and such other reasonable additional duties as may be prescribed from time to time by the Company's Chief Executive Officer which are reasonable and consistent

[33] On or about Friday, September 4, 2009, and then again on or about Sunday, September 6, 2009, immediately following Defendant Graham's departure from Amedisys, his executive assistant, Kethlen Owens, was seen entering corporate headquarters around midnight and leaving a short time later with what appeared to be boxes of documents and a computer. CAF ¶17.

> with the expectations of the Company and the Company's operations, taking into account GRAHAM's expertise and job responsibilities, including but not limited to, adherence to internal compliance and governmental and regulatory rules, regulations and applicable laws. GRAHAM shall report directly to the Chief Executive Officer of the Company or his designee.

Defendant Graham had control over the operational activities of Amedisys and was primarily responsible for speaking on behalf of Amedisys to the investing public providing information on matters relating to Amedisys's operational status, and in fact did make multiple statements during the Class Period to the public as evidenced herein. Graham directly reported to Borne and shared control over Amedisys's business and public statements.

419. Defendant Graham was at the July and October 2007 Board meetings where Defendant Schwartz presented on the A-Team and the Case Mix Refinement Plan.

420. Defendant Graham was a recipient of documents referenced by the Senate Report, including the Data Mining Strategies documents discussing data mining for most profitable diagnoses and ranking diagnoses by average profit per episode and Tasha Mears Amedisys's VP of Quality Management and Analytics) email to the DOOs, VPs of Operations, Regional Administrators, Senior VPs of Operations, and Episode Management concerning increases in revenue per episode for moving from bucked to bucket.

421. Defendant Graham was also a member of Amedisys's Compliance Committee, and was a settling defendant in the related ERISA and Derivative Actions.

4. Defendant Jeter

422. Throughout the Class Period, Defendant Jeter served as the Company's CCO. In that capacity, as he told analysts during the October 28, 2008 conference call in connection with Amedisys's Third Quarter 2008 earnings announcement, Jeter was "the person responsible for oversight of the compliance functions of Amedisys."

423. According to Defendant Jeter's employment agreement with the Company dated

October 26, 2006, Jeter was responsible for and had control over the Company's compliance with policies, regulations, and laws, "including but not limited to adherence to internal compliance policies, regulatory agency rules and regulations and applicable Federal and State laws." Jeter reported directly to Defendant Graham for much of the Class Period and indirectly to Defendant Borne, and shared control over Amedisys's business and public statements.

424. Defendant Jeter also served on the Company's Compliance Committee during the Class Period, further evidencing his knowledge of the Company's severe compliance failures and its improper focus on maximizing Medicare reimbursement regardless of need. The Compliance Committee oversaw and was responsible for compliance practices and initiatives at the Company. In that capacity, Jeter was responsible for and had access to all relevant information concerning Amedisys's purported legal and regulatory compliance, including with Medicare regulations.

425. Defendant Jeter was directly, personally aware of key compliance problems at Amedisys. As part of the Company's purported compliance efforts, Amedisys maintained a fraud reporting hotline that – as numerous CWs confirmed – allowed employees to report compliance problems directly to Jeter. *See* Appendix A. For example, CW-37, who worked as a nurse in Kentucky from November 2008 through December 2009, called the confidential hotline twice to report Medicare fraud, including harassment toward those employees who refused to participate in the Company's fraudulent practices. Because Jeter thereby regularly received information concerning the Company's endemic compliance problems, he knew or recklessly disregarded that Amedisys was committing Medicare fraud.

426. There can be no genuine question that Company-wide compliance with applicable laws and regulations was Defendant Jeter's responsibility, or that he publicly reinforced the false contention that the Company at all times did so comply. On the October 28, 2008 call, Jeter represented that, under his direction, Amedisys's "targeted and tiered training strategy to train all of

our staff about the seminal importance of compliance in our day-to-day jobs," including "the constraints and legal limitations placed on [] marketing activities by the federal anti-kickback law and the Stark law."

427. Defendant Jeter repeatedly touted the Company's Point-of-Care system as a key tool to help Amedisys ensure and enforce compliance with all applicable laws and regulations. For instance, during the October 28, 2008 conference call with investors, Jeter stated that "our point-of-care system represents a fundamental compliance control and is the sort of technology that helps us improve not only what we do in terms of clinical care but how we do it in terms of our adherence to Medicare rules and regulations," and that "one simply cannot overemphasize the importance of this technology as a means for strengthening our compliance with the law." Jeter further touted "the quality of our documentation" that the Point-of-Care system provided.

428. Tellingly, Defendant Jeter reassured investors about the Company's practices that implicated certain of the fraudulent practices discussed herein. Specifically, Jeter stated that "[b]eginning in early 2005, we identified three key areas to which any home healthcare agency may be susceptible because of the inherent revenue impacts of each": (i) "excessive therapy, where a high number of therapy visits are conducted, which results in increased reimbursement and may be potentially suggestive of fabricated or unnecessary visits just to increase reimbursement"; (ii) "LUPA exaggeration . . . which may be suggestive of potentially fabricated or unnecessary visits so as to avoid having reimbursement automatically reduced by the government"; and (iii) "up-coded case mixes, where an agency has a higher than average case mix weight that may be suggestive of possible manipulation of coding occasioned by scoring patients as sicker than they actually are."

429. Defendant Jeter explicitly stated that he personally, and his compliance staff, were focused those three areas – each of which were central to Amedisys's fraudulent conduct. As Jeter noted, "because of the revenue implications of each, there exists a potential for improprieties," which

"warrant[ed] a compliance review," and "[s]ince 2005, my staff has audited those agencies that stand out based on these high revenue audit focus areas."

430. In reality, however, and as Defendant Jeter knew, Amedisys and its agencies did not comply with governing laws and regulations. Among other things, as Defendant Jeter knew, the Point-of-Care system was central to the improper and illegal steps that Amedisys took to maximize Medicare reimbursement regardless of patient need.

431. The use of the Point-of-Care system to maximize Medicare reimbursement regardless of patient need was consistent with the emphasis that Defendant Jeter personally and repeatedly placed on maximizing reimbursement. As CW-7 confirmed, during a week-long Amedisys conference in Florida that likely occurred in 2006, Jeter – along with Defendant Borne and all the upper management – stressed to sales and branch directors of operations the importance of making sure that patients receive at least 10 therapy visits (or at least 5 total visits, to avoid a LUPA).

432. CW-55 discussed another Amedisys conference that Jeter attended where management made clear that, after the 2008 changes in Medicare reimbursement targets, the Company's focus was still on maximizing reimbursement. According to CW-55, at a March 2008 Amedisys leadership conference for directors of operations, regional vice presidents, and sales personnel in Orlando, Florida – attended by Jeter along with Defendants Borne, Graham, and Schwartz and other top executives – Borne told the assembled crowd (including Jeter) that Amedisys would survive where other companies did not because it had developed programs to ensure that the Company continued to obtain higher reimbursements.

433. Defendant Jeter was also involved in the implementation of "Mercury Doc," the kickback scheme that Amedisys used to entice physicians to refer patients to Amedisys with the promise of Care Plan Oversight Billing. Mercury Doc functioned as a physician software platform that permitted physicians to bill Medicare for their time overseeing patients under the care of a

Medicare-certified home health agency. As the Company has admitted, by February 2009, Mercury Doc was responsible for increasing physician referrals to the point that 16% of referrals came through the Mercury Doc portal. Those significant referrals were due in large part to the fact that Amedisys's account executives enticed physicians to refer patients by explaining that, if they did not, they would be leaving "$25,000 to $45,000" a year in CPO Medicare reimbursement on the table.

434. In reality, far beyond properly using Mercury Doc to help manage patient care, Amedisys encouraged doctors to use Mercury Doc to secure improper Medicare payments. Despite the fact that CMS Conditions of Coverage do not permit CPO reimbursements for simply opening a computer file, Amedisys representatives encouraged physician attendees at the 2008 Amedisys Physician Consultant conference at the Ritz Carlton in New Orleans to "have your nurse log in for you" in a bald attempt to induce referrals by promoting fraudulent CPO billing.

435. Defendant Jeter played a key role in working to abuse Mercury Doc to maximize patient referrals. The Company's "Mercury Doc Enhancement Tracking Log" included Jeter's request to "Add Physician Consultant invoice capabilities" to Mercury Doc. In other words, Jeter was working to ensure that the same physicians who received unearned CPO reimbursements for referring patients could also receive additional revenue or benefits as Amedisys Physician Consultants.

436. Defendant Jeter attended by teleconference the July and October 2007 Amedisys Board meetings where Schwartz presented on the A-Team and the Case Mix Refinement Plan.

437. Jeter was also aware of, and failed to correct, legal violations such as HIPAA violations that came directly to Jeter's attention. In or around August 9, 2008, Amedisys partner Outcome Concept Systems mistakenly sent Amedisys agency reports containing protected health information of 4,084 Amedisys patients (including patient names, start of care, and discharge dates) to seven home health care entities outside of Amedisys, in direct violation of HIPAA regulations.

Jeter consulted with Defendant Schwartz regarding whether to report those HIPAA violations to the government, but they decided not to report the violations and instead to "let it die" and to "move on."

438. Further, Jeter was a named defendant to the derivative action, based on the same operative facts set forth herein, that Amedisys and other defendants (including Defendants Borne, Redman, Browne, Graham, and Schwartz) settled in September 2013. Pursuant to that settlement, the Company agreed to adopt and maintain certain corporate governance reforms, including establishing a compliance and Ethics Committee of the Board of Directors in order to bring Jeter and his compliance function under direct board oversight.

5. Defendants Browne, Giblin and Redman

439. Amedisys had three different CFOs during the Class Period, Defendants Browne, Giblin, and Redman. According to the employment agreements between Amedisys and each of those executives, they were each responsible for and had control over the Company's financial matters, including public reporting and compliance with applicable policies, regulations and laws. The relevant passage of Browne's employment agreement, which is substantially identical to those of Giblin and Redman, is found below:

> BROWNE shall perform such duties as are usually performed by the Chief Financial Officer of health care companies of a business similar in size and scope as the Company and such other reasonable additional duties as may be prescribed from time to time by the Company's Chief Executive Officer which are reasonable and consistent with the expectations of the Company and the Company's operations, taking into account BROWNE's expertise and job responsibilities, <u>including but not limited to, adherence to internal compliance and governmental and regulatory rules, regulations and applicable laws</u>. BROWNE shall report directly to the Chief Executive Officer of the Company or his designee.

As Amedisys CFOs, Defendants Browne, Giblin and Redman had control over the reporting of Amedisys's financial activities and were primarily responsible (during their respective tenures) for speaking on behalf of Amedisys to the investing public providing information on matters relating to Amedisys's financial status, and in fact did make multiple statements during the Class Period to the

public as evidenced herein. This included certifying pursuant to the Sarbanes-Oxley Act that the financial information in Company reports "fairly presents, in all material respects, the financial condition and result of operations of the Company." These Defendants directly reported to Borne and shared control over Amedisys's business and public statements.

440. For example, on February 20, 2007, Amedisys issued a press release announcing the Company's earnings for the fourth quarter and year-end 2006. In that press release, wherein the Company announced Defendant Giblin's sudden resignation, Giblin stated that he "believe[d] the Company [wa]s poised to continue its impressive trend of growth and profitability." In addition, in the Company's annual report filed with the SEC that day on Form 10-K and certified by Defendant Giblin, the Company told investors that, among other things, Amedisys "develop[ed], implement[ed] and maintain[ed] comprehensive compliance and quality improvement programs as a component of the centralized corporate services provided to our home health and hospice agencies" and that "[o]our compliance and quality improvement programs are intended to ensure that our employees are well trained and capable of delivering high-quality service."

441. In reality, however, Giblin knew that the Company's positive earnings and any "impressive trends" were due to not to any "compliance and quality improvement services" or "high-quality service," but rather to Amedisys's scheme to maximize Medicare reimbursements discussed herein.

442. On February 22, 2006, Amedisys announced the resignation of then-CFO, Defendant Browne in order for him to "pursue other professional interests." Browne's abrupt resignation was particularly suspicious because he resigned without any immediate successor in place.

443. Amedisys went eight months without anyone in the key CFO function, until October 23, 2006, when Amedisys issued a press release announcing the appointment of Defendant Giblin as CFO. The press release touted Giblin's more than 27 years of financial experience, including the fact

that he had spent the previous eight years at Crawford and Company, an international insurance services firm, and the preceding 10 years at an international public accounting firm. However, Giblin's tenure at Amedisys was very short-lived. On February 20, 2007 – only four months after Giblin assumed the CFO position –Amedisys announced that Giblin was resigning as CFO for "personal reasons." As TheStreet.com reported on August 27, 2008, by resigning so abruptly, Giblin had walked away from stock options "valued at $418,000." After Defendant Giblin left the post, Defendant Redman was appointed as CFO, making him the third CFO at Amedisys during the Class Period.

444. As TheStreet.com reported on August 27, 2008, however, Redman had been part of a management team at his former employer, United Companies Financial Corp. ("UCFC"), that was "accused of hiding hundreds of millions of dollars worth of losses at UCFC" and "the company's stock wound up worthless in the end." According to TheStreet.com:

> Although UCFC flew high for years – with its stock topping $75 halfway through Redman's reign as CFO – the company came crashing down in 1999, long before the rest of the industry. UCFC filed for bankruptcy that spring and announced that Redman would be leaving "to pursue outside interests." With their once-valuable stock almost worthless, angry shareholders filed class-action lawsuits against UCFC and its ousted leaders for allegedly concealing the bleak condition of the company.
>
> Redman worked for himself in the meantime, operating an obscure consulting firm for eight years before suddenly surfacing as Amedisys' CFO early [in 2007]. His boardroom ties may have helped – notably, he served on the board at Piccadilly Cafeterias when Ronald LaBorde – Amedisys's lead independent director – ran the floundering restaurant chain. Like UCFC, Piccadilly wound up bankrupt in the end.

445. Defendant Redman was at the July and October 2007 Board meetings where Schwartz presented on the A-Team and the Case Mix Refinement Plan. Defendant Redman was also a member of Amedisys's Compliance Committee, and was a settling defendant in the related ERISA and Derivative Actions.

446. Defendant Redman was a recipient of the A-Team document "Therapy Initiatives Update" discussing using Balanced for Life to increase revenue.

447. On November 1, 2011, less than one month after release of the Senate Report, Amedisys announced that Chief Operating Officer Michael Snow was leaving the Company, and that Defendant (and CFO at the time) Dale Redman would transition to the role of Executive Vice President and Treasurer in anticipation of his retirement in the first quarter of 2012.

448. Further, Browne was a named defendant to the derivative action, based on the same operative facts set forth herein, that Amedisys and other defendants (including Defendants Borne, Redman, Jeter, Graham, and Schwartz) settled in September 2013. Pursuant to that settlement, the Company agreed to adopt and maintain certain corporate governance reforms, including establishing a compliance and Ethics Committee of the Board of Directors, and (according to the derivative plaintiffs" otherwise directly "address the alleged internal control and compliance failures that led to the allegedly fraudulent Medicare billing scheme, and the related alleged deficiencies in the Company's disclosures to shareholders."

6. The Manipulation of Amedisys's Computer Systems

449. Each Defendant knew or had access to non-public information that contradicted Amedisys's public statements – which further supports a strong inference of scienter. As discussed more fully above, Amedisys has highly-sophisticated computer systems (including the AMS2 and Point-of-Care systems) that allow detailed reports to be generated for management to review while treatment of Amedisys's patients was ongoing. These systems provided senior Amedisys management with the opportunity to monitor and influence the coding and number of visits for patients.

450. Defendants Borne, Graham, Redman, Jeter and Schwartz have each displayed a close familiarity with the Point-of-Care system and spoke positively to investors about the system's relation to compliance efforts. Defendant Borne stated during the October 25, 2006 Amedisys earnings call that the "[P]oint of [C]are implementation will enhance [Amedisys's] compliance efforts by

mandating and standardizing documentation while validating clinical necessity for all care provided." In a statement by Defendant Graham during the October 30, 2007 Amedisys earnings call, he claimed that one of the primary purposes of the Point-of-Care system was to improve the Company's compliance: "It is very important to us as we continue to grow that we stay focused on three very important areas, our care coordination abilities, our clinical outcomes and most importantly, our compliance controls. The design of our point-of-care system was very purposeful in order to further enhance these areas." Later during that October 30, 2007 earnings call, Defendant Redman also claimed that the Point-of-Care system had enhanced the Company's compliance. During the Amedisys earnings call on October 28, 2008, Defendant Jeter also claimed that the Point-of-Care system was fundamental to the Company's compliance with Medicare rules and regulations:

> Additionally, our point-of-care system represents a fundamental compliance control and is the sort of technology that helps us improve not only what we do in terms of clinical care but how we do it in terms of our adherence to Medicare rules and regulations.
>
> Through our point-of-care system**,** we're better able to ensure the accuracy and completeness of our documentation, and when used in concert with our clinical management dashboards, allows for real-time assessment and review of our coding and documentation. One simply cannot overemphasize the importance of this technology as a means for strengthening our compliance with the law.

451. During the same October 28, 2008 conference call, while discussing the business system controls Defendant Schwartz commented on the Point-of-Care system noting the three goals Amedisys had when developing the system: "[1] Enhanced standardization with consistency and compliance control, [2] the ability to have most all of our notes in digital format and [3] the ability to provide more intensive care management services to our populations." She went on to say that the "point-of-care technology rolled out in 2007 [] enhanced many clinical documentations" and "compliance controls."

452. However, despite these statements by Defendants Borne, Graham, Redman, Schwartz, and Jeter, the Point-of-Care system, designed purposefully by Amedisys, would actually manipulate

the user to steer him or her toward additional visits or higher acuity case mix scores as he or she completed the OASIS form on the Point-of-Care system. Further, once the OASIS form was submitted by the clinician, the Point-of-Care system allowed management to manipulate the OASIS form for the desired outcome.

