Appeal No. 22-15862

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

MARCIA STEIN, ET AL.,

Plaintiffs-Appellants,

v.

KAISER FOUNDATION HEALTH PLAN, INC., ET AL.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of California
Hon. Edward M. Chen, Senior District Judge
Case No. 3:16-cv-05337-EMC

APPELLEES' ANSWERING BRIEF

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, Defendants-Appellees Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, and Kaiser Foundation Health Plan of Washington identify Kaiser Foundation Health Plan, Inc. as their parent corporation. Defendants-Appellees Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, P.C., Southern California Permanente Medical Group, Colorado Permanente Medical Group, P.C., Kaiser Foundation Hospitals, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.), and Northwest Permanente, P.C. have no parent corporation. No publicly held corporation owns 10% or more of any Defendant's stock.

Dated: February 24, 2023

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INTRODUCTION

By the time Appellants Marcia Stein and Rodolfo Bone brought their *qui tam* action under the False Claims Act ("FCA") accusing Kaiser Permanente-affiliated entities of knowingly submitting false claims for payment to the Medicare Advantage program, five other relators had already filed three actions over the previous three years, all making substantially the same allegations. The FCA's first-to-file bar, 31 U.S.C. § 3730(b)(5), exists precisely to prevent such duplicative suits that add nothing to the United States' investigation of fraud claims. After a relator brings a *qui tam* action, the bar ensures that no other relator can "bring a related action based on the facts underlying the pending action." Recognizing that Appellants' action ("*Stein*") added nothing new to the fraud schemes alleged in the three earlier-filed *qui tam* actions, the district court dismissed *Stein* under the first-to-file bar without leave to amend. The Court should affirm.

The first *qui tam* relator to file, Ronda Osinek, alleged in 2013 that Kaiser Permanente engaged in an "upcoding" scheme through which it reported diagnosis codes for Medicare Advantage members[1] to the U.S. Centers for Medicare &

[1] "Members" refers to the individual Medicare beneficiaries who are enrolled in the Medicare Advantage program and receive their healthcare coverage through a private insurer known as a Medicare Advantage Organization ("MAO"). Members become patients when they receive medical care covered by the Medicare Advantage program. Thus, for purposes of this Answering Brief, the terms

Medicaid Services ("CMS") that did not comply with coding and documentation requirements, resulting in overpayments from the Medicare Advantage program. She was followed by Dr. James Taylor in 2014 and three more relators (the "*Arefi* Relators") in 2015. In total, despite Osinek having already given the United States notice of an alleged "upcoding" fraud, ten relators seeking to cash in on the FCA's bounty system filed six repetitive *qui tam* actions, all alleging a similar upcoding scheme. Stein and Bone were the fourth set of relators to do so, alleging a scheme to upcode diagnoses for two particular medical conditions: sepsis and malnutrition.

The district court properly dismissed *Stein* under the first-to-file bar without leave to amend. As an initial matter, the district court recognized that Appellants' original complaint was the operative complaint for the first-to-file analysis. Stein and Bone argue here that their most recent amended complaint should have been the focus, because it raises an additional FCA cause of action related to the alleged upcoding of a third medical condition: aortic atherosclerosis ("AA"). But the district court correctly concluded that it must compare Appellants' initial complaint to the allegations in the three pending earlier-filed actions to determine whether the actions are related. The statute's text compels this conclusion, focusing on the moment a relator brings an "action," not a complaint. The Ninth

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"members," "beneficiaries," and "patients" are synonymous unless otherwise stated.

Circuit also treats the bar as jurisdictional, and jurisdiction is assessed at the outset of a case. Although Stein and Bone request that the panel hearing this appeal call for an initial hearing en banc to reconsider the jurisdictional question, they admit that there is no intra-circuit split, and they ignore that the bar's text centers the first-to-file analysis on their initial complaint.

In any event, the three *qui tam* actions filed before *Stein*—*Osinek*, *Taylor*, and *Arefi*—encompass the sepsis, malnutrition, and AA allegations in Appellants' most recent complaint. Simply alleging the same essential scheme in greater detail or with more specific examples than a previous relator has alleged will not suffice. The earlier-filed complaints allege a widespread upcoding scheme implicating Kaiser Permanente-affiliated entities across the country from at least 2004. They put at issue the same time period and entities as *Stein* does. And they allege violations of purported diagnosis coding and documentation requirements that would have led the United States to the condition-specific fraud alleged in *Stein*. In fact, the earlier-filed complaints explicitly allege that the upcoding schemes applied to both sepsis and malnutrition diagnoses, the two conditions at issue in the initial *Stein* complaint. Their allegations extend to the hospital setting, just as *Stein*'s allegations do. And they allege the same type of conduct that led to the purported upcoding of AA that *Stein* alleges—improper diagnosing from the results of diagnostic and radiologic tests.

Finally, the district court properly denied Stein and Bone leave to amend. The first-to-file bar's text makes clear that if a relator violates the bar, the action must be dismissed. A relator cannot cure a first-to-file violation through amendment. A chorus of caselaw agrees, none of which Stein and Bone address.

ISSUES PRESENTED

1. Did the district court properly conclude that the FCA's first-to-file bar, 31 U.S.C. § 3730(b)(5), required dismissal of the later-filed *Stein* action?

2. Did the district court properly deny leave to amend?[2]

STATEMENT OF THE CASE

A. The Medicare Advantage Program

This case concerns an alleged fraud on the Medicare Advantage program. Medicare is a federal health insurance program for older adults and individuals with disabilities. *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 872 (D.C. Cir. 2021).[3] CMS, an agency within the U.S. Department of Health and Human Services, administers the Medicare program. *Id.* Traditional Medicare consists of Medicare Part A, which covers inpatient hospital care, and Medicare Part B, which covers outpatient medical care. *Id.* CMS also administers Part C, which is known as Medicare Advantage, through which beneficiaries receive their Medicare

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[2] The Addendum to this Answering Brief includes pertinent statutes, regulations, and rules in compliance with Circuit Rule 28-2.7.

