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IN THE CIRCUIT COURT FOR BALTIMORE CITY

STATE OF MARYLAND,
200 Saint Paul Place
Baltimore, MD 21202

Plaintiff,

v.

OPTUM, INC.
1 Optum Circle
Eden Prairie, MN 55344

Serve On:
United Agent Group, Inc.
2405 York Road
Suite 201-C
Lutherville-Timonium, MD 21093

and

UNITEDHEALTH GROUP, INC.
1 Health Drive
Eden Prairie, MN 55344

Serve On:
United Agent Group, Inc.
2405 York Road
Suite 201-C
Lutherville-Timonium, MD 21093

Defendants.

Civil Case No. C-24-CV-26-005796

JURY TRIAL DEMANDED

COMPLAINT

The State of Maryland ("State"), by Attorney General Anthony G. Brown, files this complaint against Optum, Inc., and UnitedHealth Group, Inc., (collectively "Defendants") to recover monetary damages that Defendants caused the Maryland Medicaid Assistance program ("Medicaid") to sustain by submitting fraudulent claims in violation of the Maryland False Claims Act, Md. Code Ann., Gen. Provis. § 8-101 *et seq.* (LexisNexis 2019), breach of contract, as well as numerous other Maryland common law violations, and alleges as follows:

PRELIMINARY STATEMENT

1. In 2019, the Maryland Department of Health ("MDH") awarded Optum, Inc., a four-year contract to run the system that enables access to mental health and substance abuse services by the 1.5 million Marylanders on Medicaid—nearly a quarter of the State's population. That decision gave rise to the costliest and most disruptive debacle in Maryland Medicaid's history.

2. Optum, the wholly owned subsidiary of the nation's largest health care company, UnitedHealth Group, claims to possess a wealth of experience and deep sophistication in healthcare administration, as Optum touted in its bid to persuade the State to select Optum for this contract. However, due to Optum's knowing and reckless decision to swap out its own proprietary information technology platform, the one marketed to the State during the bid process, for a software platform created by an obscure subcontractor that had never been tested in Maryland's Medicaid program or in any Medicaid program of similar volume and complexity, Optum's administration of the system was an immediate and catastrophic failure that resulted in the loss of tens of millions of taxpayer dollars.

3. The Optum system failure, from day one, threw the State's Medicaid program into chaos. The system could not figure out which services were medically necessary and which were frivolous. It began denying legitimate claims. It did not provide receipts to large-scale providers like hospitals, which in turn struggled to run their businesses. It paid wrong amounts to providers, and failed to block rampant, multi-million-dollar fraud in substance abuse treatment and laboratory urine testing.

4. Optum continually deceived Maryland officials about its ability and intent to quickly or effectively fix the system and submitted invoice after invoice seeking payment for its failed system, repeatedly pressuring MDH, in meetings, emails, letters and calls, to pay up. Despite its continuous representations to MDH that it could and would provide a fully functioning system, Optum's system was never, over four years, fully functional. Nevertheless, the State was forced to pay Optum $126.9 million using Maryland taxpayer funds.

5. The State seeks: (a) to require each of the Defendants to pay $10,000 for each false claim it submitted or caused to be submitted to Medicaid; (b) to hold Defendants jointly and severally liable to pay to the State three times the amount of damages sustained by the State, an amount that exceeds $75,000; and (c) court costs and reasonable attorney's fees. Additionally, the State seeks for the Defendants to pay compensatory and punitive damages, as determined by a jury, for violation of numerous Maryland common law provisions.

PARTIES

6. Plaintiff State of Maryland is a free, sovereign, and independent State. Maryland law authorizes the State to bring a civil action against a person(s) who violates the False Claims Act. Md. Code Ann., Gen Prov. § 8-103(a).

7. Defendant Optum, Inc. is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota. Optum, which provides health care technology services, served over 120 million customers and had over $253 billion in revenue in 2024. It has worked with over 100 federal, state and local government agencies, in all 50 states including Maryland, to facilitate provision of health care services. Optum is a wholly owned subsidiary of UnitedHealth Group, Inc.

8. Defendant UnitedHealth Group, Inc. ("United") is a Delaware corporation with its principal place of business in Eden Prairie, Minnesota. United provides health insurance and health care services, insuring over 50 million people and earning over $400.3 billion in revenue in 2024.

JURISDICTION & VENUE

9. This Court has subject matter jurisdiction over this action, which seeks monetary damages, pursuant to Cts. & Jud. Proc. § 1-501, and Gen. Provis. § 8-103 (allowing the filing of a Maryland False Claims Act as "a civil action in a court of competent jurisdiction within the State").

10. This Court has personal jurisdiction over each Defendant because each Defendant transacts business in the State and uses or possesses real property in the State. Cts. & Jud. Proc. § 6-103(b)(1), (5).

11. Venue is proper in this Court because each Defendant carries on a regular business in Baltimore City.

BACKGROUND

The Medicaid Program

12. The Medicaid program, enacted in 1965 under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, provides funding for medical care for indigent individuals. The Medicaid

program is a joint federal-state program in which the United States provides a portion of the funding (often a majority) and the State provides the remainder. *See* 42 U.S.C. § 1396b.

13. Approximately 1.4 million Maryland residents obtain health care through Medicaid, accounting for about a quarter of the State's population. About one-third of those covered are children. The program costs about $17 billion annually.

14. The Maryland Legislature has designated MDH as the State agency that administers Medicaid for the State of Maryland. *See* Health Gen. §15-103; COMAR 10.09.62 – 10.09.75; and 42 C.F.R. § 431.10.

15. As a condition of participation in Medicaid, providers must "[e]nsure compliance with all the provisions listed in the Code of Maryland Regulations (COMAR) designated for their provider type." COMAR 10.09.36.03(A)(1).

Maryland False Claims Act

16. Under the Maryland False Claims Act, a person may not "[k]nowingly present or cause to be presented a false or fraudulent claim for payment or approval" or "[k]nowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim." Gen. Provis. § 8-102(b).

17. In this statutory context, "knowingly" means that a person "[h]as actual knowledge of the information;" "[a]cts in deliberate ignorance of the truth or falsity of the information;" or "[a]cts in reckless disregard of the truth or falsity of the information." *Id.* § 8-101(f).

18. A person found liable for violations of the Maryland False Claims Act is liable for up to a $10,000 penalty per violation and up to three times the damage sustained by the State. *Id.* § 8-102(c).

Maryland's Public Behavioral Health System

19. In Fiscal Year 2018, when the events at issue began, Maryland's population was about six million. Medicaid provided health coverage for about 1.4 million of these people. Within the State's Medicaid population, about 200,000 people obtained mental health services and 100,000 people obtained substance abuse disorder services. About one-third of this population had dual diagnoses of mental health and substance abuse disorders.

20. Medicaid coverage includes treatment for a range of mental illnesses, including schizophrenia, bipolar disorder, and obsessive-compulsive disorder. The coverage also includes people diagnosed along the autism spectrum, eating disorders, depression, Attention Deficit Disorder (ADD), and Attention Deficit Hyperactivity Disorder (ADHD). Medicaid patients also receive treatment for stress, anxiety, grief, suicidal ideation and a wide range of psycho-emotional issues.

