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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA *ex rel.* KATHY ORMSBY,

Plaintiff,

v.

SUTTER HEALTH and PALO ALTO MEDICAL FOUNDATION,

Defendants.

Case No. 3:15-cv-01062-LB

DEFENDANTS' REPLY IN SUPPORT OF MOTION TO DISMISS UNITED STATES' COMPLAINT-IN-INTERVENTION

Date: October 24, 2019
Time: 9:30 a.m.
Courtroom: Courtroom C, 15th Floor

Hon. Laurel Beeler

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I. INTRODUCTION

In its Opposition to Defendant's Motion to Dismiss, the government doubles down on its attempt to impose a heightened standard on Medicare Advantage participants that it has never imposed in traditional Medicare. Its enforcement theory in this False Claims Act case relies on the exact same legal theory that it tried, unsuccessfully, to adopt in the 2014 Overpayment Rule. The government insists (at 18) that the judicial decision rejecting that theory "is neither controlling nor persuasive," but it never genuinely grapples with the directly applicable reasoning underlying that decision. Instead, it relies on off-point Ninth Circuit authority that never even *mentioned*, let alone decided, the implications of the Medicare statute's "actuarial equivalence" requirement, as Judge Fitzgerald of the Central District of California recognized in rejecting the exact same government arguments in another recent False Claims Act case. *See United States ex rel. Poehling v. UnitedHealth Group, Inc.*, 2019 WL 2353125, at *6 (C.D. Cal. March 28, 2019).

When Congress designed the Medicare Advantage program, it specifically directed that payments under that program should be made in a way that would "ensure actuarial equivalence" with traditional Medicare. 42 U.S.C. § 1395w-23(a)(1)(C)(i). That mandate for equivalence means that when the Centers for Medicare and Medicaid Services (CMS) evaluates risk in Medicare Advantage, it has to do so using an accurate, apples-to-apples comparison to the risk that it would face for an identical population in traditional Medicare. CMS itself has previously recognized that one implication of that requirement—particularly relevant here—is that Medicare Advantage participants "are coding 'accurately' when they are coding in a manner similar to fee-for-service coding used on the beneficiaries to whom MA plan enrollees are being compared." CMS, Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies 20 (April 6, 2009), https://www.cms.gov/Medicare/health-Plans/MedicareAdvtgSpecRateStats/downloads/announcement2010.pdf ("CMS 2010 Rate Announcement").

In recent years, however, CMS has chafed under that statutory requirement. In 2014, it adopted a formal regulation that would have held Medicare Advantage participants to a different standard of accuracy, under which any imperfections identified in their data would have to be remedied, *regardless* of how their data on the whole compared to the data in traditional Medicare. But following several years of litigation, that regulation was declared invalid after a court found that it would "inevitabl[y]" violate the "actuarial equivalence" mandate because it would result in Medicare Advantage participants being "paid less to provide the same healthcare coverage to their beneficiaries than CMS itself pays for comparable patients." *UnitedHealthcare Ins. Co. v. Azar*, 330 F. Supp. 3d 173, 185 (D.D.C. 2018).

Ultimately, the government simply cannot defend its theory that Medicare Advantage participants have a broad obligation to identify and delete unsupported diagnosis codes without regard to whether, and to what extent, the same codes would be identified and deleted in traditional Medicare. For that reason—and because it makes no allegation that Defendants' diagnostic data was deficient when compared to data in traditional Medicare—its Complaint fails to properly allege either the false claims or the overpayments that each of its theories demands.

Beyond that, though, the government also cannot satisfy the heightened scienter element that its fraud claims require. The Supreme Court has held that "Congress could not have intended" to subject a defendant to liability under a knowing or reckless standard where the defendant "followed an interpretation that could reasonably have found support in the courts, whatever their subjective intent may have been." *Safeco Ins. Co. of America v. Burr*, 551 U.S. 47, 70 n. 20 (2007). That rule—which the government entirely ignores—fits this case like a glove, and provides a separate basis for dismissing all the government's False Claims Act counts.