[3] All emphasis is added to, and citations and internal quotation marks omitted from, quoted passages unless otherwise indicated.

benefits from private insurers known as MAOs. *Id.*

Under the traditional Medicare program, CMS compensates healthcare providers directly for all services rendered to Medicare beneficiaries. *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under the Medicare Advantage program, however, private health insurance plans "provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage." *Id.* CMS determines this flat monthly rate through an annual bidding process, and then CMS employs a risk-adjustment payment model to adjust the fixed monthly payment based on various demographic and health factors that can affect healthcare expenses, including age, gender, and medical diagnoses. *See* 42 U.S.C. §§ 1395w-23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2).

Healthcare providers typically record member diagnoses after member visits using "diagnosis codes" and send those codes to the members' MAOs. *Silingo*, 904 F.3d at 672; *see also* 42 U.S.C. § 1395w-23(a)(1)(C)(i). CMS compensates MAOs based only on those medical conditions diagnosed for members in the previous payment year. *See Silingo*, 904 F.3d at 672.

CMS's risk-adjustment payment model groups diagnosis codes into Hierarchical Condition Categories ("HCCs"). *See Becerra*, 16 F.4th at 874. Each HCC is assigned a different "relative factor," which corresponds to that HCC's

relative effect on the payment amount to the MAO. *Id.* at 874–75. During the period at issue, CMS determined the relative factors for each HCC through its statistical analysis of the average costs of treating members with those reported conditions in traditional Medicare. *Id.* Because the relative factors differ among HCCs, some HCCs have a larger effect on the payment amount to MAOs. *Id.* CMS uses the relative factors associated with each HCC applicable to a given Medicare Advantage member to calculate what the agency calls a "risk score," and this risk score is then used to compute the risk adjustment to the flat monthly payment for that member. *Id.*

B. Earlier-Filed Complaints

Beginning in 2013, ten relators filed six *qui tam* actions against Defendants-Appellees ("Defendants").[4] *See* 1-ER-3. Each action alleges that Defendants relied on so-called "upcoding" schemes to identify and report to CMS "higher

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[4] "Defendants" are Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); and Northwest Permanente, P.C. Because the various actions discussed herein do not name all of the same defendants, "Defendants" or "Kaiser" refers to the defendants named in the complaint(s) referenced in the relevant portion of the brief, unless indicated otherwise. Although Kaiser Permanente is not a legal entity, *infra* n.5, "Defendants" and "Kaiser" include Kaiser Permanente where named in the complaint at issue.

value" HCCs for the purpose of defrauding the Medicare Advantage program. Stein and Bone were the fourth set of relators to file an action against Defendants alleging an upcoding scheme. *See* 7-ER-1497–1545. Because the first-to-file analysis requires a comparison of a later-filing relator's initial complaint with earlier-filing relators' complaints, as explained *infra*, Defendants address only the allegations in the three complaints filed before *Stein*—*Osinek*, *Taylor*, and *Arefi*.

1. The first-filed *Osinek* complaint

Ronda Osinek filed the first of the *qui tam* complaints on August 22, 2013. Osinek was a medical coder employed by The Permanente Medical Group, which operates in Northern California. 8-ER-1752. Osinek's original complaint names a single defendant, Kaiser Permanente.[5] *Id.* She alleges that Kaiser directed regional entities operating as part of the Kaiser Permanente brand to engage in various documentation and diagnosis-coding practices. *Id.* Her FCA allegations date back to at least 2007. 8-ER-1757.

The crux of Osinek's complaint is that Kaiser "defrauded the United States through a sophisticated scheme to upcode diagnoses to ensure Medicare [Advantage] payments for reimbursable, high-value [medical] conditions." 8-ER-

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[5] Kaiser Permanente is not a legal entity, but rather a trade name that refers to the nationwide collaboration among nonprofit health plans, nonprofit hospitals, and provider-directed medical groups to render healthcare services to their members, including millions of Medicare Advantage members. *See* 8-ER-1701; 1-ER-31; 3-ER-322–23.

1752. She defines "upcoding" as using diagnosis codes to make Medicare Advantage members "appear less healthy than they actually are." 8-ER-1757. Osinek alleges that healthcare providers affiliated with Kaiser diagnosed members with medical conditions that were not the result of "face-to-face visits" or otherwise lacked supporting documentation in the medical record. 8-ER-1760, -1762–63.

Osinek identifies multiple business practices that she contends furthered the general upcoding scheme. She alleges that Kaiser violated CMS guidance about when a healthcare provider can amend a medical record following a member visit. 8-ER-1760. According to Osinek, a provider typically enters relevant information about a member "into a medical record at the time of service." 8-ER-1756. But sometimes a provider will amend a medical record with additional information, including additional medical diagnoses, after the face-to-face visit. *See id.* These post-encounter amendments to the medical record are called "addenda." *See id.* Osinek asserts that, under CMS guidelines, healthcare providers "must verify that they considered a diagnosis or treated a diagnosis during the [member] encounter, which means a [provider] must address what was contemporaneously considered if he or she addends a diagnosis." 8-ER-1760.

Her complaint alleges that Kaiser's healthcare providers addended medical records "with supporting statements or documentation [for medical conditions] that

were not addressed at the time of the encounter." *Id.* After a member visit, Kaiser allegedly instructed healthcare providers "to go back to see what [the] member's previous test results showed to make diagnoses," and "prompted" healthcare providers to addend records with specific diagnoses based on, for example, laboratory tests. 8-ER-1760–61. Osinek broadly asserts that Kaiser "also addended and submitted diagnostic codes for complex [medical] conditions without proper support (i.e., not a true causal connection)." 8-ER-1762–63.