453. These Defendants either misrepresented the attributes of the Point-of-Care system -- which in fact was really an instrument to commit fraud -- or misrepresented that they had a factual basis for their statements concerning the Point-of-Care system.

7. The Financial Motives of the Individual Defendants

454. Defendants also had motive and opportunity to engage in the fraudulent practices described above. Defendants' desire to personally benefit from the fraudulent income-generating scheme provides further evidence of Defendants' scienter. For example, the Company's incentive compensation plans further motivated the Individual Defendants to boost the Company's earnings, as set forth below.

455. The Company's proxy statement filed on April 23, 2008 disclosed that "Our 2007 earnings per share was $2.32, []. Therefore, the value of the performance-based portion of the [restricted stock units or "RSUs"] was, in the case of Mr. Borne, increased from $720,000 to $900,000, and, in the case of Mr. Graham, increased from $330,000 to $412,500 on the date of grant. The number of RSUs granted under the performance-based portion of the award was calculated by dividing the cash value of the RSUs on the date of grant by the closing price of our common stock on the determination date ($46.57), and resulted in a grant of 19,326 RSUs to Mr. Borne and 8,858 RSUs to Mr. Graham."

456. The Company's proxy statement filed on April 28, 2009 disclosed that "[f]or 2008, the incentive compensation opportunity was based on overall corporate performance measure of diluted earnings per share ('EPS')." If the 2008 EPS performance levels of $2.32 threshold, $2.40

target, $2.50 maximum were met, then the incentive earned as a percentage of target were 50%, 100% or 150% respectively. The Company reported that actual 2008 EPS performance "substantially exceeded the maximum targeted EPS." As a result, Defendant Borne received a $1,125,000 cash bonus and Redman received a $281,250 cash bonus.

457. The Company's proxy statement filed on April 27, 2010 also disclosed that "[f]or 2009, the incentive compensation opportunity was based on the overall corporate performance measure of earnings per share ('EPS')." If the 2009 EPS performance levels of $3.90 threshold, $4.20 target or $5.00 maximum were met, then the incentive earned as a percentage of target were 50%, 100% or 150% respectively. The Company reported that actual 2009 EPS performance was $4.89 or approximately 143% of the 2009 target EPS level. As a result, Borne received a $1,072,500 cash bonus and Redman received a $455,813 cash bonus.

C. The Individual Defendants' Insider Sales

458. During the Class Period, Defendants Borne, Browne, Graham, Jeter, and Schwartz (the "Insider Trading Defendants") sold substantial amounts of Amedisys common stock from their personal holdings. The Insider Trading Defendants' insider sales often immediately followed the exercise of options to purchase Amedisys common stock. Stock options provide the grantee with the right to purchase a company's stock at the exercise price and then sell those shares in the open market at the then-prevailing market price. Thus, option holders benefit most from exercising options and selling their shares when they believe the market value of the stock (*i.e.*, the price they will receive when selling the stock in the open market) is at a high point, or when they believe that subsequent events or disclosures will lower the value of their shares.

459. The Insider Trading Defendants' stock sales were suspicious because of the (i) large number of shares sold; (ii) significant dollar amounts of the transactions; (iii) large percentages of their holdings sold, which far exceeded prior trading patterns, and (iv) exercise of options

significantly in advance of their expiration date. Moreover, none of the Insider Trading Defendants accumulated any significant amounts of stock during the Class Period, and certain of the Insider Trading Defendants had significantly smaller holdings at the end of the Class Period in comparison to their holdings at the beginning of the Class Period. For example: Defendant Borne reported holdings of 256,431 shares on August 11, 2005, but holdings of 217,524 shares on April 1, 2011, a decrease of 15.17%. Similarly, Defendant Graham reported holdings of 8,693 shares on February 27, 2006 but holdings of 4,877 shares on July 31, 2009, a decrease of 43.90%.[34]

460. Most of the Insider Trading Defendants made no open market purchases of Amedisys stock during the Class Period, which stands in stark contrast to the vast shareholdings they sold. For example, Borne acquired stock on the open market only once during the Class Period, purchasing 3,710 shares at $31.52 per share on February 27, 2006. Borne's holdings instead resulted primarily from Company grants of options and Restricted Stock Units. Moreover, Defendants Browne, Graham, Jeter and Schwartz acquired no Amedisys stock on the open market during the Class Period, and acquired Amedisys shares only through the exercise of stock options received from the Company.

1. Defendant Borne

a) 2005 Sales

461. Defendant Borne personally profited from the sale of Amedisys stock at artificially inflated prices during the Class Period. On August 11, 2005, Borne exercised options to purchase 10,000 shares of Amedisys common stock. The exercise price of the options was $3.00 per share and his cost to exercise all 10,000 options was $30,000. Defendant Borne then sold 10,000 shares in the open market for $41.01 per share, for proceeds of $410,114 and profits of $380,000.[35] He sold an

[34] These dates are the closest Form 4 filing dates to the beginning and end of the Class Period for these individuals.

[35] On August 11, 2005, Borne also sold an additional 10,000 shares held by his family at $41.19 per share, netting another $411,900.

additional 24,500 shares from his holdings of 256,431 shares (resulting in a total sale that day of 12.48% of his holdings) at $41.00, for proceeds of $1,004,525.50, bringing his total proceeds for that day's sales to $1,414,638.50.

462. Similarly, the next day, on August 12, 2005, Borne exercised 5,455 options at $4.34 per share, 30,000 options at $6.97 per share, 10,000 options at $5.40 per share, 6,555 options at $3.00 per share, and 8,000 options at $5.13 per share (*i.e.*, a total of 60,010 shares at a total cost of $347,479.70 and an average price-per-share of $5.79). Borne then sold 30,010 shares in the open market at $40.5122 per share, 5,000 shares at $40.5122 per share, 9,089 shares at $40.7937 per share, 15,000 shares at $40.5363 per share, and another 15,000 shares at $40.5103 per share, for total sales of 74,099 shares, and total proceeds on August 12, 2005 of $3,004,805.06 (and an average selling price per share of $40.551).[36] Borne's August 12, 2005 sales represented 25.38% of his holdings at the time, and his cumulative sales over August 11, 2005 through August 12, 2005 represented sales of 38.65% of his holdings. Defendant Borne's sales in August 2005 were unusual because the total proceeds from his sales ($4,009,330) are staggering, particularly in comparison to his base salary at the beginning of 2005 ($396,153), and represented a large percentage of his holdings in Amedisys.

b) 2007 Sales

463. On November 9, 2007, Borne sold 55,000 shares at $41.13, for total proceeds of $2,262,106.00, which represented 19.48% of his holdings at that time. That same day, his family trust made sales of 5,000 shares (in three lots) at an average price of $41.12 per share, resulting in proceeds of $205,691. Also, on November 12, 2007, Borne's spouse made a sale of 5,000 shares of Amedisys common stock at $41.55 per share, resulting in proceeds of $207,750.[37] Notably, these

[36] On August 12, 2005, Borne also made a *bona fide* gift of 5,000 shares of Amedisys common stock at $40.5122 per share, for a total value of $202,561.

[37] This transaction also includes 181 shares acquired under Amedisys's 401(k) plan.

sales were unusual in timing because they were made just prior to the January 2008 change in the Medicare reimbursement structure. While the change in the Medicare payment structure was publicly known at the time of Borne's sales, the specific threat that this change posed to Amedisys (in light of Amedisys's existing practice of manipulating the Medicare payment system to hit the 10-therapy visit threshold numbers, rather than the thresholds that would be in effect after December 31, 2007) was not. Defendant Borne's November 9, 2007 sale was unusual in scope because of the enormous sales proceeds he obtained and because it represented such a large percentage of his Amedisys holdings at the time.

c) Additional Class Period Sales

464. Additional sales made by Borne after 2007 through the end of the Class Period are listed in the table below (certain of which resulted from option exercises):

Date	Number of Shares Sold	Sales Price	Holdings After Transaction	Value ($) of Shares Sold	Percentage of Holdings Sold
3/3/2008	12,500	$42.19	211,082	$527,375.00	5.59%
5/5/2008	12,500	$50.92	211,306	$636,500.00	5.59%
8/1/2008	10,834	$62.26	214,614	$674,524.84	4.81%
8/1/2008	1,666	$62.53	214,614	$104,174.98	0.77%
8/4/2008	20,000	$62.37	194,614	$1,247,400.00	9.32%
8/5/2008	10,000	$62.52	183,614	$625,200.00	5.16%
8/8/2008	10,000	$64.52	170,614	$645,200.00	5.54%
2/17/2009	12,500	$50.26	170,705	$628,250.00	6.82%
7/28/2009	12,500	$41.28	170,550	$516,000.00	6.83%
10/27/2009	12,500	$40.85	170,550	$510,625.00	6.83%
12/28/2009	12,500	$50.00	158,050	$625,000.00	7.33%
2/23/2010	12,500	$61.03	145,550	$762,850.00	7.91%
2/23/2010	6,553	$60.46	145,550	$396,182.58	4.31%
2/23/2010	5,947	$59.70	145,550	$355,057.90	3.93%

Many of these sales are unusual in timing because they were made near the Class Period high for the stock of $66.25 on July 30, 2008. For example, on August 1, 2008 Borne sold a total of 12,500 shares at the prices of $62.26 and $62.53. Those prices represented 93.97% and 94.38%, respectively, of

the highest price of the stock during the Class Period. Similarly, Borne made sales on August 4, 2008, August 5, 2008, August 8, 2008, February 23, 2010, and again on February 23, 2010, at prices representing 94.14%, 94.36%, 97.38%, 92.12%, and 91.26%, respectively, of the highest price of the stock during the Class Period.

465. In sum, during the Class Period, Borne sold a total of 332,099 shares of the 550,698 shares of Amedisys securities he held during that time (or 60.30% of the total number of securities), for total proceeds of $15,594,704.36. By contrast, Borne's total direct sales in the ten year period preceding the Class Period, from August 25, 1995 through June 23, 2005, totaled only 161,500 shares with proceeds of $3,238,778.00. In other words, in a period almost twice as long as the Class Period, Borne only sold less than half the quantity of shares before the Class Period as he did during the Class Period. In addition, during the Class Period, Borne acquired only 3,710 shares through acquisitions that were not related to stock option exercises and Restricted Stock Unit grants, meaning that his sales during the Class Period were nearly 90 times larger than his acquisitions through non-stock option exercises and grants of options and Restricted Stock Units. All of these facts support a strong inference that Borne knew or recklessly disregarded that Defendants artificially inflated the value of Amedisys stock during the Class Period.

2. Defendant Graham

466. Defendant Graham personally profited from the sale of Amedisys stock at artificially inflated prices during the Class Period. During the Class Period, Graham exercised options to purchase 47,666 shares on May 3, 2007, May 22, 2007 and October 30, 2007.

467. On May 3, 2007 Graham exercised the right to buy shares in three blocks, and then sold all of those same shares in the open market. In the first block he exercised 4,444 options at $4.05 each. In the second block he exercised 3,556 options belonging to his wife at $13.58 each. In the third block, he exercised 444 options belonging to his wife at $4.05 each. He sold all of the resulting

shares of Amedisys stock in the open market for $35.25 each. In total, on May 3, 2007, Graham paid $68,086 for his exercises, netted proceeds of $297,651, and made profits of $229,565. Moreover, the timing of these sales was unusual because they occurred just after Amedisys's announcement on May 1, 2007 that profits for the first quarter had increased 82%.

468. On May 22, 2007, Graham exercised 27,444 options at $12.16 each and sold those same shares in the open market at $37.50 each. Graham paid $333,719 to exercise these options, netting proceeds of $1,029,150 and profits of $695,431. This sale was unusual because it represented 39.53% of Graham's then-current holdings, and occurred shortly after the May 1, 2007 announcement described above.

469. Finally, on October 30, 2007, Graham exercised 11,778 options belonging to his wife in two blocks: 1,778 shares at $13.58 each, and 10,000 shares at $21.89 each. He sold all of these shares in the open market the same day for $44.25 each. Graham paid $243,045 to exercise these options, netted $521,176 in proceeds, and made total profits of $278,131. Moreover, the scope and timing of these sales was unusual because they occurred on the same day as Amedisys reported record third quarter earnings and because these sales represented over 81% of Graham's wife's holdings. Notably, these sales were also unusual in timing because they were made just a few months prior to the January 2008 change in the Medicare reimbursement structure. While the change in the Medicare payment structure was publicly-known at the time of Graham's sales, the specific threat that this change posed to Amedisys (in light of Amedisys's existing practice of manipulating the Medicare payment system to hit the 10-therapy visit threshold numbers, rather than the thresholds that would be in effect after December 31, 2007) was not.

470. In addition, Graham made sales during the Class Period that were unconnected to options exercises. On May 8, 2009 Graham sold 7,179 shares into the open market at $37.74, netting $270,935, and on July 30, 2009 Graham sold 21,827 shares into the open market at $41.12, netting

$897,724.[38] These sales were unusual in their scope and timing because the May 8, 2009 sale occurred closely following Amedisys's announcement on April 28, 2009 that the Company had beat analysts' earnings expectations by 2 cents per share. Similarly, the July 30, 2009 sales occurred right after Amedisys's July 28, 2009 announcement that the Company was raising its 2009 earnings-per-share forecast. Moreover, the May 8, 2009 and July 30, 2009 sales represented 18.96% and 69.21% of Graham's Amedisys holdings at the time. The July 30 sale was suspicious in timing because it occurred just five weeks prior to when Graham's resignation was announced publicly.

471. All told, Graham spent $644,850 to exercise options for shares he sold for total proceeds of $1,847,977 and total profits of $1,203,127. And he received another $1,168,659 in direct sales of shares and $1,507,107 in indirect proceeds, for a total of $4,523,626 in proceeds from his direct and indirect sales during the Class Period.

472. Defendant Graham's sales were unusual because of: (i) the enormous proceeds from the sales; (ii) the $4,523,626 in proceeds he made during the Class Period is very large in comparison to his base salary ($425,000 at the beginning of 2007, and $550,000 at the beginning of 2009); (iii) the large number of shares sold by Graham cumulatively during the Class Period represented 113,153 of the 118,030 shares he had available for sale, amounting to 95.87% of his total holdings of Amedisys shares and options, and a net divestiture of Graham's holdings overall. These facts support a strong inference that Graham knew or recklessly disregarded that Defendants artificially inflated the value of Amedisys stock during the Class Period.

3. Defendant Browne

473. Defendant Browne also personally profited from the sale of Amedisys stock at

[38] Graham also made indirect trades during the Class Period. On July 30, 2009 he sold 23,180 shares at $41.21 through his 401(k) plan netting $955,247 in proceeds and 12,583 shares at $41.21 through his spouse's 401(k) plan, netting $518,419 in proceeds. The next day, his spouse sold another 718 shares at $46.405, netting another $33,319, for a total of $1,506,987 in proceeds for these indirect transactions.

artificially inflated prices during the Class Period. During the Class Period, Browne exercised options to purchase 23,000 shares on three occasions: 10,000 shares at $8.43 per share on August 12, 2005; 8,000 shares at $5.40 per share on August 18, 2005; and 5,000 shares at $8.43 per share on November 17, 2005. On August 12, 2005 Browne sold the shares obtained at $8.43 each for $40.27, spending $84,300 to exercise the options, and selling the shares obtained the same day in the open market for proceeds of $402,764 and profits of $318,464. Similarly, on August 18, 2005 Browne sold the shares obtained at $5.40 each for $41.575, spending $43,200 to exercise the options, and selling the shares obtained the same day in the open market for proceeds of $332,600 and profits of $289,400. On November 17, 2005 Browne sold the shares obtained at $8.43 each for $40.01, spending $42,150 to exercise the options, and selling the shares obtained the same day in the open market for proceeds of $200,050 and profits of $157,900. All told, Defendant Browne spent $169,650 to obtain total proceeds of $935,414 and profits of $765,764.

474. Defendant Browne's sales on August 12, 2005, August 18, 2005 and November 17, 2005 were unusual because: (i) the approximately $765,764 in profits he made on these three transactions are very large in comparison to his base salary at the beginning of 2005 ($232,788); (ii) the large number of shares sold by Browne represented 81.29% of his holdings on August 12, 2005, 77.66% of his holdings on August 18, 2005 and 68.48% of his holdings on November 17, 2005. Cumulatively, according to publicly-available SEC filings, the option exercises and sales made by Browne on these three dates represented sales of 23,000 shares of the 25,301 he had available for sale during the Class Period, or 90.91% of his available holdings. During the Class Period, Browne made ***zero*** open market purchases of shares. In other words, Defendant Browne significantly curtailed his stock acquisitions and reduced his stock ownership. In combination with his decrease in overall holdings, these facts support a strong inference that Browne knew or recklessly disregarded that Defendants artificially inflated the value of Amedisys stock during the Class Period.

4. Defendant Jeter

475. Defendant Jeter personally profited from the sale of Amedisys stock at artificially inflated prices during the Class Period. Jeter exercised options to purchase 19,001 shares in three transactions occurring on November 2, 2007. In those transactions, Jeter exercised the right to buy 13,334 shares at $21.89 each, another 2,167 shares at $13.58 each, and another 3,500 shares at $13.58 each. On the same day, Jeter sold the shares obtained in the open market, selling 13,334 shares at $43.00, 2,167 shares at $43.00, and 3,500 shares at $43.00. All told, Jeter spent $368,838 to exercise the options, sold the shares obtained through exercise for total proceeds of $817,043, and made profits of $448,205.

476. These sales were unusual in timing because they were made just prior to the January 2008 change in the Medicare reimbursement structure. While the change in the Medicare payment structure was publicly known at the time of Jeter's sales, the specific threat that this change posed to Amedisys (in light of Amedisys's existing practice of manipulating the Medicare payment system to hit the 10-therapy visit threshold numbers, rather than the thresholds that would be in effect after December 31, 2007) was not. Defendant Jeter's sales on November 2, 2007 were also unusual because: (i) the $448,205 in profits he made that day is very large in comparison to his base salary at the beginning of 2007 ($105,538); (ii) the large number of shares sold by Jeter on that day (19,001) represented 61.52% of his total holdings of Amedisys shares and options and left Jeter with no remaining unexercised options; and (iii) the sales generated enormous proceeds. Moreover, Jeter had other sales during the Class Period on August 12, 2005 and August 18, 2006. When combined with his sales on November 2, 2007, Jeter sold during the Class Period 20,631 shares of the 34,804 total shares that he had available for sale during the Class Period, resulting in sales during the Class Period of 57.62% of his total holdings. As a result of these sales, Jeter's total holdings declined significantly over of the Class Period. Jeter's 20,631 shares sold during the Class Period dwarf his sales of only

2,100 shares prior to the Class Period, and his overall net accumulation of shares from 2002 through 2005.