The government tries to resist all this by arguing that there *must* be something improper about Defendants' efforts to increase their Medicare Advantage reimbursements. But as another court held in rejecting similar claims this summer, there is nothing improper—let alone fraudulent—about attempting to do a better job of capturing members' diagnoses. *See United States ex rel. Integra Med Analytics, LLC v. Baylor Scott & White Health*, 2019 WL 3713756, at *5 (W.D. Tex. Aug. 5, 2019), No. 5:17-cv-00886 (W.D. Tex. 2019); *see also U.S. ex rel.*

Williams v. Renal Care Grp., Inc., 696 F.3d 518, 528 (6th Cir. 2012) ("Why a business ought to be punished solely for seeking to maximize profits escapes us."). For all of its rhetoric, the government just does not have a fraud case here. This Court, like the other courts before it, should say so.

II. DISCUSSION

A. The Government's Allegations Fail To Show That Defendants Submitted Any False Claims For Payment Or Received Any Overpayments

1. The Medicare Statute Requires CMS To Use A Comparative Standard In Evaluating Claims And Payments

As Defendants explained in their motion (at 4-10), Congress has required by statute that the Medicare Advantage program's risk adjustment system must "ensure actuarial equivalence" with the traditional Medicare program. 42 U.S.C. § 1395w-23(a)(1)(C)(i). Last year, the United States District Court for the District of Columbia held that one implication of that statutory mandate is that the government cannot apply a different standard of documentation in Medicare Advantage than CMS uses in traditional Medicare. *See UnitedHealthcare*, 330 F. Supp. 3d at 185. That court explained that "CMS sets Medicare Advantage rates based on costs that are presumed, based on traditional Medicare diagnosis codes, to be associated with particular health status information that is not verified in underlying patient records." *Id.* Having set those rates based in part on diagnosis codes that cannot be verified in patients' charts, CMS cannot insist on paying the rates for only the subset of diagnosis codes that *can* be verified in patients' charts, because doing so would make it "inevitable" that companies participating in Medicare Advantage would "be paid less to provide the same healthcare coverage to their beneficiaries than CMS itself pays for comparable patients." *Id.* Instead, the D.D.C. held that CMS was required to use the same approach it had previously agreed to use in performing audits of data submitted by Medicare Advantage plans, under which unsupported diagnosis codes are considered invalid—and "an 'overpayment' is shown"—"only when . . . the error rate for a Medicare Advantage contract is greater than the CMS error rate." *Id.*[1]

[1] The government objects (at 19) that Defendants' reliance on this quotation in the opening brief did not include the D.D.C.'s reference to Risk Adjustment Data Validation (RADV) audits. The government claims that this was "misleading," because "[t]his case is not based on a [RADV]

2. The Government's Attempts To Circumvent The Medicare Statute's Actuarial Equivalence Requirement All Fail

The government's claims here are completely irreconcilable with the understanding of the Medicare statute and the Medicare Advantage risk adjustment program as outlined in the *UnitedHealthcare* case. *Id*. Its case depends on the notion that each unsupported diagnosis code Defendants submitted was invalid and resulted in an overpayment, *regardless* of how Defendants' risk adjustment data compared to the data in the traditional Medicare program.[2] And so, rather than try to show that Defendants' data was any less accurate than the data CMS itself utilizes in traditional Medicare, the government offers a series of arguments attempting to show that it simply does not *matter* whether Defendants' data was worse, better, or the same as CMS's data. Each of those arguments fail.

a. Swoben *and* Silingo *did not address the actuarial equivalence standard at all*

First, the government contends (at 6) that "the FCA applies no such standard" because "[n]either *Swoben* nor *Silingo* required a comparative error analysis to establish false claims." But as Judge Fitzgerald put it when the government made that exact same argument in *Poehling*, those decisions are inapposite because they "did not in any way address the actuarial equivalence requirement of the Medicare Act," which was never raised before the Ninth Circuit in either case. 2019 WL 2353125, at *6.[3] Moreover, "the Ninth Circuit specifically limited its holding to