Osinek also alleges that Kaiser improperly instituted policies and guidance meant to target high-value HCCs. She insists that Kaiser instructs healthcare providers "to change diagnoses to upcode to higher value and more complicated forms of diseases" rather than medical conditions that members' symptoms actually reflect. 8-ER-1761–62. She alleges that Kaiser's policies caused healthcare providers to "take into consideration HCCs and the Medicare [Advantage] payment system when coding and recording [member] encounters." 8-ER-1758. And she asserts that "when CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser tells its [healthcare providers] to change coding practices to reflect new reimbursable [HCCs]." 8-ER-1760.

Osinek further alleges that around 2007, Kaiser began a process called "data mining," which also caused upcoding. 8-ER-1757. Through data mining, Kaiser allegedly identified "higher value HCCs and then determined the diagnoses its

[healthcare providers] would need to make to support the HCCs Kaiser wanted to submit for Medicare reimbursement." 8-ER-1757–58. Then Kaiser allegedly used "algorithms to identify … conditions for data mining" in members' medical records to ensure that it did not fail to report potentially reimbursable medical conditions to CMS. *See id.* According to Osinek, the purpose of data mining is to submit diagnosis codes to CMS for "high value [medical] conditions for which Kaiser can maximize its reimbursement from Medicare and increase its revenue." *Id.* She alleges that Kaiser would target specific medical conditions, including chronic kidney disease, congestive heart failure, depression, chronic respiratory failure, cachexia/protein calorie malnutrition, and obesity. *See id.*

Osinek also contends that Kaiser used a process called "refresh" to further its upcoding scheme. *Id.* Because CMS compensates MAOs based on only those medical conditions diagnosed in the previous payment year, MAOs must record and report chronic medical conditions for members each year. According to Osinek, Kaiser uses the term "refresh" to describe its efforts to re-diagnose chronic conditions each year. *See* 8-ER-1768 She contends that Kaiser implemented organized efforts to refresh members' "chronic [medical] conditions" year over year to eliminate "missed opportunities." 8-ER-1757, -1765, -1768. She alleges that Kaiser used this refresh initiative to improperly increase Kaiser's "billings for high value … HCCs." 8-ER-1757.

Finally, Osinek alleges that Kaiser generally "pressures" healthcare providers "to addend diagnoses and capture the high value HCCs" to eliminate "missed opportunities." 8-ER-1765–66. Kaiser allegedly uses "data mining prompts," which are requests sent to healthcare providers to add diagnoses to medical records when Kaiser discovers "missed opportunities." *See id.* Osinek contends there is an "escalation process" for those healthcare providers to "explain their refusal" to diagnose the prompted medical conditions. *Id.* She also alleges that Kaiser ties healthcare providers' compensation directly to their performance on data-mining and refresh efforts. 8-ER-1766. And she asserts that Kaiser sponsored "coding parties," created competitions, and awarded cash prizes to encourage healthcare providers to participate in upcoding of diagnosis codes. 8-ER-1766–69.

2. *Taylor*

On October 22, 2014—more than a year after *Osinek*—Dr. James Taylor, a physician and former employee of Defendant Colorado Permanente Medical Group, filed a *qui tam* complaint against Kaiser Permanente, which he alleges comprises Kaiser Foundation Health Plan and its subsidiary health plans, Kaiser Foundation Hospitals and its subsidiary hospitals, and regional provider-directed medical groups. 8-ER-1700–01, -1748. He filed a substantively similar amended complaint on November 3, 2014. 8-ER-1640–93. In the amended complaint,

Taylor named as defendants Kaiser Foundation Health Plan and regional health plans that operate in several regions across the country. 8-ER-1647. His FCA allegations date back to 2004. 8-ER-1643.

Like Osinek, Taylor alleges a broad scheme to "upcode" diagnoses submitted to CMS for Medicare Advantage members. *Id.* He alleges that Defendants "submit false claims to CMS when they know, or in the exercise of reasonable care should know, that: (1) the [members] do not have the diagnoses for which a risk adjustment claim was submitted; and/or (2) the diagnosis" did not meet purported CMS requirements—specifically, the diagnosis "a) was neither treated nor affected the treatment provided; b) in a face-to-face visit; c) with an appropriate provider; d) in the year at issue." *Id.*; *see also* 8-ER-1658.

Taylor's allegations are not limited to a specific set of medical conditions. Rather, he alleges that Defendants conducted internal audits of diagnosis data submitted by healthcare providers, and those audits revealed widespread upcoding practices. *See* 8-ER-1667. For example, Taylor generally contends that the audits revealed "consistent problems with the application of basic risk adjustment coding rules." 8-ER-1679. He alleges that Kaiser "routinely submitted claims where a non-chronic diagnosis was listed on a problem list or elsewhere in the medical record without any notation or other evidence that the diagnosis was treated or affected the treatment provided." 8-ER-1679–80. Similarly, he alleges that Kaiser

submitted "claims where the only documentation to support the diagnosis was a radiologic or lab test, or other non-face-to-face service." 8-ER-1680.

Taylor also provides "illustrative" examples of "diagnoses and HCCs identified as frequently upcoded," such as cancer, stroke, malnutrition, respiratory conditions, and renal conditions. 8-ER-1667–71, -1674, -1676, -1678. He alleges, for instance, that cancer and stroke were frequently coded as active when they were no longer active, 8-ER-1667–72; claims for chronic obstructive pulmonary disease were "erroneous based on lack of documentation in the record, or because the doctor failed to document the patient's condition with sufficient specificity," 8-ER-1674; providers were pressured to diagnose risk-adjusting conditions such as chronic bronchitis over similar non-risk-adjusting conditions such as acute bronchitis, 8-ER-1674–75; and medical coders inappropriately reported medical conditions not diagnosed by appropriate provider types, such as for cachexia, a wasting condition, 8-ER-1676.