21. Medicaid also includes coverage for a range of substance abuse disorders, including opioid addiction, alcoholism, addiction to marijuana and hallucinogens, abuse of stimulants or sedatives, tobacco addiction, and a plethora of other substance abuse issues. Medicaid provides services to about 26,000 people with opioid addiction and is by far the single largest provider of such care in Maryland.

22. For these patients, Medicaid provides outpatient therapy and counseling, inpatient treatment, housing, long-term psychiatric rehabilitation, crisis intervention, case management and monitoring, prescription of psychiatric medications, detoxification services, residential drug treatment, peer-recovery services, and a range of other treatments to treat this population.

23. The Medicaid system pays about $1.2 billion annually for mental health and substance abuse services provided to adults, children and the elderly and disabled in Maryland.

24. The system requires the participation of a wide array of medical facilities in which there are many different types of medical providers: doctors, nurses, psychologists, psychiatrists, therapists, counselors, peer educators, and numerous other professionals. More than 2,000 providers are estimated to provide care in this system, and every corner of Maryland's healthcare system is involved in this care.

25. Thousands of the most vulnerable Marylanders rely on the day-to-day functioning of the Medicaid behavioral health system. It is literally a life and death matter.

Administrative Services Organization (ASO)

26. Around 2014, the State instituted an Administrative Services Organization (ASO) model to run the Medicaid public behavioral health system. The ASO model merged mental health and substance abuse treatments into one online system. Most of Maryland's public behavioral health system now is a fee-for-service system managed by the ASO. This model centralizes billing, data, cost management, and quality monitoring within the ASO. Under this model, Maryland contracts with a single private company to serve as the ASO for a period of five years.

27. The ASO contractor processes all payment claims by providers; provides prior authorization of services; manages utilization, provider enrollment and credentialing; and tracks incident reporting and data analytics. In short, the ASO contractor is the central entity that enables Medicaid to provide most of the mental health services and all substance abuse services it delivers to patients in Maryland. The ASO is the heart of the system that services thousands of the most vulnerable and at-risk Marylanders.

28. In January of 2015, Maryland hired its first ASO contractor. Only four companies in Maryland history have served as ASO contractors. Of these, only Optum's system catastrophically failed.

FACTUAL ALLEGATIONS

A. MDH's RFP Clearly Set Forth All Material ASO Requirements

29. On November 28, 2018, MDH issued Request for Proposals MDH/OPASS-20-18319 (the "RFP"), which requested bid proposals from entities interested in becoming MDH's next behavioral health ASO.

30. The basic, material requirements were set out in the summary statement in § 2.1.1 of the RFP: "The ASO will provide the following support services to MDH: Provider Management and Maintenance; Participant Relations; Registration, Authorization and Utilization Management; Participant and Provider Assistance and Communication; Quality Management and Evaluation; Eligibility; Claims Processing; and Special Projects/New Initiatives . . . [a]n Offeror, whether directly or through its subcontractor(s), must be able to provide all goods and services and meet all of the requirements requested in this solicitation and the successful Offeror (the Contractor) shall remain responsible for Contract performance regardless of subcontractor".

31. RFP § 2.3.1 set forth the controlling federal and state laws that were binding on any contractor:

a. Title XIX of the Social Security Act §§ 1901-1935, 42 U.S.C § 1396-1396v and concurrent federal regulations;

b. Title XXI of the Social Security Act §§ 2101-2113, 42 U.S.C. §§ 1397aa-1397mm and concurrent federal regulations;

c. Title XVIII of the Social Security Act §§ 1801-1899B, 42 U.S.C. § 1395-1395ccc and concurrent federal regulations;

d. Health—Gen., Title 8, Tile 10, Title 15 and Title 19; Health Occ.; COMAR 10.63; COMAR 10.21; COMAR 10.47; COMAR 10.09;

e. Health—Gen. §§ 4-301 to 4-309; 42 CFR Part 2; 42 U.S.C. § 1320d; 45 CFR Part 160 and Subparts A and E of 164 HIPAAA Privacy Rule;

f. Americans with Disability Act of 1990, 42 U.S.C. §§ 12101 – 12213.

32. RFP § 2.3 set forth the material requirements under the ASO contract. A non-exhaustive list of key *general* provisions include:

g. RFP § 2.3.8, providing that the "Contractor shall maintain and utilize a participant enrollment system populated with date provided by MDH for Medicaid and uninsured eligibility information collected by the Contractor to verify active [Medicaid] enrollment prior to authorizing or paying for any behavioral health services."

h. RFP § 2.3.9.A, providing that the "Contractor shall [d]evelop and maintain and accurate, efficient claims processing system to receive and adjudicate claims for medically necessary behavioral health services and submit Medicaid eligible claims to MDH for purposes of drawing down federal funds."

i. RFP § 2.3.9.M, setting forth a detailed 39-point list of functionality requirements for the ASO's system, including that it: "1. Verify participant eligibility and information on all claim transactions submitted. 2. Verify provider eligibility and information on all claim transactions submitted. 3. Maintain clear billing instructions for providers. 4. Verify any and all third-party insurance billing information. 5. Verify authorization of claims as required by MDH. 6. Have the ability to adjudicate claims based on the billing National Provider Identifier (NPI) number and rendering NPI

number. 7. Implement system edits to ensure compliance with all BHA and Medicaid policies, procedures and requirements."

j. RFP § 2.3.10.2, providing that the "Contractor's information system shall be the primary tool utilized by the Contractor to manage, monitor, and provide reports on essential system functions, based on requirements established by MDH."

k. RFP § 3.7.5, providing that "The Contractor shall ensure that State data is not comingled with non-State data through the proper application of compartmentalization security measures."

l. RFP § 4.16.1, providing that the Contractor "must be able to provide all goods and services and meet all of the requirements requested in this solicitation and the successful [contractor] shall be responsible for Contract performance including any subcontractor participation."

33. On February 28, 2019, Optum submitted a 1027-page, $196 million bid in response to the RFP, which was about $79 million lower than the incumbent contractor's bid. Optum's bid proposal addressed in detail every requirement set forth in the RFP, assuring MDH that it fully understood the demands of the project and was prepared to meet each and every requirement.

34. In its RFP bid proposal transmittal letter, Optum wrote: "For more than two years, Optum staff has traveled across the state to meet with stakeholders to increase our collective knowledge of the public behavioral health system . . . We have come to appreciate the strengths of Maryland's public behavioral healthcare delivery system and understand the impact of its unique challenges." In other words, Optum represented that it had become expert in Maryland's Medicaid system.

B. Optum and United Claim Deep Medicaid Expertise

35. Optum presented voluminous background material in support of its bid proposal, demonstrating its long-running, deep expertise in managing Medicaid programs. In the proposal, Optum listed much relevant experience.