477. These facts support a strong inference that Jeter knew or recklessly disregarded that Defendants artificially inflated the value of Amedisys stock during the Class Period.

5. Defendant Schwartz

478. Defendant Schwartz personally profited from the sale of Amedisys stock at artificially inflated prices during the Class Period. Throughout the Class Period, Schwartz exercised options to purchase 46,556 shares, selling all of the shares in the open market obtained on the same day they were acquired – *i.e.*, on November 11, 2005, November 14, 2005, January 3, 2007, February 14, 2007, and November 1, 2007. In addition, Schwartz sold shares unconnected to options exercises on December 20, 2007. These sales are set forth in the chart below:

Date	Number of Shares Sold	Sales Price	Holdings After Transaction	Value ($) of Shares Sold	Percentage of Holdings Sold
11/11/2005	7,166	$40.51	2,028	$290,283.19	77.94%
11/14/2005	7,000	$40.50	2,028	$283,500.00	77.54%
1/3/2007	1,279	$33.75	2,773	$43,166.25	31.56%
2/14/2007	7,611	$33.75	2,773	$256,871.25	73.30%
14/2007	1,777	$33.75	2,773	$59,973.75	39.05%
11/1/2007	1,779	$41.71	5,363	$74,202.09	24.91%
11/1/2007	8,889	$41.71	5,363	$370,760.19	62.37%
12/20/2007	3,341	$48.00	2,022	$160,368.00	62.30%

479. All told, Defendant Schwartz spent $794,223 exercising options that she sold, in each case, on the same day as they were obtained, receiving total proceeds of $1,387,758 and profits of $654,545. In addition, Schwartz's sale of common stock unconnected to options exercises on December 20, 2007 resulted in an additional $160,368 in value, bringing her cumulative proceeds for all sales made during the Class Period to $1,548,126.

480. Defendant Schwartz's sales in November and December of 2007 resulted in total proceeds to Schwartz of $605,330. These sales were unusual in timing because they were made just

prior to the January 2008 change in the Medicare reimbursement structure. While the change in the Medicare payment structure was publicly-known at the time of Schwartz's November and December 2007 sales, the specific threat that this change posed to Amedisys (in light of Amedisys's existing undisclosed practice of manipulating the Medicare payment system to hit the 10-therapy visit threshold numbers, rather than the thresholds that would be in effect after December 31, 2007) was not.

481. Defendant Schwartz's sales were also unusual because: (i) the $654,545 in profits she made from sales due to options exercises were very large in comparison to her base salary at the beginning of 2007 ($150,000); (ii) the large number of shares sold by Schwartz on each of the days identified in the chart above represented significant portions of her total holdings at the time, in some cases reducing her holdings to zero, such as on September 20, 2006; and (iii) during the Class Period, Schwartz sold a total of 40,509 shares of her total holdings of 42,531 shares, amounting to total sales of 95.25% of all of her available holdings during the Class Period. As of her Form 4 filing of December 20, 2007, her total remaining holdings were only 2,022 shares. This stands in stark contrast to her accumulation of shares prior to the Class Period.

6. Expiration Dates of Options Exercised

482. Analysis of Amedisys's annual Proxy Statements and the Individual Defendants' Form 4 filings establishes that substantially all of their exercised options expired substantially later than the dates on which Defendants exercised the options and sold the common shares. For example, substantially all the options (other than 8,000 options) exercised by Defendant Borne in 2005 would have expired in 2008 through 2012, and the options exercised by Borne in 2008 and 2009 would have expired on December 31, 2012.[39] The options exercised by Defendant Browne in 2005 would have

[39] Borne did not exercise options in 2007.

expired in 2012 through 2013, and Browne did not exercise other options during the Class Period. The options exercised by Defendant Graham in 2007 would have expired in 2012 through 2015, and Graham did not exercise other options during the Class Period. The options exercised by Defendant Jeter in 2007 would have expired in 2014 through 2015, and Jeter did not exercise other options during the Class Period (except for a sale in April 2010 for the purpose of obtaining proceeds to pay withholding taxes). The options exercised by Defendant Schwartz in 2005 through 2007 would have expired in 2012 through 2015, and Schwartz did not exercise other options during the Class Period. That Defendants exercised such options and sold resulting shares years before the expiration dates of the options – rather than seek to benefit from the unexpired terms of the options – supports a strong inference that Defendants had actual knowledge or strong reason to believe that the Amedisys shares were trading at inflated and unsustainable prices at the time the options were exercised.

IX. LOSS CAUSATION

483. As detailed herein, Defendants engaged in a course of conduct that artificially inflated the price of Amedisys securities throughout the Class Period. The Defendants' unlawful conduct directly caused the losses incurred by Lead Plaintiffs and the other members of the Class. The materially false and misleading statements set forth above were widely disseminated to the securities markets, investment analysts and the investing public. Defendants' materially false and misleading statements artificially inflated the price of Amedisys stock by causing Amedisys's stock price to increase (or not decrease as much as it otherwise would have if Defendants had not made those misstatements). For example:

484. In response to Defendants' materially false and misleading statements on August 2, 2005, the price of Amedisys stock rose 5.05% from a close of $39.84 per share on August 1, 2005 to a closing price of $41.85 per share on August 2, 2005, on heavy volume of approximately 2.6 million shares. In response to Defendants' materially false and misleading statements on November 1, 2005,

the price of Amedisys stock rose 7.67% from a closing price of $38.21 per share on October 31, 2005 to a closing price of $41.14 per share on November 1, 2005, on volume of 1.6 million shares.

485. In response to Defendants' materially false and misleading statements on May 2, 2006, the price of Amedisys stock rose 7.67% from a closing price of $33.00 per share on May 1, 2006, to a closing price of $35.53 per share on May 2, 2006, on volume of over 2.08 million shares. Shares of Amedisys also rose 6.16% on May 3, 2006 to a closing price of $37.72 per share on volume of 1.5 million shares, a statistically significant increase of 6.16%. In response to Defendants' materially false and misleading statements on October 25, 2006, the price of Amedisys stock rose approximately 3% from its close on October 24, 2006, of $41.49 per share to a close of $42.77 per share on October 25, 2006, on volume of 1.07 million shares.

486. In response to Defendants' materially false and misleading statements on May 1, 2007, the price of Amedisys stock rose 8.01% from a closing price of $31.35 per share on April 30, 2007, to a closing price of $33.86 per share on May 1, 2007, on volume of 1.8 million shares. In response to Defendants' materially false and misleading statements on July 31, 2007, the price of Amedisys stock rose 3.27% from a closing price of $36.65 per share on July 30, 2007, to a closing price of $37.85 per share on July 31, 2007, on volume of 1.07 million shares. In response to Defendants' materially false and misleading statements on October 30, 2007, the price of Amedisys stock rose 18.42% from a closing price of $36.65 per share on October 29, 2007, to a closing price of $43.40 per share on October 30, 2007, on volume of 2.57 million shares.

487. In response to Defendants' materially false and misleading statements on April 30, 2008, the price of Amedisys stock rose 10% from a closing price of $47.09 per share on April 29, 2008, to a closing price of $51.80 per share on April 30, 2008, on volume of 1.98 million shares. In response to Defendants' materially false and misleading statements on July 17, 2008, the price of Amedisys stock rose 7.53% from a closing price of $55.74 per share on July 16, 2008 to a closing

price of $59.94 per share on July 17, 2008 on volume of 2.9 million shares. In response to Defendants' materially false and misleading statements on July 29, 2008, the price of Amedisys stock rose 7.58% from a closing price of $60.91 per share on July 28, 2008, to a closing price of $65.53 per share on July 29, 2008, on volume of 1.5 million shares.

488. In response to Defendants' materially false and misleading statements on October 28, 2008, the price of Amedisys stock rose 4.30% from a closing price of $45.54 per share on October 27, 2008, to a closing price of $47.50 per share on October 28, 2008, on volume of 1.465 million shares. On October 29, 2008, the price of Amedisys stock rose another 9.33% to close at $51.93. In response to Defendants' materially false and misleading statements on July 28, 2009, the price of Amedisys stock rose 3.28% from a closing price of $37.76 per share on July 27, 2009, to a closing price of $39.00 per share on July 28, 2009, on volume of 3.067 million shares. In response to Defendants' materially false and misleading statements on August 9, 2010, the price of Amedisys stock rose 1.23% from a closing price on August 6, 2010 of $26.79 per share to a closing price of $27.12 per share on Monday, August 9, 2010, on volume of 3.3 million shares.

489. By making contemporaneous misstatements to the market in connection with the negative partial disclosures of new information, as alleged herein, Defendants mitigated the impact of those corrective disclosures and prevented the full truth about Defendants' Medicare reimbursement manipulation from being revealed at once. As a result, Lead Plaintiffs and the other members of the Class purchased Amedisys securities at artificially-inflated prices and were damaged when the artificial inflation gradually dissipated as a result of partial-corrective disclosures entering the market that revealed Defendants' manipulation of the Medicare reimbursement system.

490. Lead Plaintiffs' losses occurred from the declines in Amedisys stock price in response to a series of partial disclosures of new information concerning the true nature of Amedisys's business practices and the extent of the risks associated with such practices. For example, according to CW-

54, a Director of Operations at Amedisys in an Illinois office from approximately May 2005 through June 2010, Defendant Borne sent Amedisys employees a videotaped message regarding the April 26, 2010 *WSJ* article. According to CW-54, Borne informed Amedisys employees that Amedisys stock was going to plummet because of the *WSJ* article, and, as discussed herein, it did. Borne thus internally acknowledged the material link between the corrective information and Amedisys's stock price.

491. As the truth gradually became known and/or risks that had been fraudulently concealed by Defendants gradually materialized as alleged herein (including but not limited to the commencement of government investigations into Amedisys), the price of Amedisys securities declined significantly as artificial inflation was removed from the market price of these securities, causing substantial damage to Lead Plaintiffs and members of the Class, as further detailed in the "Truth Begins to Emerge" section above. Whether viewed individually or collectively, the partial disclosures detailed herein constitute a corrective disclosure in which the true nature of Amedisys's business practices, and the extent of the risks associated with such practices, was disclosed to the public and the securities markets. Discovery and expert analysis may reveal further partial disclosures of corrective information.

X. NO SAFE HARBOR

492. The statutory safe harbor provided for forward-looking statements under certain circumstances does not apply to any of the allegedly false or misleading statements set forth in this Complaint. The statements alleged to be false or misleading herein all relate to then-existing facts and conditions. In addition, to the extent certain of the statements alleged to be false or misleading may be characterized as forward-looking, they were not adequately identified as forward-looking statements when made, and there were no meaningful cautionary statements identifying important facts that could cause actual results to differ materially from those in the purportedly forward-looking

statements. To the extent that the statutory safe harbor is intended to apply to any forward-looking statements set forth herein, defendants are liable for those false forward-looking statements because at the time each of those forward-looking statements was made, defendants had actual knowledge that the particular forward-looking statement was materially false or misleading. In addition, to the extent any of the statements set forth above were accurate when made, they became inaccurate or misleading because of subsequent events, and defendants failed to update those statements which later became inaccurate.

XI. PRESUMPTION OF RELIANCE

493. Lead Plaintiffs are entitled to a presumption of reliance because the claims asserted herein against Defendants are predicated in part upon material omissions of fact that Defendants had a duty to disclose.

494. The market for the Company's securities was, at all times, an efficient market that promptly digested current information with respect to the Company from all publicly-available sources and reflected such information in the prices of the Company's securities. Throughout the Class Period:

(a) Amedisys stock was actively traded on the NASDAQ;

(b) The market price of Amedisys securities reacted promptly to the dissemination of public information regarding the Company;

(c) Securities analysts followed and published research reports regarding Amedisys that were publicly available to investors. Those analysts included Credit Suisse; Oppenheimer & Co.; Deutsche Bank; RBC Capital Markets; SunTrust Robinson Humphrey; BB&T Capital Markets; Raymond James; EVA Dimensions; First Analysis Corp; Robert W. Baird & Co.; Stephens Inc.; FBR Capital Markets; Stifel Nicolaus; Avondale Partners LLC; CRT Capital Group; Jefferies; and Macquarie;

(d) The average weekly trading volume for Amedisys stock during the Class Period was approximately 4.41 million shares; and

(e) The Company's market capitalization was in excess of $735 million on July 14, 2010 and the Company had over 28.4 million shares outstanding as of July 14, 2010.

495. Throughout the Class Period, the Company was consistently followed by the market, including securities analysts as well as the business press. The market relies upon the Company's financial results and management to accurately present the Company's financial results. During this period, Amedisys and the Individual Defendants continued to pump materially false information into the marketplace regarding the financial condition of the Company. This information was promptly reviewed and analyzed by the ratings agencies, analysts and institutional investors and assimilated into the price of the Company's securities.

496. As a result of the misconduct alleged herein (including defendants' misstatements and omissions), the market for Amedisys securities was artificially inflated. Under such circumstances, the presumption of reliance available under the "fraud-on-the-market" theory applies. Thus, Class members are presumed to have indirectly relied upon the misrepresentations and omissions for which defendants are each responsible.

497. Plaintiff and other Class members justifiably relied on the integrity of the market price for the Company's securities and were substantially damaged as a direct and proximate result of their purchases of Amedisys securities at artificially inflated prices and the subsequent decline in the price of those securities when the truth was disclosed.

498. Had Plaintiff and other members of the Class known of the material adverse information not disclosed by defendants, or been aware of the truth behind defendants' material misstatements, they would not have purchased Amedisys securities at artificially inflated prices.

XII. CLASS ACTION ALLEGATIONS

499. Lead Plaintiffs bring this action on their own behalf and as a class action, pursuant to Rules 23(a) and 23(b)(3) of the Federal Rules of Civil Procedure, on behalf of all persons and entities who purchased or otherwise acquired the publicly traded securities of Amedisys from August 2, 2005 through and including September 30, 2011, and were damaged thereby as alleged herein.

Excluded from the Class are: (i) the defendants; (ii) members of the immediate family of any defendant; (iii) any person who was an officer or director of Amedisys during the Class Period and any members of their immediate family; (iv) any firm, trust, corporation, officer, or other entity in which any defendant has a controlling interest; and (v) the legal representatives, agents, affiliates, heirs, successors-in-interest or assigns of any such excluded party.

500. The Class is so numerous that joinder of all Class members is impracticable. Amedisys common stock was actively traded on the NASDAQ throughout the Class Period. While the exact number of Class members can only be determined by appropriate discovery, during the Class Period there were millions of shares of Amedisys common stock outstanding, and based upon the volume of trading of Amedisys's common stock, it is believed that tens of thousands of investors purchased Amedisys common stock during the Class Period.

501. Lead Plaintiffs' claims are typical of the claims of the members of the Class. Lead Plaintiffs and all Class members sustained damages as a result of the wrongful conduct complained of herein. Lead Plaintiffs will fairly and adequately protect the interests of the Class members and have retained Court-appointed counsel competent and experienced in class action and securities litigation. Lead Plaintiffs have no interests that are contrary to or in conflict with those of the Class members that they seek to represent.

502. A class action is superior to other available methods for the fair and efficient adjudication of this controversy. Because the damages suffered by individual Class members may be relatively small, the expense and burden of individual litigation make it virtually impossible for the Class members individually to seek redress for the wrongful conduct alleged.

503. Common questions of law and fact exist as to all Class members and predominate over any questions solely affecting individual Class members. Among the questions of law and fact common to the Class are:

(a) whether the federal securities laws were violated by Defendants' acts as alleged herein;

(b) whether the Company's SEC filings, press releases and other public statements made by Defendants during the Class Period contained misstatements of material fact, or omitted to state material facts necessary in order to make the statements, in light of the circumstances under which they were made, not misleading;

(c) whether Defendants acted with the requisite state of mind in omitting and/or misrepresenting material facts in documents filed with the SEC, press releases and other public statements;

(d) whether the market price of Amedisys's publicly-traded securities during the Class Period was artificially inflated due to the material misrepresentations complained of herein; and

(e) whether the Class members have sustained damages and, if so, the appropriate measure thereof.

504. Lead Plaintiffs know of no difficulty that will be encountered in the management of this litigation that would preclude its maintenance as a class action. Notice can be provided to the record owners of Amedisys securities via first class mail using techniques and forms of notice similar to those customarily used in securities class actions.

XIII. CLAIMS FOR RELIEF

COUNT I

Violations of Section 10(b) of the Exchange Act and Rule 10b-5 Promulgated Thereunder Against All Defendants

505. Lead Plaintiffs repeat and re-allege each of the allegations set forth in the foregoing paragraphs as if fully set forth herein.

506. Throughout the Class Period, Amedisys and the Individual Defendants individually and in concert, directly and indirectly, by the use and means of instrumentalities of interstate commerce and/or of the U. S. mail, engaged and participated in a continuous course of conduct to conceal adverse material information about Amedisys, including its true financial results and internal controls, as specified herein. This plan, scheme and course of conduct was

intended to and, throughout the Class Period, did: (a) deceive the investing public, including Lead Plaintiffs and other members of the Class, as alleged herein; (b) artificially inflate the market price of Amedisys securities; and (c) cause Lead Plaintiffs and other members of the Class to purchase Amedisys securities at artificially inflated prices.