3. *Arefi*

On September 4, 2015, the *Arefi* Relators filed a third *qui tam* complaint against more than ten Kaiser-affiliated entities that operate across the country, including hospitals, health plans, and provider-directed medical groups. 8-ER-1548–1638. The complaint's FCA allegations date back to 2008. 8-ER-1565.

Like Osinek and Taylor, the *Arefi* Relators alleged that Kaiser perpetrated a

"Medicare Advantage diagnosis upcoding scheme" by "reporting false … diagnoses to CMS for Medicare Advantage plan enrollees." 8-ER-1565, -1571. They alleged that the improper upcoding scheme resulted from Kaiser's "after-the-fact medical record reviews, use of diagnostic criteria that find no support in medical literature or accepted standards of medical or coding practice, and systemic manipulation and pressuring of Kaiser physicians to cooperate with the scheme by over-diagnosing patients with severe medical conditions that either did not exist at [the] time of a face-to-face physician encounter or were not being currently treated." 8-ER-1550.

The *Arefi* Relators alleged that these practices resulted in the submission to CMS of inappropriate diagnosis codes for multiple medical conditions, including sepsis, septicemia, and malnutrition, among others. 8-ER-1550–51, -1574.

4. *Stein*

On May 16, 2016—nearly three years into these successive allegations—Stein and Bone brought a fourth *qui tam* action, naming over a dozen national and regional entities as defendants along with Kaiser Permanente. 7-ER-1497–1545. Stein is a Registered Health Information Administrator who was previously employed by Kaiser Foundation Hospitals and Southern California Permanente Medical Group. 7-ER-1502. Bone is a medical coder who was formerly employed by Kaiser Foundation Hospitals. 7-ER-1502–03.

Like Osinek, Taylor, and the *Arefi* Relators before them, Stein and Bone alleged "a fraudulent scheme to up-code and falsely diagnose" Medicare Advantage members with risk-adjusting medical conditions. 7-ER-1515. Their initial complaint focused on alleged upcoding of two medical conditions: sepsis and malnutrition.[6] 7-ER-1515–27.

First, Stein and Bone alleged that since 2010 Defendants have engaged "in a fraudulent scheme to up-code and falsely diagnose MA enrollees with sepsis and/or severe sepsis …. in order to increase the risk adjustment" payments from CMS. 7-ER-1515–16. The thrust of their sepsis allegations was that Defendants inappropriately coded sepsis without proper clinical findings, often in the hospital setting, and then reported those diagnosis codes to CMS to support increased risk-adjustment payments. *Id.* They alleged that Defendants used an improper diagnostic standard for sepsis that resulted in healthcare providers over-documenting sepsis for Medicare Advantage members, and that Defendants reported sepsis diagnosis codes to CMS despite a lack of clinical indicators in the relevant members' medical records. 7-ER-1515–18.

Second, Stein and Bone similarly alleged that from approximately 2010 to

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[6] Their initial complaint also included allegations about "refresh" practices, which they had asserted against Defendants across the country. 7-ER-1527. But during briefing on motions to dismiss, Stein and Bone conceded that the first-to-file bar required dismissal of their FCA claims based on "refresh" practices. 2-ER-148.

2014 Defendants engaged "in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA enrollees." 7-ER-1524. Stein and Bone asserted that Defendants submitted malnutrition diagnosis codes to CMS that were not supported by a diagnosis from an appropriate provider type. 7-ER-1525. According to Stein and Bone, under CMS guidelines, Defendants can submit diagnosis codes to CMS only for diagnoses that resulted from "a face-to-face encounter with a physician or other qualified clinician," and the diagnosis must "have the appropriate clinical findings documented" in the medical record. *Id.* Defendants allegedly violated these guidelines by reporting diagnosis codes to CMS for malnutrition or severe malnutrition where a dietician, rather than a physician, had a face-to-face visit with the diagnosed member. *Id.* According to Stein and Bone, although physicians "countersigned" the records, the physicians should have met with the member and documented relevant findings in the medical record. 7-ER-1524–25.

On November 3, 2016, Stein and Bone filed an amended complaint, which is similar to their original complaint but added allegations about a scheme to upcode AA, a medical condition involving hardening of the aortic arteries that "can be detected and diagnosed from a typical chest x-ray." 7-ER-1440–95, -1470. Stein and Bone alleged that between 2007 and 2016, certain Defendants instructed their medical coders to code AA any time a healthcare provider "noted the presence of

AA or listed AA in the patient's medical record," specifically for patients admitted to inpatient facilities. 7-ER-1471. According to Stein and Bone, this practice violated applicable coding rules that require "the patient to have received treatment for a chronic condition, such as AA," before coding the condition; that prohibit coding based solely on an abnormal test result, such as an x-ray; and that require diagnoses to be made as a result of "face-to-face physician encounters that are supported by properly documented medical records." 7-ER-1471–73.

On November 12, 2021, Stein and Bone filed a second amended complaint, alleging the same condition-specific causes of action as the first amended complaint. 6-ER-1065–1122.

C. *Qui Tam* Consolidation and Intervention by the United States

After Stein and Bone filed their action, three more relators filed two additional *qui tam* complaints, both of which also alleged that Defendants engaged in upcoding schemes to defraud the Medicare Advantage program. 3-ER-344–46. On June 25, 2021, the district court consolidated *Osinek* and the five other *qui tam* actions at the United States' request, with no opposition from the relators. 6-ER-1262, -1265. In support of consolidating the various actions, the United States cited the overlapping allegations in the complaints: "The six actions each allege that Kaiser submitted claims to the Medicare Advantage Program … for risk-adjustment payments for diagnoses that [members] did not actually have and/or

that were not actually addressed by the treating [healthcare provider] during a [member] encounter as required by Medicare billing rules." 6-ER-1263.