36. For example, Optum ran the Idaho Behavioral Health Plan from 2013 to 2024, in a role similar to an ASO. Optum there managed outpatient mental health and substance abuse services for more than 265,000 Medicaid recipients.

37. Optum has been the behavioral health ASO in Salt Lake County, Utah from 2011 to present, facilitating the provision of behavioral health and substance abuse services to more than 100,000 Medicaid recipients.

38. Optum has been the behavioral health ASO for the County of San Diego, California from 1997 to present. There, it managed Medicaid behavioral health services for more than 900,000 Medicaid recipients.

39. Optum's work in Idaho, Utah, or California did not result in any major systemic failures in the Medicaid systems in those states.

40. Optum's corporate structure has also given it deep expertise in Maryland's Medicaid system. Optum is a wholly owned subsidiary of United. United has two primary business units, UnitedHealthcare, which provides insurance, and Optum, which provides health services and administration. The two units' corporate structures are closely intertwined, including headquarters located on the same campus in Eden Prairie, Minnesota. UnitedHealthcare provides managed care services to Medicaid programs in 32 states, including Maryland, and the District of Columbia.

41. United began participating in Maryland's Medicaid managed care program in 1997. The UnitedHealthcare Community Plan ("UHC") is currently one of nine managed care organizations that service Maryland Medicaid. As such, UHC receives a fixed annual payment from Maryland Medicaid and then provides insurance coverage to a portion of the State's Medicaid recipients. In this role, UHC has processed millions of Medicaid claims and developed deep expertise in every aspect of the State's Medicaid system.

42. In the Executive Summary to its RFP proposal bid, Optum wrote: "Optum has been operating in Maryland for over 15 years. We currently employ 3,182 staff in Maryland and serve 837,029 Marylanders throughout UnitedHealthcare Community Plan . . . Additionally, we currently manage a network of over 3,000 commercially contracted providers, including 465 [physicians], 513 [substance abuse] providers, and 43 [opioid addiction] providers."

43. Attachment 2 to Optum's proposal in response to the RFP described numerous previous Medicaid contracts it had performed around the country. Notably, these previous experiences include Medicaid contracts performed by United in addition to those performed by Optum, confirming that both entities share the same knowledge base, experience and personnel when it comes to performing Medicaid contracts. According to the proposal, Optum/United had performed a over 60 Medicaid contracts in over 30 states. This list, presented to MDH by Optum in response to the RFP, showed that Optum and United had considerable sophistication in managing nearly every aspect of Medicaid programs. Optum and United did not report that any of these contracts resulted in catastrophic system failure. It appeared that Optum and United could ably manage Medicaid programs in virtually any state context in the nation and adapt to the various needs, policies and circumstances of each different state.

44. In sum, Optum and United had demonstrated: (a) deep and varied experience in managing state Medicaid programs and populations; and (b) that the companies could adjust to local and state Medicaid program requirements as needed in a variety of environments and circumstances. Optum and United were also intimately familiar with Maryland's Medicaid program through extensive, years-long experience managing Medicaid benefits as well as Medicaid providers in the State.

45. Optum and United therefore knew, or should have known, about Maryland Medicaid ASO's needs, parameters, operations, requirements, challenges, and technical aspects.

C. Optum's Bid Centered on its Proprietary OPTICCS System

46. Critically, Optum proposed that its own proprietary health care management platform, called the Optum Integrated Care Coordination System ("OPTICCS"), would be the centerpiece of its ASO system. As Optum explained in the Executive Summary of its technical bid proposal: "Optum offers MDH a customized solution to fully support the capabilities of Maryland's [public behavioral health system] ASO. Our intelligent platform stores, aggregates and analyzes data, producing advanced analytic reports to inform our strategic management of contract requirements. We have carefully designed OPTICCS to match the workflow of our clinical and operations staff, providing an easy and convenient way to enter or find information about all aspects of a participant's care and ASO operations. [OPTICCS] will enable automated system tracking of participants, clinical records, follow-up actions, workflows for systematic approaches, auditing tools, and integrated reporting features that will meet all related requirements set forth in the RFP. Our solution incorporates the operational capabilities required to interface with external entities, including MDH Medicaid management information systems (MMIS) to

guarantee compatibility between provider enrollment, licensure, credentialing, and other enrollment information and to facilitate claims payment."

47. On May 19, 2019, during the bid process, Optum staff visited MDH headquarters in Baltimore City to demonstrate the OPTICCS system. Numerous MDH staff, including the decision-makers on the RFP, as well as subject-matter experts from other State agencies, were in attendance. Optum's presentation began with a PowerPoint that noted that OPTICCS was "Highly flexible" and "Easily configurable" and had been used for "Over 20 years supporting state Medicaid systems throughout the country." Optum also did an OPTICCS demonstration on screen, showing how OPTICSS would function if MDH selected Optum for the ASO contract. The system was superior to the platforms used by previous ASO contractors.

48. Optum indicated that virtually every transaction, decision, payment and medical service would flow through Optum's OPTICCS platform. The entire ASO system, as proposed by Optum to MDH, would be built on OPTICCS.

49. The OPTICCS platform was a primary, material reason that MDH selected Optum's bid proposal. MDH contract reviewers concluded the power, flexibility and functionality of the OPTICCS system would be an unprecedented improvement on previous platforms.

D. Optum Promised a Functional ASO System

50. MDH decided to award the ASO Contract to Optum.

51. On June 12, 2019, Optum signed the MDH/OPASS-20-18319/M00B0600078 contract (the "Contract") with MDH to become the new ASO. The Contract set a Base Amount of $130,808,927 and a Base Term of January 1, 2020, through December 31, 2024.

52. The Contract made clear that all performance expectations articulated in the RFP must be meet by Optum. It provided at § 2.1 that the "Contractor shall perform in accordance with

this Contract and Exhibits A-D, which are listed below and incorporated herein by reference." The relevant exhibits were the RFP (Exhibit A), the Contract affidavit (Exhibit B), Optum's technical bid proposal (Exhibit C), and Optum's financial bid proposal (Exhibit D). These documents taken together formed the scope of work under the contract that Optum was obligated to perform.

53. The Contract provided at § 4.4 that "[p]ayment of an invoice by MDH is not evidence that services were rendered as required under this contract."

54. The Contract provided at § 40 that "UnitedHealth Group Incorporated hereby guarantees absolutely the full, prompt, and complete performance by [Optum] of all the terms, conditions and obligations contained in this Contract".

55. The Contract detailed at § 13.1 that the provisions "shall be construed, interpreted, and enforced according to the laws of the State of Maryland."

56. By entering the Contract, Optum acknowledged that it knew the material requirements in performing as the ASO and agreed to satisfy those requirements.

57. Under Maryland law, contract awards must be approved by the State's Board of Public Works. In July 2019, the Board of Public Works approved the award to Optum for the Behavioral Health ASO contract for $139,646,950. Thus, the time frame for Optum to implement its system and services would be four months. Optum never expressed any concern to MDH about this time frame.