507. In furtherance of this unlawful scheme, plan and course of conduct, the Individual Defendants, individually and jointly, took the actions set forth herein. While in possession of material, adverse non-public information, these Defendants: (a) employed devices, schemes and artifices to defraud; (b) made untrue statements of material fact and/or omitted to state material facts necessary to make the statements made not misleading; and (c) engaged in acts, practices and a course of conduct which operated as a fraud and deceit upon the purchasers of the Company's securities in an effort to create and maintain artificially high market prices for Amedisys's securities in violation of Section 10(b) of the Exchange Act and Rule 10b-5 promulgated thereunder. Each of the Individual Defendants was a direct and substantial participant in the common course of conduct alleged herein.

508. The Individual Defendants knew or recklessly disregarded that the Company's reported financial results during the Class Period, as filed with the SEC and disseminated to the investing public, were materially overstated. Further, these Defendants knew of or recklessly disregarded undisclosed existing adverse facts which undermined their representations about Amedisys's existing business, internal controls and prospects during the Class Period and which needed to be disclosed to prevent their Class Period statements from being rendered materially false and misleading.

509. In addition to the duties of full disclosure imposed on the Individual Defendants, as a result of their responsibility for the Company's financial statements and making affirmative statements and reports to the investing public, the Individual Defendants had a duty to promptly

disseminate truthful information that would be material to investors in compliance with the integrated disclosure provisions of the SEC as embodied in SEC Regulation S-X (17 C.F.R. §210.1-01, et seq.) and Regulation S-K (17 C.F.R. §229. 10, et seq.) and other SEC regulations, including accurate and truthful information with respect to the Company's financial condition, earnings and expenses so that the market price of the Company's securities would be based on truthful, complete and accurate information.

510. Amedisys and the Individual Defendants, the top executive officers of the Company, are liable as direct participants in the wrongs complained of herein. Through their positions of control and authority as officers of the Company, each of these individual Defendants was able to and did control the content of the public statements disseminated by Amedisys. With knowledge of the falsity and/or misleading nature of the statements contained therein and in reckless disregard of the true financial results of the Company, these Defendants caused the heretofore complained of public statements to contain misstatements and omissions of material facts as alleged herein.

511. Amedisys and the Individual Defendants acted with scienter throughout the Class Period in that they either had actual knowledge of the misrepresentations and/or omissions of material facts set forth herein or acted with deliberate reckless disregard for the truth in that they failed to ascertain and to disclose the true facts, even though such facts were available to them. The Individual Defendants were among the senior management of the Company and were therefore directly responsible for the false and misleading statements and/or omissions disseminated to the public through press releases, news reports and filings with the SEC.

512. Defendants' misrepresentations and/or omissions were intentional or reckless and done for the purpose of enriching themselves at the expense of Lead Plaintiffs and the Class and to conceal the Company's true operating condition from the investing public. Defendants engaged in

this scheme to inflate the Company's reported revenues and prospects in order to create the illusion that Amedisys was a successful, strong and growing company.

513. As a result of those deceptive practices and false and misleading statements and/or omissions, the market price of Amedisys's securities was artificially inflated throughout the Class Period. In ignorance of the false and misleading nature of the representations and/or omissions described above and the deceptive and manipulative devices employed by defendants, Lead Plaintiffs and the other members of the Class, in reliance on either the integrity of the market or directly on the statements and reports of Defendants and the statements for which they are responsible, purchased Amedisys securities at artificially inflated prices and were damaged thereby.

514. Had Lead Plaintiffs and other members of the Class known of the material adverse information not disclosed by Defendants or been aware of the truth behind Defendants' material misstatements, they would not have purchased Amedisys securities at artificially inflated prices.

515. By virtue of the foregoing, Defendants have violated Section 10(b) of the Exchange Act and Rule 10b-5 promulgated thereunder.

COUNT II

Violations of Section 20(a) of the Exchange Act Against the Individual Defendants

516. Lead Plaintiffs repeat and re-allege each of the allegations set forth in the foregoing paragraphs as if fully set forth herein.

517. Each of the Individual Defendants, by virtue of their positions with Amedisys and their specific acts, were controlling persons of Amedisys within the meaning of Section 20(a) of the Exchange Act. The Individual Defendants were the Company's Chairman and CEO (Borne), COO (Graham), CFOs (Browne, Giblin and Redman), CIO (Schwartz), and CCO (Jeter) and actively managed the Company and its reporting to investors and Amedisys's accounting practices. They had the power and influence and exercised same to cause Amedisys to engage in the illegal

conduct and practices complained of herein. Defendants were thereby and otherwise culpable participants in the fraud perpetrated by Defendants.

518. By reason of the conduct of Amedisys as alleged in this Complaint, the Individual Defendants are liable for the aforesaid wrongful conduct of Amedisys and liable to Lead Plaintiffs and the Class for the substantial damages which they suffered in connection with their purchases or acquisitions of shares as a result of Amedisys's violations of the Exchange Act.

PRAYER FOR RELIEF

WHEREFORE, Lead Plaintiffs pray for relief and judgment as follows:

A. Declaring this action to be a proper class action pursuant to Rule 23(a) and (b)(3) of the Federal Rules of Civil Procedure on behalf of the Class;

B. Awarding Lead Plaintiffs and the Class compensatory damages and/or rescission;

C. Awarding Lead Plaintiffs and the Class pre-judgment and post-judgment interest;

D. Awarding Lead Plaintiffs and the Class the fees and expenses incurred in this action, including expert witness fees and attorneys fees; and

E. Awarding such other relief as this Court may deem just and proper.

DEMAND FOR JURY TRIAL

Lead Plaintiffs hereby demand a trial by jury in this action of all issues so triable.

Dated: April 8, 2015

Respectfully submitted by:
IEYOUB LAW FIRM
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/s/ Richard P. Ieyoub

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Additional Plaintiffs' Counsel

Appendix A

Confidential Witness ("CW") Allegations

1. CW-1 was a case manager and registered nurse at an Amedisys branch in Kentucky from 2005 to 2010. CW-1 described how there was always a push to get more visits, and recalled how Amedisys introduced "clinical tracks" in 2008 that related to both nursing and therapy visits. Under these tracks, Amedisys nurses were required to complete a certain number of visits, even if they determined that a patient needed fewer visits. CW-1 also confirmed that therapists had similar concerns about having to make unnecessary visits. Further, CW-1 stated that Amedisys made a strong push to put "everyone" on the Balanced for Life program (and most patients at CW-1's branch were enrolled in it), but so many patients were enrolled that it seemed to be used as a means to increase Medicare reimbursements. CW-1 further stated that the Point-of-Care system would often not let the clinician submit the OASIS until it was submitted in the form required by the computer system.

2. CW-2 was a former Area VP of Operations who worked at Amedisys during almost the entire Class Period. CW-2 was Area VP of Operations for over 16 agencies in central and northern Kentucky, Ohio, and New Jersey. CW-2 reported to Cheryl Lacey. CW-2 stated that the Company's computer system could generate virtually any kind of statistical report concerning patient visits, all corporate managers had access to it, and the Company constantly monitored reports on the number of visits its patients had received, therapy countdown reports (which listed the patients who were coming due for possible recertification) and LUPA reports (listing patients who were on track to receive fewer than 5 total visits).

3. CW-3 was a registered nurse, a director of nursing, and Director of Office Operations at an Amedisys branch California during 2008 to 2009.

(a) CW-3 stated that Amedisys's corporate policy was "just push, push, push" for more therapy visits, and described the Company as "all about numbers and money." CW-3 noted that Amedisys had developed a new specialty program, Balanced for Life, and also confirmed

that Amedisys pushed to put virtually every patient into that program regardless of whether it was appropriate for the patient. CW-3 stated Amedisys did not tell many patients that they were ready to go to outpatient therapy – instead "they really wanted to keep them in home health."

(b) At Amedisys, CW-3 stated that there were many patients that s/he believed were unnecessarily recertified, but recertifications were a "big thing" that "kept the numbers up." In 30 years of nursing, CW-3 stated that she had never worked at a company where recertifications were as high as they were at Amedisys. Nurses, including CW-3, were pressured to both improperly admit and improperly recertify patients. The pressure came from the Regional Director of Operations (a woman named "Debbie") and from even higher levels. For example, after expressing the view that a certain patient should not be admitted, "Debbie" informed CW-3 that s/he "was not supporting the company, and [the company] would not stand for that." "Everything" was monitored by corporate; "there was not one report that was not generated; they knew everything;" and corporate had reports on who was going out to see whom, and how many visits patients were getting. As CW-3 stated, "I've never been under such scrutiny and have never been pressured that way." "It was awful." As a result of the constant and improper pressures imposed by corporate management, CW-3 eventually resigned.

4. CW-4 was a former RN, Account Executive and Account Manager who worked at more than one Amedisys branch in Florida from 2005 to 2007.

(a) CW-4 stated that Amedisys pushed to have every patient receive 10 therapy visits because the tenth visit brought an additional reimbursement from Medicare. The additional visits were often medically unnecessary, as when a congestive heart failure patient who did not even need a cane to walk would be scheduled for 10 therapy visits. With certain medical conditions, such as congestive heart failure and chronic pulmonary obstructive disease, patients generally did not require much in the way of therapy visits, although they generally needed a higher number of nursing visits. In such circumstances CW-4 would "bump heads" with his/her supervisors "all the time" over scheduling unnecessary or inappropriate therapy visits, but was told that patients needed to have 10 therapy visits and "that was the way it was," given that nursing visits didn't pay as much money. CW-4 felt that Amedisys was improperly recertifying patients, often as a means to recoup costs from a previous episode with a greater number of the more costly nursing visits. CW-4 noted that s/he would hear a lot of "Can we find a reason to recertify?"

(b) CW-4 also described how Amedisys generated weekly reports from its computer system that tracked how many visits each patient had and how many more they were currently scheduled to receive, which were discussed at weekly meetings with the branch office staff, the regional manager and the Vice President of Sales; in addition, all the other "higher-ups" also had access to these reports. CW-4 recalled instances where the branch heads CW-4 worked for would agree that a patient did not need more therapy visits, but would say in effect that CW-4 knew that they needed to get 10 therapy visits in. CW-4 did not, however, place primary blame on the branch heads; instead, they were just "trying to keep

their jobs" and were put under constant pressure from their bosses in corporate management to hit 10 visits.

(c) According to CW-4, outside physicians were placed on Amedisys's staff as medical directors and were paid a certain fee every month in exchange for sending a majority of their patients to Amedisys. CW-4 stated that Amedisys knew that doctors sending 100% of their patients to Amedisys would constitute a red flag to Medicare (since doctors are required to offer patients a choice in home health care agencies). Therefore, according to CW-4, Amedisys would receive 85-90% of these referrals, with a small amount going to other agencies. Amedisys only wanted to target those medical directors that were willing to send them the bulk of their patients. Further, according to CW-4, Amedisys's goal was to have an outside doctor-medical director for every program they offered (e.g., orthopedist for orthopedic program, cardiologist for heart program, etc.), with each Amedisys office having multiple medical directors willing to refer the bulk of the patients to Amedisys.

(d) CW-4 also saw problems with the OASIS coding. After a nurse submitted the OASIS, the results were reviewed by remotely-based employees whose sole responsibility was to review OASIS, and to code in a manner that would maximize reimbursement. These people would ask the nurses to use higher codes and to change their charting in order to achieve the maximum reimbursement. CW-4 resisted such overtures as inconsistent with CW-4's observations during the patient visit. However, CW-4 noted that it took a strong nurse to refuse to change their assessments, and that most nurses would simply make such changes and resubmit the assessment because if "you don't have to come back the second time, you don't have to hear everything that goes with it."

5. CW-5 was the DOO at an Amedisys branch in Indiana for roughly a year between 2005 and 2006.

(a) CW-5 had significant contact with both the Regional Director and Amedisys's National Director of Operations, Cheryl Lacey, including through weekly conference calls. CW-5 stated that directives came down from both of these individuals – including the directive that "you will have 10 PT [physical therapy] visits." CW-5 also described Lacey as "the worst" with respect to the aggressive steps that Amedisys management took to maximize the number of Amedisys patients who hit (or just slightly exceeded) the 10-therapy visit threshold.

(b) CW-5 stated that off-site personnel at corporate headquarters oversaw patient coding, and Lacey repeatedly admonished CW-5 for having nurses who refused to code patients' conditions "at a higher level" to trigger increased Medicare payments. CW-5 was written up for "insubordination" for refusing to follow the National Director of Operation's directives to change patient assessments. Similarly, as reported to CW-5 by a friend who was an inspector with the Indiana Health Department, Indiana inspectors had identified various patients in Indiana who had complained about Amedisys clinicians making unnecessary visits. Although CW-5 left before the Indiana inspectors' report was delivered, CW-5 "knew that it was a pretty bad survey."

(c) CW-5 recalled attending an Amedisys management meeting in Orlando, Florida during the early spring of 2006, which was also attended by other Amedisys Directors of Operations and certain other managers from around the country. At the meeting, CW-5 described how Defendant Borne went on a "tirade" about an unspecified investigation concerning Amedisys, and how he wanted all the branch managers at the meeting to know that, as managers, they were going to be sitting right there by him at the defendants' table, and that "I am going to hold you underwater if I go down."

(d) CW-5, after being repeatedly admonished by the Regional Director and National Director for refusing to do things that she considered illegal (such as authorizing unnecessary visits), finally resigned from Amedisys after a year. CW-5 stated that, It was a terrible, hostile environment and, being an honest person, I knew I was not going to last long at the Company.

6. CW-6 was a former Administrator in charge of five Illinois branches (including Chicago) from 2007-2008, and also the Director of Operations at one of the branches. CW-6 was also a former employee of Dyna Care, which Amedisys acquired in 2007.

(a) CW-6 confirmed that the remotely based "episode managers," in addition to applying pressure to make unnecessary visits to hit the 10 therapy visit threshold, also monitored the contents of OASIS forms – and used that information to try to get Amedisys's personnel in the branches to practice "upcoding." CW-6 explained how this process typically worked in his/her experience. First, s/he would get a call from "Episode Management" (the remotely based corporate monitors that personnel in the branch never saw) questioning the coding information. CW-6 would then reply that the nurse or clinician filled it out that way based on their in person evaluation of the patient. The "episode managers" would then try to get CW-6, as branch Director, to agree to change the OASIS form. CW-6 would confirm the lack of any error with the nurse and refuse to order any changes. The next thing that would happen would be a phone call to CW-6 from Regional Director of Operations, Peggy Taylor, who would instruct him/her to take a long, hard look at the coding. CW-6 would reply that s/he had reviewed the coding, that s/he trusted his/her field staff (who had actually visited the patients) to accurately describe the patient's condition, and would again refuse to change the coding. CW-6's refusals to change patient coding (and refusals to order medically unnecessary visits), as CW-6 observed, are the reason s/he is no longer at Amedisys. CW-6 also noted that these practices did not occur at Dyna Care, which ran the same branches before Amedisys acquired them in 2007.

(b) CW-6 observed during her time at Amedisys that there was pressure to provide additional visits to avoid LUPAs. CW-6 noted that Amedisys's sophisticated computer system allowed corporate headquarters to track potential LUPAs (i.e., patients with fewer than five visits), and that the Regional Director (Peggy Taylor) would also pressure her to keep patients on longer to avoid LUPAs.

(c) CW-6 left Amedisys soon after the reimbursement triggers changed in January 2008. However, CW-6 took part in training that was mandatory for all Amedisys Directors of

Operations (some of which was done by on-line conference), and during the training the directors were told what the new Medicare reimbursement triggers were and were instructed to obtain the maximum reimbursements available under the new system no matter what. Although CW-6 cannot recall the specifics, Directors were basically told get the highest reimbursement. As noted in the previous section above, remote corporate monitors in Baton Rouge would track visits, and would then complain to CW-6 about her therapists' refusals to do unnecessary visits, which in turn would lead to CW-6 receiving telephone calls directly from the Regional Director of Operations about CW-6's failure to get his/her therapists to go along with providing additional (and unnecessary) visits, and which in turn finally led to CW-6's departure from the Company in early 2008.

(d) CW-6 observed during her time at Amedisys pressure to improperly admit and recertify patients. Admissions and recertifications (and refusals to admit or recertify) were monitored by corporate, and CW-6 recalled, for example, the Regional Director of Operations (Taylor) personally calling CW-6 to pressure him/her to get nurses to admit patients that were not homebound. CW-6 was also aware that Taylor pressured other branch directors of operations to recertify patients who no longer needed care, and Amedisys had a very sophisticated computer system that allowed the "corporate office" to track discharges and admissions. CW-6 termed it "disgusting" how the Amedisys system would not support the field staff who were actually doing visits and assessments. CW-6 tried to resist these pressures, but had too many administrative responsibilities to get involved with every case. CW-6 was particularly concerned, for example, that the Director of Operations in the Algonquin, IL office was taking everyone and anyone that walked in the door, and saw this as a "big issue" right about the time CW-6 left Amedisys in March 2008.

7. CW-7 was the Director of Operations at an Amedisys branch in Texas for roughly a year between 2006 and 2007. According to CW-7, the "rule" at Amedisys was that therapists had to get in 10 visits, or if you didn't "you got in trouble." They were told to stretch it out to 10 visits, and then discharge the patient. Similarly, CW-7 would be reprimanded for discharging patients who no longer needed home health services. When visiting offices and sitting in on case conferences in other regions, CW-7 would hear other employees being instructed to get 10 visits of PT in, and observed that the same pressures existed in other offices in CW-7's region. For example, if a patient was going out-of-town and it appeared that it would be difficult to complete the 10th therapy visit before the end of the episode, the physical therapist would be told to go on visits every day, even though PT is normally done only three times a week. These instructions came down in regular conference calls with other branch directors of operations in Texas that were led by CW-7's Regional Director (Maggie Suggs), and Suggs' boss "Cheryl"

(presumably Amedisys National Director of Operations, Cheryl Lacey). CW-7 also recalled a week-long Amedisys conference in Florida for Amedisys sales and branch directors of operations, which likely took place in 2006, where Defendants Borne and Jeter and all the upper management talked to them about having to get 10 therapy visits (or at least 5 total visits to avoid a LUPA). Indeed, everyone who was giving direction at this conference said this. It was a given.