On July 27, 2021, the United States filed a notice of its intent to intervene in part in the consolidated actions. 6-ER-1246–51. The intervention applies only to "allegations that [Defendants] submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda under Medicare [Advantage] from the years 2009 until present." 6-ER-1249. On December 30, 2021, the *Arefi* Relators dismissed their claims with prejudice to the extent the United States did not intervene in their case. *See* 9-ER-1889.

D. Defendants' Motion to Dismiss

Defendants moved to dismiss the five *qui tam* actions filed after *Osinek* under the FCA's first-to-file bar, 31 U.S.C. § 3730(b)(5). 3-ER-328. Defendants explained that the original complaint filed by Stein and Bone—their only complaint relevant to the first-to-file analysis—alleged the same material elements as *Osinek*, *Taylor*, and *Arefi*, and thus § 3730(b)(5) required the court to dismiss *Stein*. *See* 3-ER-353–54.

In response, Stein and Bone argued that they alleged unique fraud schemes about the way Defendants upcoded diagnoses of sepsis, malnutrition, and AA. 2-ER-144–62. They also argued that the district court should focus its analysis on their second amended complaint, not their original 2016 complaint. 2-ER-150.

Despite recognizing that Ninth Circuit precedent holds that the first-to-file bar is jurisdictional, they asserted that the bar is not jurisdictional, and accordingly the court need not focus on the jurisdictional facts that existed at the time they initiated their action to determine whether the first-to-file bar required dismissal. 2-ER-156–57. Stein and Bone asked in the alternative for leave to amend, without identifying the new factual allegations they would add through amendment or how such amendment could survive the first-to-file bar. 2-ER-161.

The district court dismissed *Stein* in its entirety. 1-ER-3–48. The court first rejected their argument that the operative complaint governed the first-to-file analysis. 1-ER-12–18. The court reached this conclusion after reviewing the statute's text, which focuses on when a relator "bring[s]" an action, not when a relator amends a complaint; general jurisdictional principles that state that jurisdiction must be measured when a plaintiff initiates an action; and "practical/policy reasons" to focus on a relator's initial complaint. *Id.*

Independent of the jurisdictional issue, the district court concluded that *Stein*'s FCA "claims overlap with *Osinek*." 1-ER-42. Like Osinek's first-filed complaint, the court noted, Stein and Bone asserted that "upcoding was improper because it was based on exploiting high-value conditions – *e.g.*, exaggerating a patient's condition, diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a condition for which the patient was not

treated, diagnosing without the necessary support/documentation, and the like." *Id.* The court also held that their allegations about sepsis and malnutrition were "lesser-included conduct" alleged by Osinek. 1-ER-42–43. The court similarly rejected their argument that the hospital-related allegations set them apart from earlier-filed complaints because "nothing about *Osinek* excepts a hospital setting from the alleged upcoding." 1-ER-43. Finally, the court noted that the only material difference between their complaint and Osinek's first-filed complaint related to the geographic scope of the alleged misconduct, with *Osinek* limited to California and *Stein* applying more broadly. *Id.* But the court concluded that Taylor's action, which also predated the original *Stein* complaint, implicated a "nationwide or corporate-wide problem … broad enough to encompass the basic kind of upcoding practices alleged in *Stein*." *Id.*

The district court then denied Stein and Bone leave to amend as a "futile request since the Court's evaluation is limited to the original Stein Complaint." *Id.* The court explained that even if it had evaluated the first or second amended complaint, both of which included the AA allegations, the "nature of the conduct" alleged was similar to that alleged in *Osinek* such that "AA is a condition that the government likely would have investigated given *Osinek*'s description of Kaiser exploiting high-value conditions." *Id.*

SUMMARY OF ARGUMENT

1. The Court should affirm the district court's dismissal of *Stein* under the FCA's first-to-file bar. To start, the district court correctly focused on the initial complaint in conducting the first-to-file analysis. The bar's text and jurisdictional nature both required the district court to focus its analysis on Appellants' original complaint, not their amended complaints. Under the statute, a *qui tam* relator may not "***bring*** a related ***action*** based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). This language centers the first-to-file analysis on the later-filing relator's original complaint—*i.e.*, the complaint that initiated the action. *See id.* The Ninth Circuit also has held that the bar is jurisdictional. *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1186–87 (9th Cir. 2001); *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir. 2015) (en banc). And as a general matter, courts assess subject-matter jurisdiction at the time of filing by examining the allegations in an initial complaint.

Stein and Bone concede that the Ninth Circuit has held that the first-to-file bar is jurisdictional and that a three-judge panel cannot depart from that holding. They instead urge the Court to call for an initial hearing en banc to reconsider whether the bar is jurisdictional, noting that some other Circuits recently have held that the bar is not jurisdictional. But the Court should not accept this ill-conceived invitation—a procedural request typically reserved for issues of exceptional

importance. The jurisdictional issue is not dispositive of any question on appeal, and the Court can affirm the judgment below without delving further into a Circuit split on which the Ninth Circuit already has taken sides, particularly when the bar's text independently requires courts to analyze a relator's original complaint in conducting the first-to-file analysis.