E. Optum Shifted ASO Platform Responsibilities to an Untested Subcontractor

58. The transition from the incumbent ASO contractor to Optum began in September of 2019. According to an agreed-upon contractual timeline, Optum would spend September through December of 2019 implementing its ASO system. The system would "go live" in January

of 2020, meaning that Optum, and its proposed system and employees, would formally operate as ASO from that month forward.

59. In August of 2019, Optum first mentioned to MDH that a major change in its system had been instituted. Instead of the OPTICCS information technology platform, Optum noted that it would use the Incedo platform as the central software platform for the ASO processing system. There was no extensive discussion or debate with MDH about the shift; Optum merely noted in communications that it had happened.

60. Incedo is made by InfoMC, a small technology company based in Conshohocken, Pennsylvania.

61. Optum's technical bid proposal never stated, or even hinted, that Incedo would be used as the central claims processing platform in place of OPTICCS.

62. MDH had no advance notice that Incedo would play such a critical role in the ASO. MDH therefore had no genuine opportunity or reason to investigate InfoMC and Incedo before awarding the ASO contract to Optum. MDH was not required by law to vet subcontractors. In fact, the onus was on Optum, as the RFP and Contract clearly stated that Optum was responsible for the performance of all its subcontractors.

63. Optum had never used InfoMC's Incedo platform as the primary system for any government or Medicaid contract. Optum had never tested InfoMC's Incedo platform, in advance of becoming ASO in Maryland, to assure it could handle the volume and complexity of Maryland's Medicaid system. InfoMC had never subcontracted for Incedo on a contract of the size and scope of the Maryland Medicaid ASO. Optum's engineers and technicians were unfamiliar with Incedo. In the context of the Maryland ASO contract, Incedo was an entirely unproven, untested and unfamiliar platform.

64. Optum never discussed the decision to utilize Incedo with MDH, nor sought permission or approval to do so. Any potential challenges or problems with this change were never discussed with MDH.

65. Optum told MDH that the switch was necessary in order to comply with Maryland law, and the related RFP provision, prohibiting the commingling of Maryland Medicaid data with similar data from other states. Optum had known about this requirement since November of 2018, when the RFP was first published, nearly a year earlier. Optum used OPTICCS in other states and data from those states commingled within the OPTICCS ecosystem, which Optum knew when it bid for the ASO contact. At some point during the implementation phase, Optum told MDH staffers that it would cost up to $9 million to render OPTICCS compliant with the non-commingling provision and that it preferred to install Incedo instead.

66. Optum never explained why it had not switched to Incedo earlier, when there would have been more time to iron out any problems, rather than with only four months left in a shortened implementation time window. Nor did it explain why it had not disclosed its intent to use Incedo in its RFP.

67. Incedo is a database management program. It is an "off the shelf" system in that it is not pre-configured to ingest any particular types of data. Customers can configure Incedo to their own needs. Its lack of configuration would prove deeply problematic.

In August of 2019, Optum began integrating Incedo into the ASO framework.

F. Red Flags Proliferated During Implementation

68. The implementation process took place from September to December of 2019. At its core, the system had to allow health care providers to submit payment claims for services

provided to patients; process those claims by determining whether the claims were legitimate and how much they were worth; accept or deny claims; and issue payment to the providers.

69. To perform this core four-step function, Optum had to upload three kinds of data provided to it by MDH: (1) Provider Files; (2) Eligibility Files; and (3) Business Rules.

70. Provider Files contain the identification information for all health care providers authorized to provide Medicaid services. Collectively, the Provider Files are a straightforward list of providers, along with their identification data such as Medicaid numbers, professional credentials, and types of services provided. Optum had dealt with this sort of information in every Medicaid contract it worked on prior to becoming Maryland's ASO.

71. Eligibility Files contain the identification information for Maryland citizens who receive Medicaid benefits. Collectively, the Eligibility Files are a straightforward list of Medicaid recipients along with their identification data such as date-of-birth and Medicaid number. The files include people who are retroactively eligible for Medicaid and uninsured people whose Medicaid applications are pending. Optum had dealt with this sort of information in every Medicaid contract it worked on prior to becoming Maryland's ASO.

72. Business Rules are all the Medicaid policies and procedures, including the payment rates for different services, guidelines for which services will be covered by Medicaid, rules for pre-authorization of certain services, and various rules and limits on different services. Nearly 80 percent of these rules are set by the federal government. Optum had worked with these rules in its other Medicaid work and had them in advance of becoming Maryland's ASO. About 20 percent of the Business Rules were Maryland-specific rules. Every state has similar rules specific to its own local policies, and Optum encountered such rules on its other Medicaid contracts.

73. To function properly, any information technology platform within the ASO would have to be configured to receive and process these three types of data. Incedo had not been so configured prior to the implementation period. Optum engineers had to *simultaneously* obtain the three data types from MDH and configure Incedo to process it all.

74. In September of 2019, MDH provided all three sets of files to Optum via electronic file transfer.

75. Shortly after the transfer, still in September of 2019, InfoMC began reporting technical problems to Optum and MDH. Specifically, InfoMC reported that it lacked adequate computing power initially to store and work with all three types of files provided by MDH.

76. Members of the transition team at Optum and InfoMC went to work attempting to remedy the problem, but the time spent on this task put Optum behind schedule in implementing its system. In the meantime, other issues with the Incedo platform began arising.

77. In September of 2019, there were also some routine data transfer problems from MDH to Optum, such as missing components in the provider file and eligibility file. These problems had occurred on previous ASO contracts and were quickly remedied by MDH. But in Optum's implementation window, these problems were exacerbated by the lack of proper configuration in Incedo.

78. In October of 2019, MDH staff members working on the ASO transition began worrying aloud about Optum's preparedness to take the reins of ASO in January 2020.

79. One MDH staffer on the transition team wrote in an email to Optum that she was "very concerned . . . [Optum] does not seem to have a good project plan or understanding of what they need in order to accomplish this."

80. Another MDH staffer sent an email about the testing that would have to be done before the January "go live" date, writing "I am not confident about the testing plan . . . Is there a plan?"

81. During the implementation process, Optum was responsible for testing four aspects of its system: (i) provider file processing; (ii) eligibility file processing; (iii) proving system applies all business rules; and (iv) claims processing and adjudication. Testing required allowing providers in the community to access beta versions of the Optum system in order to determine if the system could operate in the real world of medical care.

82. In October, a MDH staffer sent an email to Optum stating, "I remain concerned whether Optum [authorization] and claims processing will be fully operational by 1/1/20."

83. In late October, an MDH staffer demanded internally "[i]f we need a face-to-face meeting later in the week with InfoMC to get their issues resolved, then we should try doing it, as time is of the essence."

84. By November of 2019, Optum's issues were leaking out to the wider health care community. One representative for Medicaid providers emailed MDH that she was "hearing very strong concerns from our members about the training schedule." A MDH staffer replied: "There is nothing we can do with this compressed time frame – we have to do internal testing, beta testing, etc. prior to releasing to the community at large."