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audit." *Id.* But the government has no basis for making that charge. A core holding of the D.D.C.'s opinion was that the same standard CMS itself had agreed to apply in RADV audits was applicable outside of those audits, too. *See, e.g.*, *UnitedHealthcare Ins. Co.*, 330 F. Supp. 3d at 187 ("[T]he fly in the ointment is that CMS recognized the actuarial need to apply an FFS Adjuster to the RADV audit program . . . but CMS refused to maintain such actuarial equivalence in the 2014 Overpayment Rule. Yet without some adjustment, the entire Rule would fail."); *id.* at 189-90 ("Having recognized that actuarial equivalence, mandated by statute, required an FFS Adjuster for purposes of defining overpayments because of dissimilar data for RADV audits, CMS provides no legitimate reason for abandoning that statutory mandate in the context of the 2014 Overpayment Rule."). The government's suggestion that the D.D.C.'s statement was somehow applicable *only* to RADV audits is exactly backwards.

[2] At one point, the government seems to take issue with Defendants' argument that its case turns on the premise that "unsupported diagnosis codes always and necessarily result in overpayments." Opp. 6 (quoting Mot. 12). But the government never actually explains how its case can proceed *without* that premise, nor does indicate how it would differentiate between unsupported diagnosis codes that are valid and unsupported diagnosis codes that are *not* valid.

[3] Judge Fitzgerald referred specifically only to the Ninth Circuit's decision in *Swoben*, but the government in *Poehling* relied on *Silingo* as well. *See* United States and Relator's Reply in

the narrow issue of false *certifications*. The Ninth Circuit explained, '[u]nder Swoben's theory . . . the false claims are the allegedly false § 422.504(*l*) certifications, *not the erroneously reported diagnosis codes.*" *Id.* (quoting *United States ex rel. Swoben v. United Health Ins. Co.*, 848 F.3d 1161, 1183 (9th Cir. 2016) (emphasis in *Poehling*)). Here, by contrast, the government is at pains to emphasize that its case is based on the individual "diagnoses submitted to CMS . . . , *not* the certifications." Opp. 3 (emphasis added).[4] *Swoben* and *Silingo* are thus far removed from the case the government is attempting to bring here, and cannot do the work the government asks of them.

b. Compliance with medical record documentation rules must be evaluated using a comparative standard rather than a perfection standard

Second, the government points (at 7-8) to various guidance documents to show that "a diagnosis must be supported by medical record documentation." But no one disputes that: As the government acknowledges, Sutter itself implemented policies and procedures indicating that diagnosis codes should be supported by medical charts. *See id.* The same policies apply in traditional Medicare, too. *See id.* at 22. So the relevant question is not whether, in the abstract, diagnosis codes should be supported (they should), but rather whether Medicare Advantage participants' documentation efforts should be evaluated against that requirement using a *perfection* standard or a *comparative* standard. And the answer, as already discussed, is that by mandating that CMS "ensure actuarial *equivalence*" between traditional Medicare and Medicare Advantage, 42 U.S.C. § 1395w-23(a)(1)(C)(i) (emphasis added), Congress opted for the comparative standard. That is why, in the past, CMS itself acknowledged that Medicare Advantage participants "are coding 'accurately' when they are coding in a manner similar to fee-for-service coding used on the beneficiaries to whom MA plan enrollees are being compared." CMS 2010 Rate Announcement. It is why CMS could not adopt a formal regulation stating that

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Support of Joint Motion for Partial Summary Judgment at 2, 4-6, 11, *United States ex rel. Poehling*, No. 16-cv-08697 (C.D. Cal. Aug. 27, 2018), ECF No. 272. Judge Fitzgerald correctly recognized that neither one of those decisions had addressed the "actuarial equivalence" mandate.