8. CW-8 was the Director of Operations at an Amedisys branch office in Illinois from 2006 to 2008, and had more than 20 years' prior experience as a registered nurse. CW-8 confirmed that Amedisys management applied pressure to hit the 10 therapy visit threshold. CW-8 described how all of the physical therapists in CW-8's branch were private contractors, and how Amedisys's corporate headquarters in Baton Rouge would arrange to bill Medicare for a full cycle of 10 therapy visits even if they had not done them. That way, the Company would not have to pay these private contractors for the full ten visits. In other words, even though Amedisys would bill Medicare for 10 visits, it wanted PT out of there before that to save money. Moreover, an acquaintance at the Company, who was assigned to train the business office managers at home health care companies that Amedisys acquired during the Class Period, told CW-8 that all new business office managers at newly acquired companies – regardless of where they were located – would be trained by Amedisys to bill Medicare for 10 visits, and to play the system to get higher reimbursement. CW-8 described Amedisys as "crooked without a doubt."

9. CW-9, who worked in home health care since 2002, served as a clinical manager and/or branch Director of Operations in several different Amedisys offices in Florida between 2005 and 2007. In these capacities, CW-9 also witnessed the pressure exerted by Amedisys to hit – without significantly exceeding – the 10 therapy visit level. CW-9 would constantly hear "if you can do 9 therapy visits, why can't you do 10?" Conversely, with respect to patients who had already reached the 10 therapy visit threshold, CW-9 would constantly hear criticism in the opposite direction along the lines of "why do you

need to do 15 therapy visits, can't you just do 10?" Similar pressures were applied with respect to hitting (but not exceeding) 5 nursing visits. As CW-9 stated, these pressures to meet – but not significantly exceed – key Medicare reimbursement thresholds came down the chain of command in the regular conference calls which included other branch Directors of Operations in the region, and which were led by the "regional VPs" (such as Pam Huffman and Joe White) and other corporate management. CW-9 stressed the amount of pressure placed on employees to hit these target levels. Reports would be distributed from corporate every week to determine where the office was in terms of hitting therapy and nursing thresholds, and the way corporate management talked, employees were made to feel "without a doubt" that their jobs could be on the line if they did not meet the triggers. Management would say this is what we do and this is why we are here. Because of these pressures, CW-9 left Amedisys and never wants to go back into the industry.

10. CW-10 was Director of Operations at an Amedisys branch in Maryland for roughly two years between 2005 and 2007.

(a) CW-10 recalled that there was always a big focus on doing 10 visits to get the maximum payment on physical therapy. Therapists were to make certain they did 10 visits: "That was like drilled in your head; there was unbelievable pressure with that." CW-10 also recalled attending regional meetings where Amedisys's Regional Vice President (Theresa Ledgerwood, who was "something else") would pressure the branches to hit 10 visits. Pressure came down from the top through the branch directors; if a physical therapist was not hitting 10 visits, they would get a talking to by the director as to what was going on and why 10 visits were not occurring.

(b) CW-10 added that "corporate" monitored the number of patient visits via Amedisys's computer system. CW-10 explained that the regional manager and Amedisys corporate would review daily, weekly and monthly productivity numbers. CW-10 also described how "corporate" had a group of remotely based OASIS reviewers who reviewed every single OASIS form – and how the group invariably sought changes to OASIS forms that would increase the reimbursement for Amedisys. The pressures placed on branches to hit their numbers was "unbelievable." Rather than cause trouble, CW-10 acknowledged that most nurses would just go along with such proposed changes.

(c) CW-10 stated that a certain percentage of patients (which was provided by the regional manager, Laura Hughes) had to be recertified, and that branch directors who failed to make their numbers would not receive a bonus.

(d) CW-10 stated that s/he left the Company because of unreasonable pressures that corporate management placed on branch directors for things that were objectively out of their control. In this regard, CW-10 specifically cited LUPAs (referring to any patient that had less than 5 nursing visits) as something that s/he viewed as being out of the branch directors' control, but corporate still insisted that s/he keep LUPAs low.

11. CW-11 worked at Amedisys in Texas from 2003 to 2008 – first as an account executive and Director of Business Development, and later as Area Vice President of Business Development

(a) CW-11 reported that Cheryl Lacey was responsible for ensuring (i) that Amedisys's agencies maintained high "censuses" (i.e., a high volume of patients receiving treatment); (ii) that 100% of treated individuals were covered by Medicare which reimbursed Amedisys at higher rates than private insurance providers; (iii) that the agencies "kept patients on" as long as possible; and (iv) that the agencies avoid LUPAs. CW-11 also stated that Lacey was responsible for gathering information on total census, revenue per agency, average length of stay, numbers of LUPAs, new admissions, and discharges, and that Lacey then forwarded that information to her supervisor Jill Cannon – the Senior Vice President to whom Lacey reported. Lacey in turn supervised and gave direction to Maggie Suggs and CW-11, who then passed along directions to their subordinates.

(b) CW-11 further reported that Lacey pressured the agencies to ensure that patients received as many physical therapy visits as possible. Amedisys was thereby pushing the envelope and, as a result Lacey held a conference call in 2006 or 2007 issuing a companywide directive to urge the agencies to more closely monitor physical therapy visits because many of those visits were in violation of the law. That call included all of Amedisys's area Vice Presidents of Business Development (such as CW-11), all of the Company's area Vice Presidents of Operations (such as Maggie Suggs), and all of the Directors of Nursing. On that call, Lacey indicated that the Company was being watched for compliance and it was clear that the Company was going to be looked at, although CW-11 did not know how the company learned they were being watched. Lacey directed each regional Vice President to communicate throughout his or her region that the agencies should back off of physical therapy visits.

(c) CW-11 also reported that Lacey suggested, during that same conference call discussed above, that the agencies see patients under different diagnoses than those under which they were initially admitted in order to prolong relationships with patients.

(d) CW-11 said that Amedisys pressured nurses to keep patients on for at least 5 visits to avoid LUPAs. CW-11 was aware of nurses who discharged patients before they received their 5th visit, only to be informed that corporate was upset that "we have another LUPA," and had also seen nurses who wanted to discharge patients being told to find a way to get in a few more visits to avoid a LUPA. Early discharges and LUPAs were among the topics discussed every Wednesday at every branch office in the region during conference calls with the branch staff and, frequently, the Area Vice President of Operations, Maggie Suggs. Although CW-11 was not in every meeting, s/he stated that it was well known how

"corporate" expected them to conduct operations (e.g., avoid LUPAs), and that Suggs' boss, Cheryl Lacey, was also aware of what the branches were being told.

(e) CW-11 said it was beneficial to physicians to keep patients in Amedisys home care longer. According to CW-11, when a physician who was an Amedisys medical director or advisor referred a patient to Amedisys, the physician could bill for monitoring and supervising the care of the patient. Thus, the longer the patient stayed in care, the more the physician could bill Medicare for services. CW-11 stated that Amedisys drove its nurses very hard and in particular exerted a lot of pressure on nurses to not only find a reason to admit patients but to then keep the patients. CW-11 added that s/he believed that the branches in Ft. Worth, Dallas and Denton in particular had issues with admitting patients who did not require treatment. According to CW-11, nurses would constantly complain that they did not want to lose their licenses for admitting patients who were not appropriate, and that they were pressured to admit patients who did not need home health care services. CW-11 noted that nurses would often complain to CW-11 because s/he was not their boss.

(f) Even while working on the sales side of Amedisys, CW-11 said she witnessed numerous practices on the operations side of Amedisys that s/he said raised "red flags" to CW-11 – including efforts calculated to maximize its reimbursement. For example, when Medicare had a reimbursement threshold of 10 visits, Amedisys employees were to reach the goal of 10 visits every time – whether the patient needed them or not. CW-11 reported being in attendance at meetings where this practice was discussed, and also reported having discussions with Maggie Suggs, the Area VP of Operations (who reported to National Director of Operations Cheryl Lacey) about having case conferences with physical therapists in her region about how they needed to keep their patients on longer. According to CW-11, Suggs said that she would visit Amedisys branches that were having operational issues – and that not doing 10 visits was an operational issue. CW-11 also confirmed that Amedisys was asking its field personnel to manipulate OASIS forms. CW-11 recalled how s/he attended monthly meetings where the Area VP of Operations (Suggs) would visit the branches and educate the field staff in how to fill out OASIS forms, and added "they were manipulating the OASIS, absolutely" to increase Medicare reimbursements.

12. CW-12 was a Clinical Manager at an Amedisys office in Tennessee from 2006 to 2008, and reported to the brach's Director of Operations.

(a) CW-12 stated that someone from corporate would review everything that employees coded, and that s/he would receive emails from corporate personnel informing CW-12 which specific diagnosis should be used as a lead diagnosis for patients. According to CW-12, corporate would invariably instruct CW-12 to change a particular primary diagnosis because it had a higher Medicare reimbursement. As a result, OASIS forms were effectively altered to say something different from what the clinicians in the field had actually diagnosed. For example, patients with chronic diabetes would be diagnosed by Amedisys as diabetic, even though the patients were being treated for another illness entirely and had been on diabetes medication for years (therefore requiring little or no therapy for diabetes). CW-12 said s/he felt that s/he had to go along with such manipulations because s/he was at the mercy of Amedisys, and his/her corporate bosses

monitored "everything." The coding manipulations (and related pressures) were one of the reasons s/he eventually left.

(b) CW-12 stated that the branch Director of Operations gave explicit orders that no patient was to be discharged without the branch director's approval (and the branch director was getting this instruction from above). CW-12 also recalled weekly case conferences at which the branch director would interrogate and argue with nurses about recertifying patients, and nurses would then be forced to recertify them. CW-12 recalled that Amedisys "had a tendency to recert people" for months, involving two or three re-certifications – which was more than any other company CW-12 was aware of. CW-12 added that s/he was certain that the pressure came down from above the branch director's level: "it was all corporate driven, they set the rules and guidelines," everything was in the AMS2 computer system and was being monitored by corporate.

(c) CW-12 also confirmed that Amedisys pushed physical therapy visits, and they would never provide only nine visits: "there was a push to hit 10 every time, if not more." CW-12 recalled that Amedisys purchased Anodyne (infrared light therapy) machines in order to have employees integrate pain management within therapy and, as a result, increase the number of therapy visits. CW-12 also believes that the branch director that s/he reported to was terminated shortly after the Senate investigation into Amedisys became public, but added that the pressure was coming from above the branch director: "it was corporate driven … they set the rules and guidelines." CW-12 added that everything the branches did was in the central Amedisys computer system, everything was viewed by corporate ("they could see everything we did").

13. CW-13 was a registered nurse who worked at an Amedisys branch in Indiana from 2005 to 2008, and reported to the Director of Operations of that branch.

(a) CW-13 confirmed that CW-13's superiors would pressure nurses to manipulate patients' OASIS scores. For example, if a nurse coded a patient's clinical condition or functionality as a "1," the branch Director of Operations would flag it on the OASIS form and request that the score be increased, because a worse score meant that Amedisys would receive higher reimbursement. Although CW-13 would tell the Director that she did not think the score should be changed, the Director would advise CW-13 that it would make sense to change it, and CW-13 would acquiesce.

(b) CW-13 confirmed ("oh yeah") that Amedisys applied pressure to increase visits to hit Medicare reimbursement both before and after the 2008 changes in the PPS payment grid. For example, CW-13 was told in case conferences that they needed 10 plus visits for patients receiving therapy (which changed to 14 in 2008), and the Director in charge of the office (and her assistant) would closely monitor the numbers of visits and which patients were coming up close to the triggers. As CW-13 stated, the majority of the time these 10 visits (later 14) were not medically necessary, but that there was constant pressure to hit the reimbursement triggers in order to generate more money.

14. CW-14 was a former Business Office Manager at an Amedisys branch in Florida from 2004 to 2006. CW-14 recalled that clinicians in CW-14's office were often pushed to keep patients past what they thought was medically necessary. Although CW-14 was initially supposed to be the person who discharged patients from the computer, the branch director of operations told CW-14 not to discharge any patients before she had been able to discuss it ("that's the game there"), and the Regional Director, Susan Hoffman, would join in patient case conferences as well. CW-14 also recalled one specific incident in which a therapist refused demands to give a patient with 8 therapy visits two additional visits in order to hit the 10 visit level; the therapist felt his license was at stake, and resigned from the Company in response to demands to provide 10 visits. According to CW-14, the pressure to maintain a higher census came from the "bigwigs" whose bonuses were increased by higher numbers.

15. CW-15 was an account executive who worked out of an Amedisys branch in Oklahoma from 2006 to 2010.

(a) CW-15 noted that, as a general rule, the branch Director of Operations would send out separate physical therapy and occupational therapy clinicians (and frequently a psych nursing and/or social work clinician as well) to visit a patient, even though Amedisys lacked physician orders for those disciplines and only had an order for basic skilled nursing. This was "absolutely" happening a lot. If these specialized clinicians came back and said further treatment in their discipline was not needed, Amedisys would still get paid for the initial visits. CW-15 described this practice as a form of "front-loading" the patient visits – and was aware that the goal was to avoid having patients with fewer than five visits because then it would be a LUPA "and they would have to write off the whole thing."

(b) CW-15 also recalled upcoding issues in CW-15's branch. Although not involved in patient coding, CW-15 noted that one of the nurses in the branch had a run-in with the branch's clinical manager over the manager's changing the diagnosis code to one that paid more.

(c) CW-15 described how the biggest "push" to send out therapy evaluations without proper doctor authorizations began with the introduction of the "Balanced for Life" program. For example, CW-15 confirmed how, on every referral, the Company started to automatically put down "evaluate for Balance for Life."

(d) CW-15 further emphasized how much pressure there was to get referrals. All of the directors and account executives in the region had regular conference calls with the Area VP of Development, as well as the Area VP of Operations (Stephanie Six). Reports on referrals were entered in the centralized computer system, and the Area VP would review

each AE's numbers every day on the call. Anyone failing to have a referral would have to email the VP of Development to explain why (even if the same AE had brought in 5 referrals the prior day).

16. CW-17 was an experienced RN and case manager based at an Amedisys office in Florida from roughly 2006 to 2008 after CW-17's former employer was acquired by Amedisys, and was responsible for conducting initial assessments of patients, filling out admission OASIS forms and recommending the type(s) of therapy needed by a patient.

(a) CW-17 stated s/he felt certain that Medicare fraud was going on at Amedisys. CW-17 recalled being specifically instructed by a superior (who now holds a regional supervisory position at Amedisys) that s/he needed to code patient admissions to bring in the most possible money to Amedisys. CW-17 said that, after s/he had completed his/her assessment and OASIS form concerning a patient, a clinical manager would review it and then change the coding in a way that would allow Amedisys to obtain the most money – for example, by changing the order of the patient diagnoses that CW-17 had listed. Coding changes were done without CW-17's approval.

(b) CW-17 remembered Amedisys pushing for more therapy visits, and that this was a constant subject of discussion. CW-17 also stated that Amedisys would often recertify patients who should have been discharged. CW-17 also stated that Amedisys directed employees to find a reason and recertify patients. CW-17, however, quit Amesisys in 2008 because s/he was "tired of the sh-t," meaning "Medicare fraud," and was unwilling to lose his/her license for Amedisys.

17. CW-19 was the Director of Operations for an Amedisys office in Louisiana from 2003 to 2009. CW-19 described how Amedisys had "reports for everything." CW-19 noted that "corporate" generated monthly operational reports, which were used to require branch directors to justify why patients were LUPAs or failed to meet their therapy visit thresholds. According to CW-19, branch directors at Amedisys would receive weekly emails from corporate indicating, for example, that there were a certain number of weeks left in a patient's certification period, and warning whether the patient would become a LUPA without receiving additional nursing visits. CW-19 added that the branch directors then had to work these and other reports to ensure that they were meeting their numbers (and at monthly regional meetings the branch directors would be either praised or "chopped up" based upon their numbers.). CW-19 also described the activities of remotely based QCCs in overseeing and reviewing all OASIS forms.

According to CW-19, remotely based personnel should not be asking clinicians in the field to change their patient evaluations. Although some field clinicians would not change their assessments, others would cave under pressure. When asked if s/he noticed whether QCC's requested changes that would increase reimbursements, CW-19 stated that as a result of the changes "a lot of patients were meeting their [therapy visit] thresholds."

18. CW-20 was Director of Operations at an Amedisys office in Virginia from 2003 to 2009. CW-20 said that s/he had to go over a report every day to ensure that therapy visit numbers were being met – and if not, CW-20 had to explain why not to the Regional Vice President of Operations. As CW-20 stated, Amedisys kept the pressure on at all times to achieve 10 therapy visits during the period that 10 visits was the "magic number." Amedisys therapists would be pressured to provide additional visits, and although CW-20 said s/he told therapists to discharge patients who did not require more treatment, employees "definitely" felt the pressure to hit the "magic number."

19. CW-22 was a former Amedisys sales representative and account executive based out of South Carolina from 2007 to 2009.

(a) CW-22 confirmed that when the Medicare triggers changed in January 2008, Amedisys changed its past focus on hitting 10 visits to reflect the new Medicare triggers. For example, if clinicians didn't hit 10 visits, they had to give an extensive defense of why they had not. CW-22 recalled staff meetings at which the branch managers expressly told their clinicians that they had to do what was necessary for the branch's profitability goals to be met, although CW-22 knew from conversations with his/her own boss (the Area Vice President of Business Development) that the pressure on the branch managers was coming down from the Area Vice President of Operations. The pressures that CW-22 saw Amedisys management apply were extreme: for example, the company would bully branch directors who did not want to follow corporate's plans to force physical therapists to enroll all of their patients in Balanced for Life, and also fired field clinicians for refusing to do additional visits that the clinicians believed were not medically necessary but which were needed to trigger additional Medicare payments. In that regard, CW-22 noted how Amedisys's sophisticated AMS2 computer system kept track of patients' number of visits and monitored which patients were nearing Medicare reimbursement triggers. CW-22 stated physical therapists were particularly irate about the "Balanced for Life" program, because Amedisys pushed to put every single physical therapy patient in the Balanced for Life program regardless of whether it was medically necessary. CW-22 recalled at least

four therapists who were forced out or resigned for refusing to enroll all of their patients in the Balanced for Life program, and how in one case a therapist had been fired shortly after calling the Company's "hotline" to complain about being forced to enroll his patients in the Balanced for Life program. In addition, on numerous conference calls and in training sessions Amedisys (through the area Director of Nursing and the Area Vice President of Operations) told employees that if they were not on board with the Balanced for Life program, then they should find another job.