85. By this time, MDH began to suspect that Optum either had failed to complete the necessary testing or that test results were inconclusive.

86. By December of 2019, Optum, InfoMC and MDH were meeting daily to work through a myriad of problems. In MDH notes for one such call, a staffer noted, "Optum needs to

assign more staff to get testing back on schedule [and] provide a reasonable alternative to ensure a working system on January 1."

87. During December, Optum repeatedly assured MDH in meetings that adequate testing had been done and that the system would function as promised. Throughout the month, Optum and MDH, along with InfoMC officials, held multiple daily meetings, sometimes on the phone and occasionally in person. In every meeting, Optum said that its system would work as promised and that any issues that had arisen would be solved before "go live" on January 2.

88. MDH officials, in repeated phone calls, urged Optum's and United's executive teams to take an active role in the implementation process. MDH leaders were frustrated that they could not reach Optum CEO Martha Temple, who was vacationing in Europe during critical weeks of the implementation process.

89. MDH urged Optum's then-CEO for Care Solutions, Patrick H. Conway, to get employees from the Optum and United teams more actively involved. Conway was new at Optum, and there were concerns at MDH that Conway and his team were not adequately engaged with the on-the-ground problems in Maryland. After repeated calls from MDH, Conway finally increased Optum's engagement on the Maryland ASO project in mid-December.

90. Right up until "go live" on January 2, Optum officials, including Conway, told MDH that its ASO system would work as promised.

G. Optum's System Catastrophically Failed on Day One

91. The Optum system went live on January 2, 2020, and *immediately* crashed. Every major aspect of the system failed to work.

92. The system could not recognize many providers and prevented these providers from submitting claims to Medicaid for services provided. In some cases, providers simply could not

log in to the ASO system. In other cases, the system mistakenly thought properly credentialed providers lacked Medicaid privileges.

93. The system could not recognize thousands of Medicaid recipients. It instead mistakenly determined that these recipients were ineligible for Medicaid and rejected payment for services rendered to them.

94. The system, in thousands of instances, made payment errors, paying providers either too much or too little money for various services.

95. The system could not enforce basic Medicaid rules authorizing only certain services in certain contexts. These authorization rules are the quality control measures for the entire Medicaid system, allowing for medically appropriate and necessary care, and denying excessive, wasteful or unnecessary claims. Optum's Incedo-based system required authorizations for services, like Emergency Room care, where no authorization should be required. In other instances, Incedo auto-generated authorizations, without an actual authorization request from a doctor or health professional, in order to facilitate payment. Incedo's authorizations were thus either fictitious or mistaken. Without reliable authorization functionality, the Medicaid claims system was operating without any guardrails, standards or quality control.

96. The system rejected nearly half of all claims submitted by legitimate providers in January of 2020 for no discernable reason.

97. The system could not generate accurate 835 Forms, which are standard industry electronic reporting forms that serve as receipts for health care providers to keep track of Medicaid revenues. Without accurate 835 Forms, providers struggled to monitor their cash flows, which most acutely impacted large-volume providers like the Johns Hopkins Health System, University of Maryland Medical System, MedStar Health, and LifeBridge Health.

98. The system could not properly process retroactive claims, which arise when indigent patients receive care while their Medicaid applications are pending. Medicaid retroactively covers costs accrued during this pendency period. After the crash, the system erroneously made duplicate retroactive payments to providers, causing Medicaid to pay out more than $100 million that it should not have paid.

99. The essential problem underlying all these failures was that Incedo could not properly "read" the Eligibility Files, Provider Files and Business Rules provided to Optum by MDH. Incedo had not been configured in advance to properly process the data, and Optum engineers could not do so during the implementation process.

100. Maryland's Eligibility Files and Provider Files mirror those used by most other states around the country. There is nothing unique about this data. While Maryland has some unique Business Rules, 80 percent of the Business Rules used in Maryland are published by the federal government and used around the country. Optum had access to these rules long before the implementation period started and had in fact implemented them in other states.

101. The failure of Optum's ASO system placed the State's Medicaid system in an untenable limbo, as claims were not being processed or paid. Many providers in the system operate on tight, month-to-month margins; these providers faced the sudden prospect of bankruptcy. The system had never before, or since, failed in such catastrophic fashion.

102. The crash was of such magnitude that media reports in Maryland, for months to come, were filled with stories chronicling the crisis: "MENTAL HEALTH AND ADDICTION PROVIDERS FOR MEDICAID PAYMENTS GO UNPAID IN MARYLAND" *The Baltimore Sun* (February 4, 2020); "MARYLAND HEALTH CARE PROFESSIONALS WHO ACCEPT MEDICAID SAY THEY AREN'T GETTING PAID" *WBAL-TV 11 (NBC)* (February 4, 2020);

"FAULTY MARYLAND PAYMENT SYSTEM THREATENS MENTAL HEALTH AND ADDITICTION PROFESSIONALS" *The Baltimore Sun* (November 24, 2020); "OPTUM'S POOR PERFORMANCE MAY WORSEN SUBSTANCE ABUSE CRISIS" *The Baltimore Sun* (December 8, 2020); "BILLING ERRORS PLAGUE HEALTH PROVIDERS IN MARYLAND" *Capital News Service* (November 17, 2021); "STATE HEALTH CLAIMS VENDOR UNDER SCRUTINY IS 'NOT UP FOR THE JOB,' LAWMAKERS ARE TOLD" *Maryland Matters* (November 1, 2022).

H. MDH Forced into Extreme Measures to Save the System

103. Just days after the crash, in early January of 2020, MDH realized the entire Maryland behavioral health system could collapse, which would cause significant harm to the State's most vulnerable populations. MDH had to act.

104. MDH sent Optum a letter demanding a fix within 10 days. Optum said it could do so in two weeks. In daily meetings and phone calls during early January, Optum repeatedly reassured MDH that the system would soon work. However, by late January, it was clear that it would not. MDH then devised a risky and extraordinary workaround to keep the system afloat.

105. The solution MDH improvised was the "estimated payments" regime put into place on January 23, 2020. Instead of using Optum's failed system, MDH would pay each provider based roughly on the total amount it paid that provider during the previous year. This payment was an estimate of what the provider might be owed. But the issuance of estimated payments risked the solvency of the Maryland Medicaid program, because it issued payment to providers without reviewing any documentation about what care was provided. Many providers likely provided less care in 2020 than they had in 2019, particularly during the COVID pandemic that

hit weeks after the system crash. As a result, Maryland Medicaid paid out far more than it should have as long as the estimated payments regime was in place.

106. Despite the enormous financial risk to Medicaid that the estimated payments represented, MDH had no alternative way to keep the system functioning given Optum's failure.

107. From January of 2020 forward, in each month during the estimated payments regime, MDH made a careful assessment of whether the regime should be extended another month. Yet it was not until August 2020 that MDH determined that Optum's system was minimally functional. This is because, even as Optum installed fixes, it struggled to repair the system's ability to accurately handle authorizations. Authorizations regulate the Medicaid system, paying only for medically appropriate and necessary care provided by duly authorized professionals. MDH found that, until August, the Optum ASO platform could not accurately perform this vital function. Therefore, with great reluctance, MDH extended the estimated payment regime until August of 2020, when it finally determined, through testing, that the system could handle authorizations. MDH then ended the estimated payments regime and went live again with the Optum system.