[4] The government has decided not to base its claims in this case on the certifications because—as Defendants explained (Mot. 21-22) and the government does not dispute—courts have repeatedly held that the certifications are not material to CMS's payment decision.

every time a Medicare Advantage plan identified an unsupported code, it had to delete the code or else be charged with retaining an overpayment. *See UnitedHealthcare*, 330 F. Supp. 3d at 184-87. And it is why the government cannot impose, through the use of a False Claims Act enforcement action here, that same perfection standard it was unable to adopt directly as a regulation.

c. The government offers no persuasive response to the UnitedHealthcare *decision, and its attempts to avoid that decision just highlight the deficiencies in its Complaint*

Third, unable to show that its enforcement theory is consistent with the statutory requirement to ensure actuarial equivalence, the government resorts to a frontal attack on that standard. It claims (at 18) that "[t]he actuarial equivalence argument is meritless," and insists that the D.D.C.'s decision in *UnitedHealthcare* "is neither controlling nor persuasive." But the government does not come even close to showing that the D.D.C.'s opinion, or the actuarial equivalence principles on which it was based, was wrong. For example, Defendants' motion (at 7-8) used a simple hypothetical to show that if Medicare Advantage participants are required to delete diagnosis codes in circumstances that traditional Medicare providers do not, it will result—as the *UnitedHealthcare* court found—in Medicare Advantage participants being "paid less to provide the same healthcare coverage to their beneficiaries than CMS itself pays for comparable patients." 330 F. Supp. 3d at 184-85. The government makes no attempt whatsoever to show that the underpayment Defendants illustrated (and that the D.D.C. found would be "inevitable," *id.* at 185) would not actually occur if more unsupported diagnosis codes are deleted in Medicare Advantage than in traditional Medicare. Instead, it just changes the hypothetical to imagine what would happen if the data from traditional Medicare had been more carefully audited than the data from Medicare Advantage. Opp. 23. In that circumstance, it says, the Medicare Advantage plan's unsupported diagnosis codes *would* result in overpayment. *See id.* But that confirms, rather than refutes, the D.D.C.'s position (and Defendants' position here): It shows that whether a Medicare Advantage plan's unsupported diagnosis codes should be treated as invalid, and as thus resulting in an overpayment, depends on a comparison to the diagnosis codes in traditional Medicare.

The government tries (at 22) to spin this concession into a (temporary) victory by arguing that it is "depend[ent] on facts that are not alleged in the United States' Complaint." That has it backwards. Defendants have explained, and the government's modified hypothetical confirms, that whether Defendants were overpaid depends on a comparison of their data to the data used in traditional Medicare. Precisely because that comparison is central to the government's claims, the government was required to plead the key facts on which the comparison depends. Such a rule applies even in cases that involve only the ordinary pleading standard of Rule 8: A plaintiff whose claims depend on a comparison between how he was treated and how others were treated, for example, has to offer allegations about both of those things. *See, e.g.*, *Austin v. University of Oregon*, 925 F.3d 113, 1138 (9th Cir. 2019) (en banc) (affirming dismissal of complaint that alleged that male students were treated comparatively worse than female students because it lacked "nonconclusory allegations that the male students were treated any differently than similarly situated female students based on sex"). And the rule applies with even more force here, where Rule 9(b) imposes a heightened requirement. *Oestreicher v. Alienware Corp.*, 544 F. Supp. 2d 964, 968 (N.D. Cal. 2008) ("A plaintiff alleging fraud must satisfy a heightened pleading standard that requires circumstances constituting fraud be pled with particularity.") (citing Fed. R. Civ. P. 9(b)).

This pleading requirement will pose little problem to the government if the government's claims have merit—that is, if the real-world facts matched their carefully constructed modification of the hypothetical. The government could simply amend its Complaint to include particularized allegations showing that Defendants' data contained a comparatively high prevalence of unsupported diagnosis codes. The problem for the government, though, is that there is every indication that the real world does *not* match its hypothetical. For example, the government conspicuously fails to address CMS's own study concluding that for some conditions in traditional Medicare, less than 10 percent of the diagnosis codes are properly documented in the medical record. *See* Mot. 13 (citing Center for Medicare and Medicaid Services, Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits – Technical Appendix 6–8). This Court should not allow the government

to get by with omitting essential factual allegations from its Complaint, just because the government claims that if it *did* include such allegations, they would be disputed.

d. That the government has alleged fraud does not reduce its burden, but heightens it