(b) CW-22 also explained that physicians receive reimbursement from Medicare in one of three ways: 1) for making a referral; 2) for managing a patient; and 3) for medical supervision, which was the highest reimbursement payment. To qualify for a medical supervisory payment, a physician would review what a therapist had done with a patient over a 30-day period (spending as little as 30 minutes a month doing so). If the physician supervised the patient for another 30 days, an additional reimbursement payment would be paid. Accordingly, physicians benefitted from patients staying in a program (such as Balanced for Life) for longer periods. CW-22 said that Amedisys had a medical director on staff as a consultant, and also had numerous other physicians that served as consultants. According to CW-22, if a patient was discharged from the hospital and did not have a physician, Amedisys's staff medical director would take over as the supervisory physician. CW-22 estimated that about 50% of Amedisys's patients had their own physician, and the other 50% used Amedisys's medical director as their physician. This allowed Amedisys to capture more patients as Amedisys's staff medical director gave Amedisys a lot of referrals. According to CW-22, the other doctors who were signed up as consultants at Amedisys also gave the Company a lot of referrals, as there was an unwritten rule that doctors who were paid consulting fees were to refer any home health patients to Amedisys first.

20. CW-23 served as an RN field nurse at an Amedisys branch in Georgia from 2005 to 2006. CW-23 stated that nurses would initially determine medical necessity and the number of needed visits, but that there were weekly meetings to discuss all patients, and the clinical manager and director had the final word on the number of visits. In particular, CW-23 stated that, after initially filling out the OASIS truthfully, management would require changes that CW-23 knew to be unjustified. During CW-23's time at Amedisys, OASIS was still initially written up on paper, hence CW-23's statement that: "We would get our OASIS back all the time with big red marks on them." CW-23 clarified that the "red marks" were the changes made to the nurses' specifications. The changed OASIS was then used as the source of information entered into the computer system. CW-23 understood that the forms would be "corrected" in

this way so that the patients would qualify for the number of visits that Amedisys wanted to give them. CW-23 also stated that Amedisys admitted and recertified patients who did not need homecare.

21. CW-26 was a nurse and former clinical manager and Director of Operations of an Amedisys branch in Mississippi from 2006 to 2010.

(a) CW-26 said that Amedisys pushed employees to conduct therapy visits that were not medically necessary. For example, the Area Vice President would tell CW-26 that s/he was not making required revenue per episode targets, and would show CW-26 how s/he could meet the branch's numbers by increasing therapy visits – indeed, there was no other way to hit the revenue numbers. CW-26 also recalled receiving numerous reports, including a report called an "operational accounting report" that displayed what percentage of patients in CW-26's branch had met Medicare therapy visit thresholds. Corporate management expected the majority of the patient visits to fall in the bracket that made the most money for Amedisys, although CW-26 also recalled getting instructions from one of the Area Vice Presidents that there should always be a certain amount below or above that bracket to avoid throwing up a "red flag" that might trigger an audit.

(b) CW-26 noted that every week s/he would receive reports (referred to as "bursts") from corporate, which would indicate whether a patient was going to be a LUPA. CW-26 would be pressured to conduct additional visits to avoid LUPAs, although CW-26 said s/he refused to order them if they were not necessary.

(c) CW-26's branch started the Balanced for Life program in early 2008 following the changes to the Medicare reimbursement "triggers." CW-26 described how the BFL program tracked remarkably closely the new 2008 PPS visit thresholds. Amedisys's branch directors of operations and clinical managers were told to put every patient on the BFL program so that Amedisys could make the associated therapy visits. As CW-26 stated, it appeared that it did not matter whether the patient needed BFL therapy or not: "it was ridiculous" (referring both to the number of therapy visits BFL patients received and how "everybody" would receive therapy (even if the patients didn't want it).

(d) According to CW-26, Amedisys put the "QCCs" in place for specialty coding to get the most out of the new reimbursement triggers, even though they never saw the patients (which really upset the field staff). According to CW-26, the QCCs exerted very considerable pressure on nurses to change their coding: They would "batter them down so bad" that the nurses would say "just put what you want; fine, put what you want." In that regard, CW-26 said that some of the QCCs were pressuring the nurses so badly that s/he raised the issue with the regional Assistant Vice President (although to CW-26's knowledge nothing was ever done).

(e) CW-26 also confirmed that Amedisys had compliance issues relating to employees purchasing improper gifts for physicians, which were swept under the rug. For example, Amedisys's business development people were providing excessive entertainment to

doctors, such as taking physicians out to eat at the country club and adding golf games to their lunches, and giving physicians Christmas gifts of cases of wine.

22. CW-29 was a physical therapist at an Amedisys branch in North Carolina between 2005 and 2006 after the Company acquired CW-29's former employer and came back in 2008 to 2010.

(a) CW-29 stated that there was absolutely pressure, which was blunt, to change OASIS answers and to get 10 or more therapy visits after Amedisys took over. "We were really very pressured to change our answers," and Amedisys wanted every patient to get 10 therapy visits. CW-29 similarly recalled that the pressure later changed to hit new therapy visit targets that would qualify for additional reimbursement payments from Medicare. CW-29 resigned from Amedisys because of the unethical practices there but then returned in 2008 when she was told the practices would be better.

(b) CW-29 also described coding issues with Amedisys's fully computerized OASIS data entry system. Although it was supposed to flag inconsistencies in OASIS answers, it would do so even when the supposed "inconsistency" accurately reflected what the patient could and could not do. In such circumstances, CW-29 would get a phone call from the QCC, wherein CW-29 was asked leading questions and pressured into accepting changes to the answers. For example, if CW-29 answered that a patient could walk independently with a walker, but needed help with some dressing, the QCC would insist that the patient could not really walk alone. The QCC would therefore want CW-29 to change the answer to "assisted ambulation" so that the patient would be bumped up to a different reimbursement level. CW-29 knew, however, that the patient needed help dressing because the patient only had a shoulder issue that did not affect ambulatory function -- but Amedisys's computer program would not accept such an assessment when inputting the OASIS. CW-29 noted that there was "no way" that these practices were limited to isolated branches.

23. CW-30 was Director of Operations at an Amedisys branch in Ohio and then at a branch in Kentucky for more than two years beginning in 2007 (when Amedisys acquired CW-30's former employer), and reported to the Area Vice President of Operations.

(a) CW-30 recalled that all branch Directors of Operations had to review a report that was generated weekly by "corporate" that listed all of the branch's patients that were currently scheduled for (a) fewer than 6 therapy visits, (b) just short of 14 therapy visits (i.e., who had 12 or 13 visits), or (c) just short of 20 therapy visits (i.e., who had 18 or 19 visits). For example, if any patient's initial OASIS assessment form was coded so that total therapy visits worked out to 13, as a branch Director of Operations CW-30 would receive a report of such patients from "clinical services" at corporate headquarters. CW-30 was then expected by CW-30's superiors to "work the report" – a euphemism for speaking to the therapist to get them to agree that more therapy visits were necessary. If the therapist said that no more visits were indicated, that would have to be reported to "corporate." There was considerable pressure to approve additional therapy visits. For example, as the "Balanced for Life" program began to be implemented, Amedisys branches that had hired

therapists to serve as Rehabilation Specialty Directors to oversee that program (as was the case at CW-30's branch) would assume responsibility for "working the report." In that case, if the therapist in the field would not approve additional therapy visits, the RSD would have to go out into the field with that therapist to supervise a "re-evaluation" of the patient – or the RSD would simply assign a new therapist to the patient who would agree that the patient required enough therapy visits to "hit the trigger."

(b) CW-30 described the involvement of QCCs in upcoding over the objections of the clinicians in the field. For example, Amedisys nurses were instructed to list every medical diagnosis that a patient may have in his medical record, and then QCCs would extract the diagnoses that would result in the most revenue and reimbursement from Medicare. Clinicians would be pressed by QCCs to change the primary diagnosis on the OASIS form. Although the clinician in the field was meant to sign "correction" forms that QCCs sent to them, CW-30 reported that there were "a lot" of times that the clinicians did not sign those forms but CW-30 observed that QCCs would edit and change the OASIS anyway using the AMS2 computer system. Similarly, the QCCs would try to upcode the OASIS characterization of a patient's functional abilities. QCCs called with lots of requested changes; it was a rarity if a nurse completed an OASIS and did not get a call. As CW-30 observed, "I think it was pretty obvious across the board that when they [the off-site QCCs] called you and requested that you make a change, it was because it was going to [increase] the reimbursement." Nurses definitely had problems with the QCCs' suggestions, but there was absolutely pressure to agree to the QCCs' changes. For example, CW-30 would receive monthly reports from "corporate" on clinicians in the field who were not cooperating with the QCCs, and as branch Director of Operations CW-30 was expected to "address" such issues. If the branch Director's initial responses were not satisfactory, the Area Vice President would come to the branch, go over these monthly reports, and reiterated in person that the branch needed to "become more compliant with QCC recommendations." CW-30's Area VP would also confide that "It's coming from above; I'm getting pressured; we've got to address this."

(c) CW-30 also described the involvement of QCCs in the certification and recertification process. For example, many Amedisys patients had chronic conditions, such as Parkinson's disease. Under Amedisys guidelines, clinicians could essentially never discharge such a patient because of the continuing risk that the patient might fall. However, such patients ultimately plateau with therapy and when it gets to the point where the therapist is just reinforcing what they have previously done Medicare does not authorize additional treatment. Similarly, QCCs would press to certify patients for marginal reasons under the Company's "guidelines," e.g., simply because the patient had had a medicine change within the last 14 days. Although some therapists would appropriately seek to discharge such patients and refuse to recertify them, "corporate" gave unwritten instructions – in the form of director training sessions in Florida and instructions from the Area Vice President – that in such situations branch directors were to find a new therapist to visit the patient who "may find something to recertify the patient for."

(d) CW-30 also recalled how Amedisys's corporate headquarters provided the branch directors of operations with a large volume of information and written materials on Medicare's revised therapy visit thresholds that came into effect in 2008, and how much money was

associated with them. The branch directors of operations were directed to thoroughly train their staff on this material. Around January 2010, however, there was a panic about having distributed these materials, and the Company's directors of operations were all directed to return them. Amedisys's corporate management was so concerned about retrieving these materials that an Amedisys Assistant Vice President was dispatched to go to CW-30's office in person to say that the Company needed to get all the information back. Although the AVP made a pretense of reciting how clinicians should make treatment decisions based on what was clinically indicated rather than on the revenue considerations detailed in the written materials, it was clear to CW-30 that headquarters had dispatched the AVP to the branches only to get the written materials back -- and that management had no intention of changing the Company's practices with respect to "working the reports" of patients whose scheduled therapy visits were falling short of the key 6, 14 or 20 visit thresholds. During this same visit, the AVP instructed CW-30 to continue "working" the weekly reports (which continued to be distributed) of patients who were scheduled to fall short of the 6, 14 or 20 visit thresholds, but that going forward CW-30 was to shred the reports after CW-30's branch had finished "working them." In addition, the AVP also instructed CW-30 to shred all of the therapy visit reports and related "alerts" from 2009 (and CW-30's related notes thereon) that CW-30 had carefully kept in binders. As CW-30 stated, this instruction was the "polar opposite" of CW-30's prior instructions -- which had been to keep the very same documents so that CW-30 could show his/her superiors that CW-30 had diligently "worked them" – and CW-30 and other branch directors actually "all laughed" about management's about-face. A few months later, in the spring of 2010, CW-30 saw the April *WSJ* article and read about government investigations.

24. CW-31 was clinical manager at an Amedisys branch in Georgia from 2009 to 2010, having had more than ten years' experience as a nurse and doing quality assurance in the home health care field.

(a) CW-31 recalled that during CW-31's tenure at Amedisys, there was always pressure to hit – or just slightly exceed – a particular trigger threshold. CW-31 also recalled that therapists who had hit the trigger number exactly were sometimes told they had to do one or two more visits because there were "too many" patients coming in exactly at the trigger level. CW-31 recalled that a woman named Renee was the area therapy supervisor for branches in the region, and that she would have monthly meetings with therapists in CW-31's branch. The field therapists would come out of those monthly meetings saying "we got it again," namely, the instruction from the regional manager to not just hit the trigger, but to do one or two more visits beyond the trigger.

(b) CW-31 also confirmed that Amedisys applied pressure to admit and recertify patients to keep the Company's numbers up. For example, the Company was not at all strict about not enforcing Medicare's requirements that patients be homebound to qualify for home health care. In addition, all discharges had to be approved by CW-31's branch director. CW-31 would tell the branch director of operations that they did not need to see a particular patient anymore, but after they heard the branch director say "Yes, we do" a couple of times, one did not question it anymore." CW-31 felt that s/he was not really being allowed to act as a clinical manager with respect to patient decisions.

(c) CW-31 also confirmed that Amedisys nurses were pressured to do as few nursing visits as possible without getting a LUPA. To that end, they were also told to engage in "front-loading," where they were told to do 2-3 visits the first week, then change to once a week, and then change to once every two weeks – or to do just a phone call with the patient (rather than a visit).

(d) CW-31 observed that although s/he oversaw the branch's nurses and therapists, s/he "was never allowed to … see the actual coding and billing of the OASIS." This structure "made the hair stand up on the back of my neck," since nothing was on paper and everything was on the computer system; CW-31 could not even access the part of the system that kept track of the number of visits and the OASIS coding. CW-31 became immediately suspicious, and felt relatively certain that that there was a lot of upcoding and changing of the OASIS going on. When the branch director went on vacation, CW-31 took calls from coders located in a centralized off-site location, which quickly confirmed his/her suspicions: "it became absolutely clear [from my exchanges with the coders] that they were playing fast and loose." Upon the branch director's return, CW-31 confronted him, demanding to become involved in the coding process because CW-31 had the most direct contact with the nurses and actually knew what was going on with the patients, and pushed to have the branch director teach him/her the computer system. These suggestions did not go over well, the branch director was upset that CW-31 had spoken to the coders, and CW-31 was terminated soon after.

25. CW-32 was Director of Operations at an Amedisys branch in Oklahoma during 2008-2009.

(a) CW-32 confirmed that there were weekly regional team calls, led by the Area Clinical Manager for Oklahoma (Stephanie Six) and a female executive one or two levels above Ms. Six who was responsible for the entire region (which included Oklahoma, Louisiana, Mississippi, Alabama and Georgia). During these regular conference calls, the branch directors of operations would be "encouraged" to maximize the number of visits – and 14 therapy visits was a highly emphasized number. CW-32 confirmed that the area manager and the "higher ups" were definitely looking at everyone's number of visits; "they watched [visit] numbers very closely," and had access to computer reports that showed the number of visits, by type, as well as date information showing when patients were getting close to the end of a 60-day episode. The pressure was especially strong for more therapy visits because therapy involved the highest reimbursement, and regional management would call CW-32 to ask for more visits on patients when they were approaching a trigger level. Although CW-32 denied allowing CW-32's office to make unnecessary visits, CW-32 confirmed that unnecessary visits were "an issue" at the Oklahoma City branch (which was the largest Amedisys branch in Oklahoma). CW-32 ultimately ended up leaving Amedisys after less than a year because of how Amedisys was billing Medicare, and how its upper management did business.

(b) CW-32 also expressed concerns about the extent of the incentives and remuneration that Amedisys paid to doctors. CW-32 believes that Amedisys went over and above the guidelines for parties, dinners and trips in quite a few cases, and saw issues with Amedisys's practices at both the branch and corporate level. CW-32 knew that the Director

of the Oklahoma branch was not comfortable with a number of these events, and reported them to Stephanie Six, the area director, but the concerns never seemed to be addressed.

26. CW-33 was an Amedisys manager from 2005 to 2008, serving initially as Regional Administrator overseeing Amedisys sales and operations staff located (at various times) in parts of Mississippi, Louisiana, Tennessee, Arkansas and/or Missouri. As CW-33's mix of territories gradually expanded, CW-33's title became a vice president of operations, reporting to Cheryl Lacey.

(a) CW-33 described "struggling" when CW-33 started reporting to Lacey because there were "things that went against my grain" as an ethical person. One major and troubling issue was Amedisys's launch into new therapy programs, such as Balanced for Life, immediately after it became known that Medicare was going to implement the revised therapy visit payment "buckets" in 2008. CW-33 believed that if patients really needed so much additional care going forward, then such patients would have needed that care before the revised therapy buckets were put in place. CW-33 also recalled attending a quarterly regional meeting in Chattanooga, TN in the spring of 2007, at which Amedisys Senior Vice President Jill Cannon stated that Amedisys was implementing new therapy programs to meet the new visit thresholds for reimbursement. Although CW-33 claimed that s/he always told therapists to do what was best for each individual patient and to not make unnecessary visits, CW-33 heard rumblings in other regions about therapists being pressured. CW-33 also recalled that, in CW-33's region, Amedisys would send therapists to do wound care visits – even though this was a task that only nurses were qualified to perform – in order to increase the number of therapy visits.

(b) CW-33, although an administrator rather than a health care professional, also admitted that s/he was uncomfortable with the Company's practice of having OASIS forms reviewed remotely, since CW-33 felt it was inappropriate for someone who knew little or nothing about the patient to make the decisions on coding for that patient. CW-33 was particularly concerned that a new staffing plan implemented in early 2008, which involved hiring more "Quality Care Coordinators" at the regional level to review OASIS forms remotely, would further undercut the role of personnel in the field, and that s/he was aware that some [branch] directors were frustrated with the plan because the people who would be making the decisions under it did not know the patient.