108. During the estimated payments regime, from January 23 to August 3, 2020, MDH paid out $1.6 billion to providers. Many providers kept accurate records and voluntarily reimbursed MDH for excess payments, but many others did not. As a result, MDH had to audit providers one by one. By the end of 2021, MDH had identified $223.5 million in outstanding overpayments. MDH decided to forgive all debts below $25,000, mostly to ease the burden on small business providers. In doing so, it gave up $13 million in overpayments. For the rest, MDH had to gradually claw back overpayments from hundreds of providers, consuming considerable time and resources at MDH.

109. This reconciliation effort continues to the present day, with MDH still short $28 million because of the issuance of estimated payments. It is unclear whether this money will ever be recouped.

I. The State Suffered Additional Downstream Losses

110. The State suffered considerable losses in addition to those stemming from the estimated payments. MDH intends to conduct an audit to quantify these knock-on losses. But some general categories have been identified:

111. The federal government awards states which implement ASOs using information technology best practices. Optum's failure prevented Maryland from obtaining this award, a loss of $28.8 million.

112. In Maryland, Medicaid will not pay for urine tests separately from drug treatment. Optum's system did not flag this and paid for such "unbundled" urine tests. Audits estimate losses to the State could have been about $80 million over the course of the Contract, as urine testing is among the most fraudulent or mistakenly billed type of service in the entire Medicaid system.

113. Optum's system paid for residential substance abuse treatment through the State's General Fund. These services should have been paid through Medicaid, which is half funded by the federal government. Thus, Maryland paid about 50 percent more than it should have for this care over the course of the Contract.

114. In Maryland, Medicaid will not pay for multiple substance abuse treatments for the same patient on the same day. Optum's system did not prevent this and paid such "unbundled" claims. The estimated loss to the State stemming from this error exceeds $2 million.

115. Claims submitted by professional counselors for care provided to dual eligible Medicare-Medicaid patients should be paid by Medicare, a federal program. But Optum's system paid these claims through Medicaid, resulting in losses to the State likely in excess of $1 million.

116. The Maryland Office of Attorney General, Medicaid Fraud and Vulnerable Victims Unit, dropped all fraud cases involving Medicaid claims from 2020 to 2021, and further out in time in certain instances, because these claims might not survive legal evidentiary challenges in court due to Optum's compromised system through which the claims were processed and documented.

J. Optum's System Never Fully Worked

117. The Optum system was never fully operational at any time during the entire five-year period that Optum served as ASO. Problems persisted until the end.

118. MDH worked with Optum issue by issue. Staff from both organizations met on a near-daily basis for five years. MDH regularly issued letters, called operational exceptions or Op-X directives, identifying a major problem, and Optum would try to institute a fix. About 23 such letters were implemented over the course of the Contract. Additionally, 13,504 discrete technical fixes to Incedo were required during the course of the Contract, all of them documented in MDH's JIRA project management software. But some problems, likely totaling tens of millions of dollars in overpayments, were never fixed.

119. In the Maryland system, claims submitted by Licensed Clinical Professional Counselors for care provided to people eligible for both Medicaid and Medicare should be paid by the federal government, Optum's system kept paying these claims with State funds.

120. Optum's system never implemented certain "combination of service" restrictions which prevent providers from obtaining payment for certain services simultaneously (*e.g.,* two

therapists on same day, substance abuse and mental health treatments on the same day). The system kept paying such "unbundled" claims.

121. Optum's system was never able to prevent the unbundling of urine testing and drug treatment.

122. To the present day, Optum has never offered MDH a comprehensive explanation for why and how its system failed.

K. Optum Repeatedly Submitted False Claims for Payment

123. On February 19, 2020, Optum submitted its first invoice for services rendered in January of 2020. The invoice sought $1,885,426.11 in payment from MDH.

124. Before payment, the MDH contract officer had to obtain approval from the MDH Steering Committee assigned to the Contract. This committee consisted of several MDH staffers involved in overseeing the Contract, including the contract officer, as well as the Chief Operating Officer for Medicaid. The Steering Committee questioned whether it should approve payment of each invoice. Where contracts are adequately performed, approval is usually straightforward. But with the Optum contract, the Steering Committee discussion was more complicated. In determining whether to approve payment, the Steering Committee relied on Optum's assessment of how the system performed in the past month and how it would perform in the next month. Optum conveyed this information to MDH staff in repeated daily meetings, described in Section E and F above.

125. The Steering Committee was also constrained by the fact that there was no other option other than Optum's system. MDH therefore *had* to approve the invoices because denying payment likely meant that Optum would cease performing, which would have ground the ASO system, and the ongoing efforts to fix it, to a complete halt. The ASO system was too big to fail.

126. Each invoice submitted to MDH and considered by the Steering Committee was supported by Optum's consistent and unwavering insistence that the system would work as promised in the following month. MDH's decision to pay each and every invoice from January of 2020 to December of 2024 relied upon Optum's assessment in this regard.

127. Had Optum provided an accurate and truthful assessment, MDH would not have paid any of the invoices.

128. Over the duration of the Contract, Optum submitted the following invoices and MDH paid the following amounts:

Service Period	Invoice #	Amount
January, 2020	151248	$1,885,426.11
February, 2020	151769	$1,893,672.92
March, 2020	151987	$1,903,575.67
March,2020 (Implementation)	151768	$4,419,011.60
April, 2020	152689	$1,916,302.67
May, 2020	153059	$1,943,023.65
June, 2020	153561	$1,959,186.94
July, 2020	155927	$1,896,049.31
August, 2020	155928	$1,908,360.58
September, 2020	155929	$1,926,355.24
October, 2020	156225	$1,941,803.36
November, 2020	157154	$1,958,301.67
December, 2020	157359	$1,978,356.90
January, 2021	158151	$2,008,424.89
February, 2021	158934	$2,019,665.18
March, 2021	159424	$2,033,425.59
April, 2021	159733	$2,046,963.44
May, 2021	160654	$2,059,924.82
June, 2021	161323	$2,071,983.49
July, 2021	161963	$2,085,566.96
August, 2021	162725	$2,099,461.46
September, 2021	163275	$2,112,309.48
October, 2021	164125	$2,125,052.45