Fourth, the government argues (at 18-19) that whatever legal rule might apply in "an APA challenge to a CMS rule," that rule "does not govern an FCA case that alleges knowing fraud." But this distinction cuts against the government, too. As discussed above, prior to 2014 CMS had agreed that in performing audits of Medicare Advantage participants, the relevant question was not whether the Medicare Advantage participant had reported *any* unsupported diagnosis codes, but rather whether "the error rate for an MA contract is greater than the CMS error rate" in traditional Medicare. *UnitedHealthcare*, 330 F. Supp. 3d at 186. If it was not greater, then even CMS conceded that no overpayment had been made, consistent with its longstanding view that Medicare Advantage participants "are coding 'accurately' when they are coding in a manner similar to fee-for-service coding." CMS 2010 Rate Announcement. In 2014, CMS tried to adopt a new, prospectively applicable administrative rule, promulgated through the notice-and-comment process, that would have replaced that comparative standard with a "perfection" standard—and the D.D.C. held that even in that posture, the agency could not abandon the comparative metric required by the Medicare statute. *See UnitedHealthcare*, 330 F. Supp. 3d at 186. Here, where the government is effectively seeking to enforce the exact same perfection standard, but is doing so through a backward-looking False Claims Act enforcement action rather than a prospectively applicable notice-and-comment process, it is even *more* obvious that its attempted change of position is inappropriate.[5]

[5] As the *UnitedHealthcare* court recognized, the fact that the government's proposed "perfection" standard is inconsistent with the Medicare statute does not mean that the government can never prosecute a fraud case. *See UnitedHealthcare Ins. Co. v. Price*, 330 F. Supp. 3d 208, 211 (D.D.C. 2017) (refusing to stay Administrative Procedure Act case pending completion of False Claims Act case, and noting that "[w]hether a government contractor knowingly engaged in fraud, and whether a government agency appropriately promulgated a rule" are different questions). The "most relevant question[]" in a fraud case, *id.*, is whether the defendant knowingly violated the applicable standard. In answering that distinct question, though, it matters a great deal that the applicable standard is comparative rather than absolute.

The government insists (at 19) that "[t]he object of this suit is not perfection in diagnosis coding, but rather truthfulness." But that rhetorical flourish is analytically empty. The government's theory that Defendants were not "truthful" boils down to a claim that they were willfully blind to the fact that their data was not perfect, because it contained unsupported diagnosis codes. That is just another way of alleging that Defendants are liable for fraud because they knowingly failed to comply with a perfection standard for diagnostic documentation. If that perfection standard does not exist in the first place (and it does not, for the reasons already discussed), then it makes no sense to speak of a knowing "failure" to comply with it.

e. The government is seeking to impose through its False Claims Act suit new obligations that it tried, and failed, to adopt through the regulatory process

Fifth, the government claims (at 21) that Defendants "essentially argue that the MA payment system that is in place . . . is unlawful," and contends that "challenging the legality of a rule is no defense to fraud." But this contention rests on a false premise, too. Defendants are not arguing that the current Medicare Advantage payment system is unlawful. The argument, instead, is that *the government's enforcement theory* here—that Defendants were required to delete every unsupported diagnosis code they identified or even could have identified—is fundamentally inconsistent with the current Medicare Advantage payment system. As the D.D.C. recognized in *UnitedHealthcare*, the Medicare Advantage payment system that is currently in place recognizes "the necessity of an FFS Adjuster-type procedure" that would ensure an accurate comparison between traditional (i.e., Fee-For-Service, or FFS) Medicare and Medicare Advantage. 330 F. Supp. 3d at 189. The D.D.C. held that even if the Medicare statute allowed the agency to modify that existing payment system, CMS would need to provide a reasoned explanation for its decision to do so—which it had not done. *Id.* And having been rebuffed in its attempt to modify the risk adjustment program in *UnitedHealthcare*, the government cannot pretend in *this* case that the new perfection standard it tried but failed to put into effect there somehow governs.