27. CW-36 was the Business Office Manager for an Amedisys branch in Florida from late 2007 through the second half of 2010.

(a) CW-36 described how Amedisys typically put patients on a "therapy track" at admission – such as of a "Balanced for Life" therapy "track" -- which called for a pre-specified number of X visits. Corporate would then tell the therapists that the patients would have to do X number of visits. There were several therapists in the branch, however, who strongly objected to having to complete the pre-specified number of therapy visits because doing so was not medically necessary. For example, CW-36 heard a number of therapists complain

that just because Amedisys said they needed to do five more visits did not mean that a patient needed the visits – but CW-36 could see the pressure that was placed on therapists to do unnecessary visits. For example, CW-36 recalled the names of two "damn good" therapists who simply refused to do such visits and eventually resigned from the Company rather than continue to work in such an oppressive environment. "Therapy drives revenue" was "drilled into everyone's brains," therapists had to get in a certain number of visits per patient, and the pressure on therapists came down from the "corporate office" through reports and emails to the branch directors of operations.

(b) CW-36 also confirmed that Amedisys clinicians were told to engage in the practice of "front-loading" clinical visits to avoid LUPAs. In other words, because they needed to get in five visits of any type to be reimbursed, they would front-load the visits in the event that "something happened" to the patient – such as being admitted to the hospital or dying – that would cause a LUPA. "All of the nurses would walk around worrying about LUPAs."

28. CW-37 was a nurse at an Amedisys branch in Kentucky from late 2008 to late 2009.

(a) CW-37 stated that Amedisys was committing "out and out Medicare fraud" by providing unnecessary visits, and therefore quit the Company because CW-37 valued his/her nursing license too much to stay. CW-37 objected to the recertification of patients who CW-37 would "swear on a stack of bibles" had received all the visits they needed. "Corporate," however, "has set it up so that they are going to do whatever they can to get their patients."

(b) Several other nurses also left the same office within a few months of each other, after one of them had flown to Baton Rouge to complain in person to one of the Company's lawyers, who thereafter did nothing to help them. The head therapist in CW-37's branch also left rather than put up with the games that Amedisys played in terms of providing unnecessary visits to some patients while denying services to others who needed additional care.

(c) Although CW-37 (a nurse) was not familiar with how the therapy triggers worked, CW-37 knows that "a lot" of therapists quit, including a friend who quit due to the excessive pressure, and who had described to CW-37 (1) how the office would "count the visits" and (2) how visit information was transmitted daily through the computer system so the main corporate office could access and review it. Based on conversations with another friend who was still at the Company, CW-37 believes that the wrongful practices at Amedisys were still continuing.

(d) CW-37 called the confidential hotline twice to report Medicare fraud, and harassment towards those employees who would not participate in the fraud at the Company.

(e) CW-37 stated you had to have five visits to avoid a LUPA, which required the Company to give back money to Medicare. As CW-37 further stated, if you had a LUPA at Amedisys "you were in trouble." "You'd better not have a LUPA, and that was it." CW-37 recalled specific instances of being instructed to provide additional, and plainly unnecessary, nursing visits to avoid having a LUPA. CW-37 also reported how Amedisys encouraged its nurses not to send patients back to the hospital (which might result in a LUPA), and that

"if we send anybody, it better be because they were blue." CW-37 characterized Amedisys as a "horrible company," and is surprised how it can still be in business.

29. CW-39 served as a Vice President of Business Development based out of Louisiana during 2008 to 2009. CW-39 "absolutely questioned" Amedisys's business practices, stating that "it was all about numbers," and that corporate headquarters placed tremendous pressure on field personnel to increase the number of "profitable" therapy patients (such as those that could be enrolled in the Balanced for Life program). CW-39 stated that if plaintiffs could gain access to Amedisys's internal emails they would be "as good as gold," as they evidenced the pressure to make numbers and increase profitability; for example, branches were told to concentrate on Balanced for Life patients to "get their numbers up." These emails came out 3-4 times a month, and were sent primarily by Ric Pitchard, a Senior Vice President whom CW-39 described as the chief of the "data police" at Amedisys's corporate headquarters.

30. CW-41 served as a registered nurse in the field based out of an Amedisys branch in Massachusetts from 2006 to 2008, and had previously worked at another home health care company that was acquired by Amedisys in 2006.

(a) CW-41 stated that there were many times when the clinical nurse manager in CW-41's branch would forbid CW-41 from discharging a patient who no longer needed treatment. In addition, Amedisys also practiced "up-loading," which was the practice of front-loading three or four visits in a patient's first week of treatment, *and then sharply curtailing visits in subsequent weeks.* Such heavily lopsided front-loading was unusual in the home health care industry, in part because newly-enrolled home care patients cannot easily absorb home treatment information if it is packed into such a tight initial period. CW-41, however, viewed this practice as being intended to help Amedisys avoid LUPAs where the patient had the potential to go back into the hospital – and that in such situations the goal at Amedisys was not to make the patient better but to keep him or her out of the hospital (which would require the patient to be discharged from home health care) until the patient received enough visits to avoid a LUPA. While engaging in "up-loading" to help ensure that the Company avoided LUPAs, at the same time CW-41 also reported that Amedisys imposed strict guidelines about how many times a patient could be seen by a nurse after hitting five visits; for example, a patient with a total knee replacement could not be seen by a nurse more than 6 times.

(b) CW-41 confirmed that it was "absolutely true" that Amedisys imposed a system designed to strip RNs and case managers of their autonomy in regards to admitting, discharging and recertifying patients. For example, there were many times when the clinical nurse manager

in CW-41's branch would force CW-41 to recertify patients who no longer needed treatment (including in cases where patients, who no longer needed treatment, were asking to be discharged and threatening to refuse further treatment if they were recertified). CW-41 would receive nasty phone calls from corporate headquarters and be written-up in her personnel file for refusing to discharge patients when requested to by remote, Louisiana-based monitors, and was given punitive on call duties and ultimately terminated as a "problem nurse" as a result of her refusal to discharge patients on command.

(c) CW-41 also described how Amedisys's system was designed to manipulate patient coding information in order to fraudulently extract inflated reimbursement payments from Medicare. As CW-41 recounted, remotely based Amedisys personnel in Louisiana would routinely review information contained in a patient's OASIS form in order to identify all the medical conditions that the patient suffered from -- and would then change the primary diagnosis as listed by the nurse in the field to whichever of the patient's *other* medical conditions was associated with the highest Medicare reimbursement payments, irrespective of whether it was the reason for the patient receiving treatment. For example, if a patient with a primary diagnosis of congestive heart failure did not pay as much as one with a primary diagnosis of diabetes, after being reviewed off-site in Louisiana then all of a sudden diabetes would be the new primary diagnosis. CW-41 would note that the majority of her patients had been diabetic for years, that such patients had long since learned how to monitor their blood sugar and otherwise care for their diabetes, and that to put down a patient who had just been treated for congestive heart failure as having a primary diagnosis of diabetes was simply a lie. Similarly, Amedisys personnel would have a physician statement telling them that a patient's new medications were for congestive heart failure, that the doctor was monitoring the patient for congestive heart failure, and that Amedisys should let the doctor know of any problems related to the patient's congestive heart failure -- and there would be no mention of diabetes in the doctor's original referral -- yet Amedisys would list diabetes as the primary diagnosis because it resulted in the biggest Medicare reimbursement payment. Although the doctor would later sign a Form 485 prepared by Amedisys reflecting (among other things) the new primary diagnosis, CW-41 commented that doctors have a hundred Form 485's to look at and that in her years as an RN she has never had a doctor review a Form 485 as the doctors rely on the nurses to be honest in filling them out.

31. CW-42 was an RN with 20 years' experience and a former nurse at an Amedisys branch in New Mexico during 2009 and 2010.

(a) CW-42 described the pressures applied by Amedisys's remotely based QCCs, and the Company's attitude that the QCCs' instructions should be obeyed. For example, CW-42 recalled multiple occasions when QCC personnel would call CW-42 to say that what had been listed as a patient's third diagnosis should instead be listed as the primary diagnosis. CW-42 would explain that the lower-listed diagnosis was not the main reason why the patient needed home health care treatment, and CW-42 is certain that the only reason that such changes in diagnosis were requested (and made) was to increase the reimbursement from Medicare. In other words, the patient assessments were "manipulated." If something on the OASIS form was not written up the way the QCCs wanted it to be, the nurse would

be called again and again; the nurses would ultimately succumb and finally agree. As CW-42 further stated, it was made very clear to the nurses that they were to do the assessment work – but that the QCC knows how it should be written up and the nurses were to follow the QCCs' directions and not ask questions. As CW-42 added, being under this kind of pressure was "not a nice feeling."

(b) CW-42 noted that "LUPA" was a very familiar term that was used a lot at Amedisys, and would be discussed at weekly staff meetings. As CW-42 put it, the managers "all knew very well how to gently persuade you to make sure we're getting the right amount of visits because if you don't have the right amount of visits then its called [a] LUPA, and it [reduces] the reimbursement."

(c) CW-42 also described how Amedisys had a checklist that had to be completed when a patient was up for discharge or recertification. As CW-42 stated, having a checklist was not a bad idea in and of itself, but the reason for the checklist was to find a reason to recertify patients – even if it was on the slimmest of pretexts. For example, Amedisys would look to see if there had been even a modest change in the dosing of a patient's medication. CW-42 noted that the majority of patients were either reasonably intelligent or had capable family members, and that it was unprofessional – if not illegal – to recertify a patient for multiple weeks of additional home health care just because their dosing had been modified. CW-42 would have conversations with other nurses to the effect of "What are we seeing this patient for?"

32. CW-43 was an RN who worked out of an Amedisys office in Pennsylvania between 2007 and 2009.

(a) CW-43 described Amedisys as having abused the system "something fierce," which included never discharging anyone until the end of the certification period and ensuring that all admitted patients definitely received at least five visits to avoid LUPAs.

(b) CW-43 also stated that the Company definitely kept patients on who no longer needed home health care. For example, CW-43 recalled a patient who was getting home health care for peripheral vascular disease, but was regularly going out to play golf, etc.; nonetheless, Amedisys kept recertifying that patient. CW-43 raised this with his/her supervisors, but explained that nurses at Amedisys had to do what they were told and were instructed to "go with the flow." Basically, it was standard practice at CW-43's branch to improperly recertify patients, and the branch manager attributed the pressure to enage in dubious practices to corporate, saying she was just passing down what she was told to do.

(c) CW-43 also confirmed that nurses at Amedisys were pressured to change their OASIS coding in a manner intended to increase Amedisys's Medicare reimbursements. CW-43 described how an offsite nurse (Kelly from the South) would regularly call about changing OASIS forms, and how, for example, Kelly would say that the Company could get more reimbursement by listing something else on the OASIS. The nurses would go along with what Kelly said, because although they were frustrated by it they knew to do what they were told if they wanted to have a job at the Company.

33. CW-46 worked as an account manager (a position filled by nurses that was primarily responsible for selling Amedisys services and pre-evaluating patient files before a field nurse would make an in-person patient visit and assessment), and was based in north Texas during 2005-2008. CW-46 repeatedly described the push for new business in north Texas, and for the Balanced for Life program in particular, as "over the top" and "very, very extreme." For example, if a new patient referral came in and the clinician came back from the full assessment and said the patient did not qualify for services, Amedisys was "just dug into the ground to re-evaluate them and get them on board." Nurses were also pushed "really, really above and beyond" on recertifications. For both referrals and recertifications, when a clinician would "dig their heels in" and refuse to admit or recertify patients because they did not qualify, the case would be kicked up to Maggie Suggs (Regional Vice President for Operations) and the Vice President of Business Development (or even to Suggs' boss, Cheryl Lacey) for review – which often resulted in a different clinician being sent out to evaluate the patient (or prospective patient). According to CW-46, these executives were sending out a different clinician to get a different answer on the patient, and reiterated that the push for admissions and recertifications was extreme. Sales persons were placed on demanding quotas to bring in new patients; if they fell short in a given month they would be put on a performance improvement plan (or "PIP"); if they then failed to meet their quota for the next quarter they would be terminated. "It was very money driven;" and "at the end, it was all about financial growth and not servicing the public." CW-46 added that the VPs could also be fired if their sales people were not hitting their quotas – and the pressure rolled down from the top.

34. CW-47, a former TLC employee, stayed on as scheduling coordinator in an Amedisys branch in Georgia after Amedisys acquired TLC in early 2008. CW-47 noted that Amedisys stressed the issue of recertification, and its employees were to "find something" to recertify Medicare patients. In contrast, CW-47 noted that TLC had only recertified patients when care was needed. CW-47 also noticed

that there were decidedly more therapy visits after Amedisys took over the branch, even though s/he would hear the therapists say that patients did not need the visits that they were being told to make. From his/her conversation in the office CW-47 believes that the pressure to recertify patients and increase therapy visits came from corporate headquarters; it came from the top.

35. CW-48 worked as an RN out of an Amedisys office in Illinois from 2006 to 2008, and described how the higher-up area managers would get angry if nurses in CW-48's office refused to admit a patient because they did not need home health care. The area managers monitored which patients were up for recertification (as well as how many visits they received). CW-48 also recalled that when s/he refused to admit a patient, Amedisys would assign that patient to a different nurse, and nurses who refused to admit patients would be punished by having patients taken away from them. CW-48 stated that nurses were pressured to admit, *inter alia*, non-homebound patients. The pressure to admit and recertify patients, even if they did not need home health care, came from the area managers who supervised CW-48's office and who participated in weekly conferences where recertifications were discussed; as CW-48 stated, "[i]f you complained, you are on their crap list."

36. CW-49 was Director of Operations at an Amedisys office in Florida for approximately 4 years (2006 to 2010), and reported that Amedisys corporate management was so intent on recertifying patients that s/he was required to call the Regional Vice President to give them an explanation if CW-49 was ***not*** going to recertify a patient.

37. CW-52, a Business Office Manager for Amedisys in Wisconsin from 2009 to 2010, stated that Amedisys was improperly and unnecessarily recertifying patients, up to 4 to 5 times, and that this was a common practice to keep census numbers up. According to CW-52, the Quality Care Coordinators (QCCs) would oversee the paperwork in the beginning of an episode and would tell the director of nursing, nurses, or therapists, that they should change the coding before assessments were locked in. The QCCs

frequently called about OASIS scores, often to request changes going against what the very knowledgeable clinicians in the field had recommended. As a result, many of the treating nurses felt their expertise was not being valued, but they would do what they were told and would approve the changes. Such calls were frequently about newly admitted patients. When the investigations began in 2009, according to CW-52, Amedisys began firing the QCCs.

38. CW-53, who is a registered nurse with prior experience in the home health care industry, was an account executive at an Amedisys branch in Indiana during most of 2006; CW-53 also covered unofficially for the clinical supervisor and branch Director of Operations at times. CW-53 worked at the same Amedisys branch as CW-5 in 2006.

(a) CW-53 reported that during his/her tenure (even though s/he was on the sales side) s/he participated in several meetings and calls about having nurses "correct the OASIS forms," arising out of Amedisys's practice of asking nurses to backdate and change OASIS information in order to "capture reimbursement." According to CW-53, the Regional Director would call the branch's Director of Operations and instruct him/her to have the nurses change OASIS forms. CW-53 noted that it did not take a rocket scientist to figure out that the changes being sought by corporate management were to increase reimbursement. CW-53 and the branch Director of Operations tried to push back against management. However, both CW-53 and the branch director left the Company later that year because they were worried that they were going to lose their license if they ended up staying in such an environment, as instructions from the Regional Director to change documentation went against everything they knew.

(b) CW-53 also attended the same 2006 meeting in Florida that CW-5 described, and corroborated CW-5's recollection of that meeting. CW-53 similarly recalled Borne telling them that an unspecified government investigation of Amedisys was going on, and how "if he [Borne] was sinking in the ocean, he would step on our heads, hold our heads underwater, and take our last breath of air and come up above water." Borne also told attendees, in substance that they would be sitting beside him in the courtroom if it came to that. Borne's staff immediately tried to get him away from the microphone and a break was called before the meeting continued; when Borne returned he changed subjects and said nothing further about any investigations.

(c) CW-53 was told by his/her superiors that if s/he could bring on physicians in that area, Amedisys would pay them as consultants. CW-53 understood this to be a kind of kickback. Consultants were paid on a monthly basis and were meant to show up for quarterly meetings, but Amedisys "blatantly said" that consultants were brought on because they were good referral sources. CW-53 was also told that they could bring on more than one medical director per branch, which did not make sense to CW-53.

39. CW-54 was Director of Operations at an Amedisys branch in Illinois from 2005 to 2010.

(a) CW-54 described how Amedisys's Point-of-Care computer system used software that prompts the nurses filling out an OASIS form to answer certain questions in only a certain way so that a certain minimum number of therapy visits (such as 10) would result. (As CW-54 explained, answers to various questions on the OASIS form determined how many visits a patient would be scheduled to receive). If the person entering patient data did not answer certain questions the way that Amedisys's software wanted (or was designed to accept), the system would report an "error" and would force the person to go back again and again until the answers were acceptable to the system; in fact the system would not close down until the questions were answered in the desired way (e.g., until they justified at least Amedisys's 10 physical therapy visits). The system also always demanded that one list every patient diagnosis, even if that diagnosis was not the reason that Amedisys was seeing the patient. In sum, it was a bad computer system, but you could not tell that to anyone in corporate in charge of the system – they were always right. CW-54 would try to override the system to get accurate (but less remunerative) answers input over the objections of the computer, but would constantly get in trouble for trying to do so. CW-54's branch was always on the hot seat and under pressure from the boss of the QCC department (who would then call CW-54's Regional manager to complain) – but CW-54 was unwilling to "commit fraud."

(b) According to CW-54, Defendant Borne sent Amedisys employees a videotaped message regarding the April 26, 2010 *WSJ* article. According to CW-54, Borne informed Amedisys employees that Amedisys stock was going to plummet because of the *WSJ* article.

40. CW-55 was a former Director of Operations at an Amedisys branch in northern Texas for approximately four years from mid-2006 through mid-2010, during which time she reported to Area VP of Operations, Maggie Suggs.