November, 2021	164781	$2,136,319.01
December, 2021	165037	$2,147,582.80
January, 2022	166045	$2,164,983.19
February, 2022	166544	$2,176,728.06
March, 2022	167394	$2,054,451.63
April, 2022	168235	$2,045,954.48
May, 2022	168899	$2,052,498.76
June, 2022	169433	$2,059,974.78
July, 2022	170121	$2,070,957.95
August, 2022	170828	$2,081,638.37
September, 2022	171484	$2,088,482.63
October, 2022	172330	$2,095,588.17
November, 2022	172682	$2,104,402.35
December, 2022	173502	$2,113,368.60
January, 2023	174662	$2,125,105.41
February, 2023	174661	$2,130,228.59
March, 2023	175722	$2,139,247.36
April, 2023	176510	$2,132,989.30
May, 2023	177201	$2,140,482.15
June, 2023	178270	$2,126,396.59
July, 2023	178633	$2,109,585.53
August, 2023	179631	$2,080,380.41
September, 2023	180434	$1,928,961.44
October, 2023	181292	$2,086,663.69
November, 2023	181534	$2,093,306.53
December, 2023	182702	$2,057,660.73
January, 2024	183753	$2,033,500.51
February, 2024	184623	$2,033,891.36
March, 2024	185101	$2,026,275.51
April, 2024	185680	$2,020,850.34
May, 2024	186576	$2,014,833.84
June, 2024	187321	$1,993,970.68
July, 2024	188231	$1,982,986.96
August, 2024	189050	$1,962,284.70
September, 2024	190107	$1,948,439.19
October, 2024	190733	$1,926,554.25
November, 2024	190989	$2,061,041.34
December, 2024	0001696437	$1,864,199.94

129. Based on these invoice claims submitted, and Optum's inaccurate statements that the system would work as promised, MDH paid Optum a total of $126,604,971.51 over the course of the Contract. Payment of these false claims constitutes damage to the State.

L. Optum Inflicted Trauma on Maryland

130. Optum's unprecedented failure as Maryland's ASO provider inflicted trauma on Medicaid recipients, Medicaid providers, and MDH's beleaguered staff. MDH and the State approached its Medicaid behavioral health and substance abuse program with the utmost seriousness. This program is how Maryland deals with the opioid epidemic that has devastated our state. It is how we care for those with debilitating mental illness. It is how we help the most vulnerable of our citizens heal and move through life. And this *taxpayer-funded* system, through Optum's conduct, was placed in jeopardy.

131. In the state's history, the ASO contract had never been a problem. Every other vendor was able to run it properly. Optum, the most experienced of all vendors, could not. Thus, in January of 2020, this crucial system teetered on the brink of collapse. Two months later, the COVID pandemic started, compounding the stressors on the system. Through this maelstrom, hundreds of MDH employees struggled to maintain the system.

132. In late 2024, MDH awarded the next ASO contract to another, smaller company, which implemented its system in 2025 without issue.

133. Meanwhile, the Maryland General Assembly held hearings into the debacle, eventually passing a law requiring MDH to scrutinize all subcontractors when awarding an ASO contract.

20. Optum's failure to provide the agreed-upon ASO system caused MDH to spend years trying to correct Optum's failures. As one MDH staffer put in an email to a colleague:

"When you didn't think things could get worse, there would be another bombshell. It was such a state of chaos for five years."

CAUSES OF ACTION

COUNT I – MARYLAND FALSE CLAIMS ACT

134. The allegations contained in the preceding paragraphs are incorporated herein by reference.

135. The State of Maryland brings this cause of action against Defendants under the Maryland False Claims Act. Gen. Provis. § 8-101 *et seq.*

136. Under the Maryland False Claims Act, a person or company may not "[k]nowingly present or cause to be presented a false or fraudulent claim for payment or approval"; "[k]nowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim". *Id.* § 8-102(b).

137. Under the Maryland False Claims Act, "knowingly" means that a person "[h]as actual knowledge of the information;" "[a]cts in deliberate ignorance of the truth or falsity of the information;" or "[a]cts in reckless disregard of the truth or falsity of the information." *Id.* § 8-101(f).

138. Optum fraudulently induced MDH to accept its bid proposal by proposing an ASO system with a specific information technology platform that was material to MDH's decision to accept Optum's bid but then knowingly providing a system with a different, substandard information technology platform.

139. Optum knowingly submitted, or caused to be submitted, false and fraudulent invoices for reimbursement to the State.

140. Each of the above-referenced submissions was a "false claim" within the meaning of the False Claims Act because each falsely certified compliance with applicable state laws and regulations.

141. These false claims were material to the State in determining whether to pay the claims, and the State would not have paid such claims had it known of their falsity.

142. In reliance on these false claims, the State paid Optum.

143. Under the False Claims Act, the State may obtain civil penalties of up to $10,000 for each violation of the Act, in addition to an award of *three times* the amount of damages sustained by the State as a result of the violations of the Act, and court costs and attorney's fees. *Id.* § 8-102(c).

144. WHEREFORE the State requests that this Court enter judgment in its favor, and against each of the Defendants, jointly and severally, and issue an order: (a) requiring each of the Defendants to pay $10,000 for each false claim it submitted or caused to be submitted to Medicaid; (b) holding Defendants jointly and severally liable to pay to the State three times the amount of damages sustained by the State, an amount that exceeds $75,000; and (c) awarding court costs and reasonable attorney's fees to the State.

COUNT II – BREACH OF CONTRACT

145. The allegations contained in the preceding paragraphs are incorporated herein by reference.

146. On or about June 12, 2019, the State entered into an agreement with Defendants, whereby Defendants would provide a functional ASO system for the State for a five-year period from January 1, 2020 until December 31, 2024. Per the terms of the agreement, the State agreed to compensate Defendants $130,808,927. In turn, Defendants, per the terms of the agreement,

agreed to provide a functional ASO system meeting all the specific requirements of the RFP and the Contract. The binding Contract set forth express terms of performance as well incorporating all relevant federal and state statutes, regulations, and rules.

147. As set forth in the preceding paragraphs, Defendants conduct violated numerous express terms in the Contract as well as applicable federal and state statutes, regulations, and rules. At no point in the five-year contract length did Defendants provide the agreed-upon ASO system to the State. For the first eight or so months of the Contract, the immediate crash of the system caused chaos, making payment errors to the point where it threatened the entire mental health and additional medical field in the State.

148. Even after the outright crash of first several months of Optum's ASO system was eventually somewhat alleviated, critical errors, such as permitting unbundled urine tests, paying for treatment which should have been half covered by the federal government, and permitting multiple substance abuse treatments in a single day, persisted throughout the life of the Contract.

149. By virtue of this conduct, Defendants are liable to the State for damages and any other relief that the Court deems appropriate. Optum's failure to deliver the agreed-upon ASO system cost the State millions of dollars. Pursuant to the Contract, Defendants "shall be liable for any loss or damage to the State occasioned by the acts or omissions of Contractor, its subcontractors, agents or employees: . . . [f]or all other claims damages, loss, costs, expenses, suits or actions in any way related to this Contract and regardless of the basis on which the claim is made, Contractor's liability shall be unlimited." Contract at §§ 29.1 and 29.1(c). Further, the terms of the Contract state that "[i]n no event shall the existence of a subcontract operate to release or reduce the liability of Contractor hereunder. For purposes of this Contract, Contractor agrees that it is responsible for performance of services and compliance with the relevant obligations

hereunder by its subcontractors. "[United] further agrees that if the State brings any claim, action, lawsuit or proceeding against [Optum], [United] may be named as a party in its capacity as Absolute Guarantor." *Id.* at § 40.