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f. If Defendants were not overpaid, then the government has no claim for unjust enrichment or payment by mistake

Finally, the government contends (at 24-25) that notwithstanding its inability to allege the comparative facts necessary to establish an overpayment, it should at least be able to continue with its common law claims. But this argument makes no sense: If the government cannot allege that Defendants were overpaid, then it simply has no basis for alleging that Defendants were "unjustly enriched" or paid "by mistake." *United States v. Mead*, 426 F.2d 118, 124 (9th Cir. 1970); *United States v. Bellecci*, 2008 WL 802367, at *6 (E.D. Cal. Mar. 25, 2008). The government points to no case holding otherwise.

For all of those reasons, the government has failed to plead adequately the most basic element of its case: That Defendants sought and obtained improper payments from the government. This Court need go no further in order to dismiss the Complaint-in-Intervention.

B. The Government's Allegations Fail To Show That Defendants Acted With The Necessary Scienter

If the Court does desire to go further, the government's False Claims Act allegations are also deficient for an additional reason: They fail to show that Defendants acted with a culpable state of mind.

Throughout its brief, the government repeatedly insists that the D.D.C.'s decision in *UnitedHealthcare* is "subject to a pending motion for reconsideration," "non-binding," and "neither controlling nor persuasive." Opp. 1, 18. For the reasons already discussed, the government's criticisms of that decision on the merits—to extent it engages with them at all—are misplaced. Beyond that, though, the government also loses sight of the heavy burden it bears in this fraud case. To make out its False Claims Act allegations, the government has to show not just that the D.D.C.'s interpretation of the statute is wrong, but that it is *objectively unreasonable*.

The government disputes that requirement, pointing to *United States ex rel. Oliver v. Parsons Co.*, 195 F.3d 457, 460 (9th Cir. 1999), for the proposition that "[s]cienter is a subjective inquiry which may be shown even if the defendant had an objectively reasonable interpretation of that requirement." Opp. 11. But *Oliver* considered the objective reasonableness

of a regulatory interpretation in connection with its discussion of *falsity*; its separate discussion of whether the complaint adequately alleged scienter did not discuss the reasonableness (or lack thereof) of the defendant's interpretation at all. *See Oliver*, 195 F.3d at 464-65. And any doubt that *Oliver* might have created on this score was eliminated eight years later, in *Safeco Ins. Co. of America v. Burr*, when the Supreme Court squarely held that a company that acts in accordance with a reasonable interpretation of applicable standards cannot, by law, be held to be a knowing or "reckless" violator of those standards. 551 U.S. 47, 70 (2007) (holding that imposition of "reckless liability" is inappropriate where a defendant's "reading [of the applicable statutory text] was not objectively unreasonable"). The Supreme Court explained that where existing law is subject to "more than one reasonable interpretation, it would defy history and current thinking to treat a defendant who merely adopts one such interpretation as a knowing or reckless violator." *Id.* at 70 n.20. And directly refuting the government's insistence here that objective reasonableness is irrelevant if the plaintiff alleges that the defendant was *subjectively* culpable, the Court held that "Congress could not have intended such a result"—*i.e.*, liability as a knowing or reckless violator—"for those who followed an interpretation that could reasonably have found support in the courts, *whatever their subjective intent may have been*." *Id.* (emphasis added). The Court therefore rejected the plaintiffs' argument that they should be allowed to present evidence showing that the defendant had subjectively believed that it was violating the statute, holding that even if such evidence were credited it could not support liability under a knowing or reckless standard. *Id.*

Remarkably, the government never even acknowledges *Safeco*'s directly on-point holding (though it was discussed in Defendants' motion).[6] Nor do they address the numerous False Claims Act cases that have held, in light of *Safeco*, that where the conduct alleged in the complaint is consistent with an objectively reasonable interpretation of the applicable law, the

[6] The government does cite (at 11) the Supreme Court's decision in *Halo Electronics, Inc. v. Pulse Electronics, Inc.*, a case about patent damages in which the Court held that "culpability is generally measured against the knowledge of the actor at the time of the challenged conduct," such that in assessing whether a defendant acted recklessly a court need not "look to facts that the defendant neither knew nor had reason to know at the time he acted." 136 S.Ct. 1923, 1933 (2016). But Defendants' argument here is not based on any intervening facts; their interpretation of the Medicare statute's "actuarial equivalence" standard has *always* been reasonable.