Even if this Court were to look to the most recent amended complaint, the bar still would require dismissal based on related allegations in the earlier-filed *Osinek*, *Taylor*, and *Arefi* actions. The key question is whether the earlier-filed actions allege the same material elements as *Stein*, such that they would have given the United States grounds to discover the fraud alleged in *Stein*. The earlier-filed actions put the United States on notice of all the information it needed to discover the alleged fraud in *Stein*. They allege widespread upcoding schemes against Kaiser-affiliated entities across the country that encompass the condition-specific fraud alleged in *Stein*. They focus on the same types of allegedly improper practices at issue in *Stein*—such as improperly coding medical conditions diagnosed without a face-to-face visit, without proper documentation in the medical record, and with only a diagnostic or radiologic examination as support—and they explicitly allege that their upcoding allegations applied to sepsis and malnutrition, the two medical conditions at issue in *Stein*.

2. The Court should also affirm the district court's denial of leave to amend

because amendment here would be futile. The first-to-file bar absolutely prohibits a person other than the United States from bringing an action while a related action is pending and requires dismissal of the later-filed action. Relators cannot amend themselves beyond the reach of the statute. The great weight of authority agrees, none of which Stein and Bone address in this appeal.

STANDARD OF REVIEW

This Court reviews *de novo* the district court's interpretation of the FCA and its decision to dismiss for lack of subject-matter jurisdiction. *Hartpence*, 792 F.3d at 1126. A district court's relevant factual findings on all jurisdictional issues must be accepted unless clearly erroneous. *Id.* at 1126–27.

Denial of leave to amend is reviewed for abuse of discretion. *United States ex rel. Lee v. SmithKline Beecham, Inc.*, 245 F.3d 1048, 1051 (9th Cir. 2001). A court need not grant leave to amend when amendment would be futile. *Rutman Wine Co. v. E. & J. Gallo Winery*, 829 F.2d 729, 738 (9th Cir. 1987). The question of futility, however, is reviewed *de novo*. *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1172 (9th Cir. 2016).

"In reviewing decisions of the district court," this Court "may affirm on any ground finding support in the record," regardless of whether the district court relied on that ground. *Cigna Prop. & Cas. Ins. Co. v. Polaris Pictures Corp.*, 159 F.3d 412, 418 (9th Cir. 1998).

ARGUMENT

I. The Court Should Affirm the District Court's Dismissal of *Stein*

The district court correctly held that the FCA's first-to-file bar required dismissal of *Stein*. The court properly compared the initial complaint in *Stein* to the earlier-filed relator complaints pending at the time Stein and Bone brought their action. Based on this comparison, the court correctly concluded that their allegations that Defendants engaged in a scheme to "up-code" certain medical conditions were encompassed by earlier-filed *qui tam* complaints that alleged similar upcoding schemes. The Court should affirm the district court's analysis.

A. The district court correctly focused on Appellants' original complaint in conducting the first-to-file analysis.

The district court correctly compared the original complaint filed by Stein and Bone to earlier-filed pending complaints in conducting the first-to-file analysis. The bar's text and jurisdictional nature both required the district court to focus on Appellants' original complaint. The Court should refuse to indulge their extraordinary request for an initial hearing en banc to reconsider Ninth Circuit precedent on jurisdiction. The request—made for the first time 12 pages into the Opening Brief—is procedurally improper and substantively meritless.

1. The text of the FCA's first-to-file bar required the district court to focus on Appellants' original complaint.

The text of the first-to-file bar plainly requires courts to evaluate the allegations in a relator's original complaint when conducting a first-to-file analysis.

The statute states: "When a person brings an action under this subsection, no person other than the Government may intervene or ***bring a related action*** based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). "One 'brings' an action by commencing suit"—not by amending a previously existing complaint. *See United States ex rel. Chovanec v. Apria Healthcare Grp. Inc.*, 606 F.3d 361, 362 (7th Cir. 2010); *Goldenberg v. Murphy*, 108 U.S. 162, 163 (1883) ("A suit is brought when in law it is commenced[.]"). "The statutory command is not ambiguous: a claim is barred by the first-to-file bar if at the time the lawsuit was *brought* a related action was pending." *United States ex rel. Wood v. Allergan, Inc.*, 899 F.3d 163, 172 (2d Cir. 2018) (emphasis in original).

Courts thus must look to a later-filing relator's original complaint to determine whether the first-to-file bar requires dismissal. *See, e.g.*, *id.* at 172 ("[E]ven after Wood filed his Third Amended Complaint, his action still violated the first-to-file bar because he instituted legal proceedings, by filing the initial complaint, while a related action was pending."); *Cho on behalf of States v. Surgery Partners, Inc.*, 30 F.4th 1035, 1042 (11th Cir. 2022) ("[W]e conclude that the FCA's plain text tethers our analysis to the moment a qui tam action is filed."); *United States ex rel. Carter v. Halliburton*, 866 F.3d 199, 206–07 (4th Cir. 2017) (holding, based on "the relevant statutory text," that "the appropriate reference point for a first-to-file analysis is the set of facts in existence at the time that the

FCA action under review is commenced").[7] Although Stein and Bone urge the Court to consider their most recent amended complaint, AOB 21 n.11, 43, they have not even attempted to offer an alternative reading of the statutory text that would allow the Court to do so. Nor have they addressed the legion of cases concluding otherwise.