(a) CW-55 recalled intense pressure to admit every single patient. According to CW-55, Amedisys's approach was to admit every patient that was homebound – and a reason to provide home healthcare would be found. If a patient had a home health aide, then Amedisys required agencies to perform occupational therapy visits as well. CW-55 said that the pressure came down from the regional vice presidents – who were getting pressured from their respective superiors. CW-55 explained that corporate looked at "trigger reports" that showed for each agency: (i) what the Medicare reimbursement could be; (ii) what reimbursement they were getting; (iii) and what they would get (in the post 2007 period) if they reached the 14 visits. According to CW-55, the Company was "wild" over these "trigger reports," which were reviewed on virtually a daily basis, and went to corporate and the regional vice-presidents. Every single morning, every director and sales person in CW-55's area had to be on a conference call to go over their admissions, recertifications, discharges and what admissions were pending. CW-55 said these calls were "brutal" and were led by the regional sales personnel and regional vice presidents. CW-55 said that, to determine how home health care companies such as Amedisys were working the system, one need only "follow the money."

(b) CW-55 also recalled that there was pressure to recertify patients. CW-55 said s/he often heard "A recert is as good as an admit." According to CW-55, no one was allowed to discharge patients without the director of operations reviewing the case to make certain that the patient had been recertified as many times as possible and had received therapy. CW-55 said it was an unwritten rule that if a patient had any fall, any medication change, change in health status or even if they moved to a new residence – that patient was supposed to be recertified.

(c) CW-55 recalled that LUPA reports were reviewed on a weekly basis to determine how close Amedisys was to avoiding a LUPA. According to CW-55, clinicians were told that they needed to get 5 visits. CW-55 said "it was just wild for us to be on top of those reports, [including] the LUPA reports." Further, CW-55 recalled that they were drilled to "front-load" visits – i.e., to schedule more patient visits up-front in the first few weeks to ensure that 5 visits were achieved and a LUPA was prevented. According to CW-55, the pressure came down from the regional vice presidents – who were, in turn, getting pressured from their respective superiors.

(d) CW-55 said that, in March 2008, s/he attended a leadership convention in Orlando, Florida at which Defendant Borne discussed the changes to the Medicare system. In attendance at the meeting were all Amedisys directors of operations, regional vice presidents and sales personnel as well as the top executives, including Defendants Borne, Graham, Jeter and Schwartz. CW-55 remembered Defendant Borne announcing that many smaller home healthcare companies were going to close down because they had not figured out a way to get to the higher reimbursement rates. However, Defendant Borne said that Amedisys was ahead of the game and on top of the new system because they had developed programs to obtain a higher reimbursement, which would be put in place in time for the changes to the Medicare payment system. According to CW-55, Defendant Borne was communicating that Amedisys put the new programs in place specifically to deal with the new reimbursement system. CW-55 said that it was obvious to anyone on the frontline that these new programs were specifically designed to obtain higher Medicare reimbursements.

(e) According to CW-55, one of the programs designed to deal with the new reimbursement system was the Balanced for Life program. CW-55 said that Amedisys "just pushed it, pushed it, pushed it; it didn't even make sense at times." Amedisys wanted everyone tested for the program – whether or not it was medically necessary. For example, CW-55 said that Amedisys therapists were told by Rehab Specialty Directors to do a vestibular test even on people who did not need to be tested. The goal was to hit the new Medicare reimbursement triggers. CW-55 also said that if a therapist failed to hit the reimbursement triggers – then other programs would be suggested for the patients. According to CW-55, Amedisys "really pushed" employees to hit the reimbursement triggers. CW-55 recalled that, initially, the approach at Amedisys was if you can do 9 visits, then you could do 10. Later, after the Medicare changes, the approach was if you can do 12 visits, then why can't you do 14 visits. CW-55 said that Amedisys would try to spread the therapy visits out so people would not question why so much therapy was coming in at one time.

41. CW-56 was the Director of Operations at an Amedisys branch in Indiana for four years from 2007 through 2011. CW-56 reported to the Area Vice President of Operations.

(a) CW-56 confirmed that everyone s/he dealt with at Amedisys was very well aware of "the 10 visit rule" with respect to therapy visits. CW-56 confirmed that, when initially hired in 2007, the push was for 10 visits. CW-56 recalled that therapists would often discuss the pressure they were under at Amedisys to satisfy the 10-visit rule. CW-56 also remembered the changes to the Medicare reimbursement system to the bucket system of therapy visit thresholds.

(b) CW-56 recalled that there was a lot of pressure – big pressure and a big push – to meet therapy thresholds. CW-56 also recalled a lot of reporting that had to be done – i.e., regarding the number of therapy visits and what percentage of patients fell into each category. CW-56 said there were scorecards prepared for each separate Amedisys agency (branch), which measured their statistics, including where they fell with respect to meeting the Medicare reimbursement thresholds. Bonuses were meted out based on an agency's scorecard. CW-56 also said that the number of visits received by patients was discussed during weekly case conferences – and monitored closely by Amedisys. Numerous reports also recorded the percentage of patients that were at certain levels of therapy visits – for example, this percentage of patients had received X amount of therapy visits, this percentage had received Y amount of therapy visits. According to CW-56, corporate generated all of the reports and scorecards.

(c) CW-56 said that nurses would be questioned on why they were not recertifying patients. According to CW-56, each patient coming up for recertification had to be discussed with referred to a checklist of criteria, including such items as a medication change or a visit to the hospital. CW-56 said that, if there was an increase in the dosage of medication that a patient had already been on, Amedisys management wanted that patient recertified, and accordingly Amedisys recertified patients when it was medically unnecessary.

(d) CW-56 described his/her belief that the practice of the Amedisys QCCs was to increase the OASIS scores that Amedisys recorded so that it could obtain higher reimbursements.

(e) CW-56 said that his/her agency would be penalized for having LUPAs, which would be recorded on the agency's financial scorecard. CW-58, the former clinical manager and later the Director of Operations at an Amedisys branch in Tennessee, confirmed that employees at Amedisys needed to provide at least 5 visits before discharging a patient – or the Company would lose money due to the resulting LUPA. CW-56 recalled the Balanced for Life program, which increased therapy visits. CW-56 said that therapists had to evaluate every single patient for entry in the Balanced for Life program – and noted that some therapists believed that Balanced for Life was unnecessary for various patients yet they were pressured to utilize that program. CW-56 explained that Amedisys agencies were measured based on Medicare admissions, which CW-56 disagreed with. Further, CW-56 said that Amedisys was a very structured company with very strict guidelines they were supposed to follow. According to CW-56, concerns surfaced at national meetings that certain areas of the Company were violating Medicare rules – yet, even though the concerns

were supposedly reported up the chain of command, nothing was ever done about it. CW-56 heard from Amedisys's Vice President of Business Development that there was all kinds of shady stuff going on in the region in which CW-56 was based (which also included Kentucky) – and despite reports to area supervisors, nothing seemed to be done. CW-56 said that if Amedisys employees challenged the way corporate required things to be done – they were branded troublemakers. While calls to the compliance hotline were supposed to be anonymous, CW-56 recalled that these complaints were often given to the Area Vice President in the same territory to investigate.

42. CW-57 was a Regional Director of Clinical Operations at Amedisys based in Kentucky from mid-2005 through the spring of March 2006. CW-57 had worked at another home healthcare provider (Housecall Home Healthcare) that was acquired by Amedisys – and worked for three to four months as a part of the team working to transition the newly-acquired agencies over to Amedisys. CW-57 was responsible for the agencies in Kentucky and part of Indiana. CW-57 reported to Donna Massie, Amedysis's Clinical Department Supervisor, who oversaw the whole Clinical Department at Amedisys (rather than just one region).

(a) CW-57 stated that in situations when OASIS questions were answered in a way that gave rise to a new clinical diagnosis, Medicare would stop reimbursement and then re-start to account for the new diagnosis. According to CW-57, however, Amedisys came up with a way to get around the interruption of reimbursement. CW-57 also confirmed that, if a therapist made 9 visits, there was a push to do one more visit [i.e., to reach the 10-visit threshold] – and that they were specifically told "surely there is one more visit you can make" even when there was no legitimate reasons for further visits. CW-57 said that in some cases the suggestion was legitimate – but in other cases it was not. CW-57 highlighted that there was a significant difference between the way Amedisys did business and the way his/her former employer (Housecall Home Healthcare) had done business. CW-57 said s/he reviewed Amedisys's records in detail and recalled thinking that, when s/he was at Housecall, it would have been coded and staffed in a less questionable manner.

(b) CW-57 said that Amedisys employees were told that, in completing OASIS forms, they needed to interpret the OASIS questions so that they could continue with the episode. CW-57 said that he/she believed that the way Amedisys was answering the OASIS form questions was improper, and that the Amedisys answers seemed to be more of a "work around" than the correct answers. Further, when OASIS forms would come back following review, s/he would note how diagnoses were rearranged, and in the majority of cases the changes were inappropriate, which further confirmed CW-57's belief that Amedisys engaged in upcoding.

(c) CW-57 recalled that Amedisys headquarters set a percentage of total patients it wanted to see recertified every 60 days. According to CW-57, if the agency got in their number of

visits and met the recertification goal set by Amedisys – the patient could be discharged. CW-57 said that the recertification percentage number was set by Amedisys management on a company-wide basis. Recertification quotas and recertification numbers were carefully tracked in written reports, and would be discussed in regular conference calls with Amedisys regional management. CW-57 described how, after leaving Amedisys, s/he worked in compliance at another home health care company (Intrepid USA). According to CW-57, employees at Intrepid would describe how they simply could not compete with Amedisys when going into doctor's offices to try to obtain referrals because Intrepid had a $15 limit on the amenities it could offer doctors – whereas Amedisys was offering dinners and tickets to ballgames or plays.

43. CW-58 was a former clinical manager and later the DOO at an Amedisys branch in Tennessee for approximately 6 years from 2004 to 2011. CW-58 initially reported to Sabrina Gann, Director of Operations, and later to Ladonna Scism, Area Vice President.

(a) CW-58 confirmed that Amedisys pressured employees to hit therapy visit thresholds. Initially the focus was on the 10 visit threshold, which changed to the new thresholds of 6, 14 and 20 visits following the changes to the Medicare reimbursement system in 2008. CW-58 stated that all employees were made aware of the reimbursement "buckets" and, indeed, received formal training on them through conference calls with supervisors and, later, Rehab Specialty Directors. According to CW-58, the information came down from a higher level, such as the regional managers and Defendant Borne. Prior to the 2008 Medicare reimbursement changes taking effect, CW-58 recalled Defendant Borne specifically discussing the coming therapy reimbursement "buckets" at a yearly leadership meeting attended by Directors of Operations, Vice Presidents and Area Vice Presidents. According to CW-58, Defendant Borne discussed how to make money with the new reimbursement system and the Company had a plan in place. However, CW-58 stated that Amedisys stopped discussing the reimbursement "buckets" completely once the SEC started its investigation into Amedisys.

(b) CW-58 confirmed that employees at Amedisys needed to provide at least 5 visits before discharging a patient – or the Company would lose money due to the resulting LUPA.

44. CW-60 was a Quality Care Coordinator with at an Amedisys branch in Michigan from early 2009 through 2010 – and had served as Director of Operations in at the same branch from mid-2008 through early 2009.

(a) CW-60 was responsible for reviewing the OASIS forms submitted by clinicians, conferencing with them regarding the OASIS forms and coding. CW-60 reported to the team leader, Diana Lee. CW-60 confirmed that Amedisys therapists told him/her that they were being pressured to do unnecessary patient visits. CW-60 further confirmed that the bottom-line was that the therapists felt scared to say no (i.e., to not succumb to the pressure to increase therapy visits) because they would lose their jobs for doing so. At Amedisys,

according to CW-60, people were fired for no reason. CW-60 said that a few clinicians were so upset and unhappy due to the pressure they felt, that CW-60 advised them to leave Amedisys. CW-60 recalled reviewing an Amedisys blog available on the Internet in which Amedisys employees posted that they were being pressured to do things they were uncomfortable with doing – and being fired for refusing. CW-60 shared with the team leader the information CW-60 had received from clinicians regarding the pressure to do more visits than planned and to recertify patients – but was assured that this type of thing was not taking place (but CW-60 remained suspicious given the information available to him/her). According to CW-60, clinicians indicated that the pressure was coming from Amedisys supervisors and from the Area VP. Further, according to CW-60, the bonuses of Amedisys's Regional Managers were based on their census, their recertification rate and their therapy thresholds, which incentivized them to do things that were not right.

(b) CW-60 said that management at Amedisys paid close attention to recertification rates. CW-60 also said that the bonus system for Regional Managers at Amedisys – by being based on things such as the census, their recertification rate and meeting their therapy thresholds – created incentives to do things that were not right. However, Amedisys employees were afraid of being terminated if they did not meet the quotas given to them. According to CW-60, when the investigations into Amedisys began, employees started to recertify patients the proper way – and, as a result, the census went down at Amedisys in Michigan.

45. CW-63 was the Director of Operations at Amedisys's office in Houston, Texas during 2009. As Director of Operations for Houston, CW-63 was responsible for a large team and reported to Guy Ranzino, a Regional Vice President based in Louisiana.

(a) CW-63 referred to Amedisys as a "good old boy system." CW-63 recalled that there was a benchmark for visits, and it was understood at Amedisys that if one had a certain number of visits – and went for one more – it would push one up to a higher reimbursement. According to CW-63, communications came from the regional level that Amedisys employees had to be aware of therapy reimbursement triggers. CW-63 said that written evidence of pressure existed in binders maintained at Amedisys, which dictated what the tracking patterns for certain diagnoses would be a certain number of visits.

(b) CW-63 also described how Amedisys pushed to recertify, and how Amedisys closely monitored recertification and pressured employees to find reasons to recertify patients.

(c) CW-63 said that Amedisys employees were very aware of avoiding LUPAs. Amedisys's Houston office would do utilization reviews on a weekly basis to review each patient.

(d) CW-63 recalled having concerns about the doctors on the professional advisory board because some doctors were paid to serve on a professional advisory board – and it was not always clear to CW-63 which ones were being paid. CW-63 received referrals from doctors on the professional advisory board and believed they were pressured behind the scenes to provide referrals. CW-63 also saw invoices from doctors, which caused CW-63

to wonder why Amedisys was paying the doctors. According to CW-63, a large number of doctors were involved. CW-63 also said that doctors would occasionally show up at weekly Amedisys staff meetings, which CW-63 found odd.

46. CW-65 was an account manager at an Amedisys branch in Virginia for approximately three years from 2007 through 2009. CW-65 was responsible for (among other things) account management and getting patient referrals from hospitals, nursing homes, assisted living facilities and churches. CW-65 reported to the regional director of marketing, Joann Seidner. CW-65 recalled being pushed with respect to the Balanced for Life program. According to CW-65, Amedisys was out to make money and so they pushed Balanced for Life and would try to come up with excuses to not discharge existing patients. CW-65 also stated that the pressure to get referrals was "driven by corporate" at Amedisys, and if one did not meet expectations they "would replace you." CW-65 had to keep "beating the bushes and get referrals." In that regard, CW-65 recalled that, at case conferences, everyone was pushed to maintain (i.e., not discharge) patients, and Amedisys closely tracked which doctors were willing to make the most home health referrals.

47. CW-66 worked at an Amedisys branch in Virginia from 2008 through 2010, first as a field nurse (mid-2009 – early 2009), then as a Clinical Manager (early 2009 – early 2010) and finally as a Director of Office Operations (early 2010 – summer 2010). CW-66 spent most of his/her time at Amedisys as a Clinical Manager supervising nurses and therapists. CW-66 reported to a director named Tammy Teebles-Forest and the Area Vice-President for Virginia.

(a) CW-66 stated that Amedisys pushed therapy a great deal – and that Amedisys wanted employees to do at least 14-16 therapy visits in a certification period. Further, Amedisys had clinical tracks that would conveniently meet the Medicare reimbursement "buckets" or thresholds. CW-66 recalled therapists arguing that they did not need to see a patient for so many visits – for example, a therapist might feel that the patient was fine after 8 visits – but the clinical track indicated that 16 visits were to be done. While some therapists resisted, others did as they were told and delivered the extra, unnecessary visits.

(b) CW-66 also recalled pressure to see patients even if they were not homebound. In 2010, Amedisys switched the therapists' pay structure so they were paid per visit instead of salaried – and would explain to the therapists that if they made a certain number of visits

per week, they would make as much as their previous salary. CW-66 said that s/he had talked to an occupational therapist that had left Amedisys recently who said that s/he just could not work there anymore. According to CW-66 that therapist said s/he was getting paid less because s/he would not write for more visits than the patient needed. There was also pressure to use the Balanced for Life program. CW-66 said that the Area Vice President would put pressure on the director, and the pressure would be exerted down the chain of command. According to CW-66, the Area Vice Presidents were the links between the branches and corporate headquarters. Corporate would pressure the Area Vice President – and she, in turn, would exert pressure on the directors reporting to her. According to CW-66, various reports generated at Amedisys indicated how many therapy visits had been scheduled, how many times a patient had been seen and how many visits were missed. CW-66 said the reports allowed management at Amedisys to point out to employees that, for example, they had scheduled 16 visits but only delivered 8 visits.

(c) According to CW-66, the nurses would complain a great deal about the QCCs instructing them to answer a question a certain way – for example, pushing them to give patients more severe ratings – when the nurses did not feel it was appropriate.

(d) According to CW-66, Amedisys absolutely wanted nurses to avoid LUPAs. CW-66 said that employees were told that, if you admit a patient, you'd better get 5 visits.

(e) CW-66 said that s/he saw a lot of patients get recertified when it was unnecessary. For example, CW-66 said that Amedisys mandated that if a patient started a new medicine – even if it was Tylenol or allergy medicine – that patient had to be recertified regardless of whether the patient was stable and should have been discharged. According to CW-66, Amedisys's recertification practices were just understood – they trickled down from the Area Vice President to the director.