district court can and should dismiss the complaint rather than allowing it to move forward. *See, e.g.*, *United States ex rel. McGrath v. Microsemi Corp.*, 690 F. App'x 551, 552 (9th Cir. 2017) (cited in Defendants' motion); *see also United States ex rel. Hixson v. Health Mgmt. Sys., Inc.*, 613 F.3d 1186 (8th Cir. 2010) (affirming dismissal of complaint and holding that following *Safeco*, a defendant's "reasonable interpretation of a statute cannot support a claim under the FCA if there is no authoritative contrary interpretation of that statute … because the defendant . . . could not have acted with the knowledge that the FCA requires"); *United States v. Space Coast Med. Assocs., L.L.P.*, 94 F. Supp. 3d 1250, 1262-63 (M.D. Fla. 2015) (dismissing False Claims Act allegations for lack of knowledge where defendants' interpretations of the regulations at issue were not unreasonable); *Visiting Nurse Ass'n of Brooklyn v. Thompson*, 378 F. Supp. 2d 75, 96 (E.D.N.Y. 2004) ("[A]s a general rule, unresolved disputes about the proper interpretation of a statute or regulation should not lead to suits under the FCA, at least where a claimant's interpretation of the governing law is reasonable."). And little wonder: It has no genuine response. Whatever else it might say, the government cannot seriously contend that Defendants' interpretation of the Medicare statute's "actuarial equivalence" requirement is objectively unreasonable. Accordingly, under *Safeco* and *McGrath*, the government cannot satisfy the False Claims Act's heightened state of mind requirement. As the Supreme Court put it, "Congress could not have intended" to impose fraud liability on "those who followed an interpretation" that has already been embraced by the only court to have squarely addressed the issue. *Safeco*, 551 U.S. at 70.

The government's inability to show that Defendants were acting pursuant to an objectively unreasonable interpretation of the governing law also disposes of its separate reliance (at 14-15) on the Ninth Circuit's decision in *United States v. Bourseau*, 531 F.3d 1159 (9th Cir. 2008). In *Bourseau*, the defendants had submitted cost reports that were objectively false under any possible understanding of the law. *See*, *e.g.*, *id.* at 1168 (describing the defendants' inclusion of "a non-existent rental expense of $396,209 on a cost report"). The Ninth Circuit held that their willful blindness to that fact was no defense. *See id.* (noting that defendants acted with scienter where they "did not rely on good faith interpretations of the regulations in

including the disputed costs in the cost reports"). Here, by contrast, Defendants' submissions were consistent with what is, at the very least, a correct interpretation of the law. *Bourseau* does not remotely speak to that scenario.

In a separate section of its opposition, the government seems to suggest (at 22) that applying settled precedent in this way would give Medicare Advantage participants "endless bounds to submit false diagnoses and keep the payment in perpetuity with no redress." But that is wrong twice over.

First, the government has ample means at its disposal to recover any actual overpayments that it made, including administrative audits and potentially its common law claims. Those remedies do not require the government to show that the party that was overpaid was acting under an objectively unreasonable interpretation of the law. Here, though, the government is charging that Defendants' conduct amounted to *fraud*, and seeking treble damages as a result. It is only because it chose to seek that drastic remedy that the government must make a showing of objective unreasonableness.

And second, the problem the government complains of is one of its own making. Participants in the Medicare Advantage program have been asking CMS to disclose the rate of unsupported diagnosis codes in traditional Medicare for more than a *decade*. *See UnitedHealthcare*, 330 F. Supp. 3d at 181. Yet the government steadfastly refused to provide those figures for years. It is the height of chutzpa to accuse Defendants, now, of being willfully blind and seeking to avoid their obligations under the Medicare Advantage program, when it was the government itself that for years refused to disclose the information necessary for parties like Defendants to fully assess the comparative accuracy of their data.

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III. CONCLUSION

For the foregoing reasons, this Court should dismiss the government's claims.

DATED: September 30, 2019

By: */s/ Katherine A. Lauer*

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