Focusing on the original complaint also accords with the purpose of the bar: to give "the government notice of the essential facts of an alleged fraud" while "stop[ping] repetitive claims." *See Lujan*, 243 F.3d at 1186–87. The bar provides "incentives for whistle-blowing insiders" to file suit early. *Id.* A contrary rule that placed the focus of the first-to-file analysis on the latest amended complaint would frustrate this important incentive. Every relator could thwart the first-to-file bar simply by amending a complaint. *See United States ex rel. Carter v. Halliburton*

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[7] *See also United States ex rel. Mohajer v. Omnicare, Inc.*, 525 F. Supp. 3d 447, 459 (S.D.N.Y. 2021) ("[T]he Court looks only at the original complaint [the relators] filed in 2017 - and not the amended complaint they filed in March 2020 in a desperate effort to save their status as relators."); *United States ex rel. Shea v. Verizon Commc'ns, Inc.*, 160 F. Supp. 3d 16, 29 (D.D.C. 2015) ("[T]he language of § 3730(b)(5) itself … requires the Court to look to the moment when Plaintiff filed his initial Complaint[.]"); *United States ex rel. Moore v. Pennrose Props.*, 2015 WL 1358034, at *14 (S.D. Ohio Mar. 24, 2015) (stating that "the language of the first-to-file bar does suggest" that the court must examine "the time of filing of a complaint" to determine whether to dismiss the action); *United States ex rel. Branch Consultants, L.L.C. v. Allstate Ins. Co.*, 782 F. Supp. 2d 248, 259 (E.D. La. 2011) (holding that "use of the term 'action'" in the first-to-file bar means that the court must evaluate the "facts that existed at the time the action was filed, as opposed to facts that existed when the relator filed an amended complaint").

Co., 144 F. Supp. 3d 869, 882 (E.D. Va. 2015) ("allowing a relator to avoid the first-to-file bar by amending would interfere with the efficient operation of *qui tam* suits"). Indeed, "courts would face a wave of problematic questions" about how to sequence the various complaints:

> For example, if the first-filed action is dismissed while the second-to-file and third-to-file are still pending, who gets to proceed as the new first-filed case? Is it the first to amend the complaint or the second to have filed the initial complaint? If the amended complaint relates back to the time of filing, then could the third-to-file move forward only to be stopped again once the second-to-file amends? … Such a system would also make any statute of limitations obsolete.

Wood, 899 F.3d at 173.

As the district court here acknowledged, focusing the first-to-file analysis on the initial complaint also "has the advantage of simplicity," an obvious virtue in this case, which involves "multiple claims, complaints, and defendants, as well as other relators whose complaints have themselves been amended and involve multiple defendants." 1-ER-16 (quoting *Branch*, 782 F. Supp. 2d at 264). Following the plain text of the bar ensures consistency and predictability—"strict adherence to the procedural requirements specified by the legislature is the best guarantee of evenhanded administration of the law." *Hallstrom v. Tillamook County*, 493 U.S. 20, 31 (1989).

2. This Court's holding that the first-to-file bar is jurisdictional also required the district court to focus on Appellants' original complaint.

The district court also correctly focused on the original complaint filed by Stein and Bone when conducting its first-to-file analysis because, as Stein and Bone concede, courts in the Ninth Circuit must treat the first-to-file bar as jurisdictional. AOB 17, 19–20. And jurisdiction must exist at the outset of a case.

The Ninth Circuit twice has stated that the first-to-file bar is jurisdictional. It did so more than two decades ago in *Lujan* and again fourteen years later, sitting en banc in *Hartpence*. *Lujan*, 243 F.3d at 1186–87 (explaining that 31 U.S.C. § 3730(b)(5) is a "jurisdictional bar"); *Hartpence*, 792 F.3d at 1130 ("We treat the first-to-file bar as jurisdictional."). The Fourth, Fifth, and Tenth Circuits agree that the bar is jurisdictional.[8]

Courts that treat the first-to-file bar as jurisdictional have held that the analysis under the bar should focus on a relator's original complaint. *See, e.g.*, *Grynberg*, 390 F.3d at 1279 ("We judge whether § 3730(b)(5) barred Grynberg's [later-filed] qui tam action by looking at the facts as they existed at the time the action was brought[.]"); 1-ER-13 (collecting additional cases). That is the correct starting point for the analysis because subject-matter jurisdiction must exist at the

[8] *Halliburton*, 866 F.3d at 203; *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 376–77 (5th Cir. 2009); *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1278 (10th Cir. 2004).

time an action was commenced. *Strudley v. Santa Cruz Cnty. Bank*, 747 F. App'x 617, 618 (9th Cir. 2019); *Morongo Band of Mission Indians v. Cal. State Bd. of Equalization*, 858 F.2d 1376, 1380 (9th Cir. 1988).[9]

Notwithstanding this binding precedent, Stein and Bone argue that the bar is not jurisdictional. They note that other Circuits have concluded that the bar is not jurisdictional in light of the so-called clear-statement principle, first announced by the Supreme Court in *Gonzalez v. Thaler*, 565 U.S. 134 (2012). AOB 13–17. In *Gonzalez*, a habeas decision that did not address the FCA or the first-to-file bar, the Supreme Court held that a rule is jurisdictional if Congress "clearly states that a threshold limitation on a statute's scope shall count as jurisdictional." *Id*. at 141. Following *Gonzalez*, the D.C., First, Second, Third, and Sixth Circuits have

[9] Stein and Bone cite dictum in a *Hartpence* footnote stating that the court would look to amended complaints to determine jurisdiction. AOB 21 n.11; *Hartpence*, 792 F.3d at 1125 n.2. But the footnote is distinguishable. First, as the district court concluded, the footnote "does not mean that, for purposes of the first-to-file bar, [] a court should look to an amended pleading in a later-filed case." 1-ER-16. The Ninth Circuit relied exclusively on the Supreme Court's opinion in *Rockwell*, which evaluated a different FCA provision (the public-disclosure bar) that was also at issue in *Hartpence*, but is not at issue here. *See Hartpence*, 792 F.3d at 1125 n.2 (citing *Rockwell Int'l Corp. v. United States*, 549 U.S. 457, 473–74 (2007)). Second, *Rockwell* concerned when a plaintiff can "amend himself or herself ***out of jurisdiction*** by withdrawing allegations that appeared in the original complaint." *See Branch*, 782 F. Supp. 2d at 261; *Rockwell*, 549 U.S. at 468 ("[T]he issue is whether … a clear and explicit ***withdrawal*** of jurisdiction withdraws jurisdiction."). But *Rockwell* "does not suggest that a plaintiff can ***establish*** jurisdiction by amendment when jurisdiction did not previously exist." *Branch*, 782 F. Supp. 2d at 261–62.