150. WHEREFORE the State requests that this Court enter judgment in its favor, and against each of the Defendants, jointly and severally, and issue an order: (a) holding Defendants jointly and severally liable to pay to the State compensatory damages in an amount in excess of $75,000; (b) holding Defendants jointly and severally liable to pay to the State punitive damages in an amount to be determined by a jury; and (c) awarding court costs and reasonable attorney's fees to the State.

COUNT III – UNJUST ENRICHMENT

151. The allegations contained in the preceding paragraphs are incorporated herein by reference.

152. The State conferred benefits on Defendants in the form of payments of $126,604,971.51 in exchange for Defendants' agreement to provide services in compliance with all Maryland laws and regulations in order to provide a functional ASO system.

153. Defendants appreciated and had knowledge of the benefits the State conferred upon them based upon their submission of 49 invoiced claims for payment.

154. Defendants' acceptance and retention of the benefits conferred upon them by the State under the circumstances alleged above make it inequitable for Defendants to retain the benefits without a return of the money which they obtained through fraud and misrepresentations, and which Defendants continue to hold improperly. The State paid the claims submitted by Defendants in reasonable reliance on the misrepresentations made by Defendants, thereby conferring a benefit on Defendants.

155. The benefits retained by the Defendants, in justice and equity, belong to the State.

156. WHEREFORE the State requests that this Court enter judgment in its favor, and against each of the Defendants, jointly and severally, and issue an order: (a) holding Defendants jointly and severally liable to pay to the State compensatory damages in an amount in excess of $75,000; (b) holding Defendants jointly and severally liable to pay to the State punitive damages in an amount to be determined by a jury; and (c) awarding court costs and reasonable attorney's fees to the State.

COUNT IV – INTENTIONAL MISREPRESENTATION/FRAUD

157. The allegations contained in the preceding paragraphs are incorporated herein by reference.

158. The Defendants knowingly made and/or caused to be made, false material representations to the State regarding both the nature and components of its contracted-for services as well as the future performance of those services. Specifically, Defendants stated that they had the ability to provide the agreed-upon ASO system using its propriety software. Even after this was shown to be false, Defendants continued to make false assurances that it could deliver on the contractual obligated terms for its ASO system.

159. The Defendants knew their representations were false or fraudulent or, in the alternative, made such representation with reckless disregard for the truth of the contents thereof.

160. The Defendants made the false or fraudulent representations for the purposes of obtaining the Contract and payments from the State of more than 100 million dollars.

161. The State justifiably relied upon the Defendants' misrepresentations, awarded the Contract, which Defendants never fully provided, and paid Defendants millions of dollars. As a result, the State sustained significant monetary damages as a result of that reliance.

162. WHEREFORE the State requests that this Court enter judgment in its favor, and against each of the Defendants, jointly and severally, and issue an order: (a) holding Defendants jointly and severally liable to pay to the State compensatory damages in an amount in excess of $75,000; (b) holding Defendants jointly and severally liable to pay to the State punitive damages in an amount to be determined by a jury; and (c) awarding court costs and reasonable attorney's fees to the State.

COUNT V – NEGLIGENT MISREPRESENTATION

163. The allegations contained in the preceding paragraphs are incorporated herein by reference.

164. In negotiating the Contract, the Defendants owed the State a duty to speak with reasonable care.

165. As set forth above, the Defendants negligently represented to the State false or misleading material facts regarding both the nature and components of its contracted-for services as well as the future performance of those services.

166. Although the Defendants' actions were at the very least negligent, the Defendants intended for the State to act or rely upon the false and/or fraudulent misrepresentations.

167. The Defendants knew that the State would reasonably rely upon the negligent assertions and/or misrepresentations of fact. Defendants went to considerable lengths to demonstrate its ability to deliver the ASO system the State required, including demonstrating and highlighting its own proprietary software that would be at the center of its ASO system.

168. The State justifiably relied upon the Defendants' misrepresentations, awarded Defendants a Contract worth more than 100 million dollars, and sustained significant monetary damages as a result of that reliance.

169. WHEREFORE the State requests that this Court enter judgment in its favor, and against each of the Defendants, jointly and severally, and issue an order: (a) holding Defendants jointly and severally liable to pay to the State compensatory damages in an amount in excess of $75,000; (b) holding Defendants jointly and severally liable to pay to the State punitive damages in an amount to be determined by a jury; and (c) awarding court costs and reasonable attorney's fees to the State.

COUNT VI – CONSTRUCTIVE FRAUD

170. The allegations contained in the preceding paragraphs are incorporated herein by reference.

171. As a party to the Contract, the defendants owed the State a contractual duty of care to comply with all of the express terms of the Contract as well as all relevant federal and state statutes, regulations, and rules.

172. Among the contractual duties owed to the State by Defendants was both a legal and equitable duty to refrain from making false representations to the State in order to receive payment.

173. The Defendants breached that duty by making false and/or fraudulent representations as set forth herein.

174. As a result of the Defendants' breach of its duties, the State sustained significant monetary damages.

175. WHEREFORE the State requests that this Court enter judgment in its favor, and against each of the Defendants, jointly and severally, and issue an order: (a) holding Defendants jointly and severally liable to pay to the State compensatory damages in an amount in excess of $75,000; (b) holding Defendants jointly and severally liable to pay to the State punitive damages

in an amount to be determined by a jury; and (c) awarding court costs and reasonable attorney's fees to the State.

COUNT VII – FRAUDULENT INDUCEMENT

176. The allegations contained in the preceding paragraphs are incorporated herein by reference.

177. The Defendants made false material representations to the State regarding both the nature and components of its contracted-for services as well as the future performance of those services during contract negotiations. Specifically, Defendants stated that they had the ability to provide the agreed-upon ASO system using its propriety software.

178. The Defendants knew this misrepresentation was false, or at the very least the misrepresentation was made with such reckless indifference to the truth as to impute knowledge on Defendants.

179. The Defendants made this representation with the purpose to defraud the State and for the purposes of obtaining the Contract and payments from the State of more than 100 million dollars

180. The State justifiably relied upon the Defendants' misrepresentations, awarded the Contract, which Defendants never fully provided, and paid Defendants millions of dollars.

181. As a result, the State sustained significant monetary damages as a result of that reliance

182. WHEREFORE the State requests that this Court enter judgment in its favor, and against each of the Defendants, jointly and severally, and issue an order: (a) holding Defendants jointly and severally liable to pay to the State compensatory damages in an amount in excess of $75,000; (b) holding Defendants jointly and severally liable to pay to the State punitive damages

in an amount to be determined by a jury; and (c) awarding court costs and reasonable attorney's fees to the State.

Respectfully submitted,

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DEMAND FOR JURY TRIAL

The State of Maryland hereby demands a trial by jury on all issues so triable.

/s/ Raja S. Mishra
Raja S. Mishra