concluded that the first-to-file bar is not jurisdictional, primarily because the bar does not explicitly reference "jurisdiction."[10]

This argument is of no consequence here, as Stein and Bone themselves recognize. They concede that a three-judge panel of this Court cannot depart from *Lujan* and *Hartpence*. AOB 20. Indeed, as Stein and Bone acknowledge, *Hartpence* postdates *Gonzalez* by three years, and the Ninth Circuit in *Hartpence* did not change its conclusion that the first-to-file bar is jurisdictional based on the clear-statement principle. "[A] three-judge panel must apply binding precedent even when it is clearly wrong because (for example) it failed to recognize an intervening change in the law. Only an en banc court has the power to fix these errors." *Silva v. Garland*, 993 F.3d 705, 717 (9th Cir. 2021). Thus, even if *Gonzalez* and the "clear-statement principle" announced by the Supreme Court constituted an "intervening change in the law," *Hartpence* did not recognize it as such. And, in any event, no Supreme Court decision has held that the first-to-file bar is not jurisdictional. *Hartpence*'s conclusion that the first-to-file bar is jurisdictional binds both Ninth Circuit district courts and the three-judge panel

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[10] *United States ex rel. Heath v. AT&T*, 791 F.3d 112, 120 (D.C. Cir. 2015); *United States ex rel. Hayes v. Allstate Ins. Co.*, 853 F.3d 80, 86 (2d Cir. 2017); *United States v. Millenium Labs., Inc.*, 923 F.3d 240, 249–51 (1st Cir. 2019); *In re Plavix Mktg., Sales Pracs. & Prods. Liab. Litig. (No. II)*, 974 F.3d 228, 232 (3d Cir. 2020); *United States ex rel. Bryant v. Cmty. Health Sys., Inc.*, 24 F.4th 1024, 1036 (6th Cir. 2022).

considering this appeal. *See id.*; AOB 20.

3. The Court should reject Appellants' request for an initial hearing en banc.

Recognizing that the district court had to follow *Lujan* and *Hartpence* as binding precedent, and that a three-judge panel cannot depart from *Hartpence*, Stein and Bone urge this Court to call for an initial hearing en banc to reconsider whether the bar is jurisdictional. AOB 21. There is no reason to do so. First, Stein and Bone have failed to properly petition for en banc review as a procedural matter. Second, an initial hearing en banc is not warranted since there is no intra-circuit split and the jurisdictional question is not dispositive of any issue on appeal.

A party may petition for an initial hearing en banc at the same time the appellee's brief is due.[11] Fed. R. App. P. 35(c). The petition "must begin" by stating the grounds for the en banc request. Fed. R. App. P. 35(b). Under Ninth Circuit General Order 5.2, the petition "shall be referred to the three-judge panel assigned to the case for resolution," and the panel "may deny the petition on behalf of the Court or request that the Court vote on whether to hear the case initially en banc." No Rule of Appellate Procedure or Court rule states that a party can request an initial hearing en banc in a merits brief, as opposed to a petition under Federal Rule of Appellate Procedure 35 and General Order 5.2. *See Paulette v. Lozoya*,

[11] At the time this Answering Brief was filed, Stein and Bone had not separately petitioned for en banc review. They have raised their request only in their Opening Brief.

577 F. App'x 291, 292 (5th Cir. 2014) (rejecting request for hearing en banc where petitioner did "not herself follow the procedure to seek an initial hearing en banc" under Rule 35(b)).

The three-judge panel assigned to this case for resolution should deny Appellants' request for an initial hearing en banc without requesting that the Court vote on whether to hear the case initially en banc. *See* G.O. 5.2. The halfhearted request is not procedurally proper. Instead of petitioning for initial en banc review as Federal Rule of Appellate Procedure 35 contemplates, Stein and Bone have buried their request in the middle of their Opening Brief. It is not clear until page 12 of the brief that Stein and Bone request en banc review. AOB 12. They have not pointed to any authority permitting a party to petition for en banc review through such means. They have not even styled their brief as a joint petition and opening brief. If Stein and Bone wanted the Court to consider whether to call for an initial hearing en banc, they should have complied with Rule 35 and properly petitioned for review. *See Paulette*, 577 F. App'x at 292.

Further, en banc hearings are "not favored and generally will not be ordered" unless en banc consideration "is necessary to secure or maintain uniformity of the court's decisions" or "the proceeding involves a question of exceptional importance." Fed. R. App. P. 35. Initial hearings en banc have been called an "unusual" action and a "procedure in which [the Court] engage[s] infrequently."

John v. United States, 247 F.3d 1032, 1033 (9th Cir. 2001) (Reinhardt, J., concurring).

The Court "ordinarily" uses an initial hearing en banc "only when there is a direct conflict between two Ninth Circuit opinions and a panel would not be free to follow either." *Id.* In *United States v. Washington*, for example, the court granted an initial hearing en banc because the appeal presented "a clear conflict in our precedent that gave difficulty to the district court here and would give difficulty to other district courts in the future." 593 F.3d 790, 798 (9th Cir. 2010) (en banc). By contrast, in *Lerjanthuk v. Sessions*, a three-judge panel rejected a request for an initial hearing en banc to overturn Ninth Circuit precedent where the appellant identified no conflict in Ninth Circuit caselaw and the Ninth Circuit had "recently revisited this area of precedent" only seven years prior. 709 F. App'x 506, 507 (9th Cir. 2018).

Here, Stein and Bone also have not substantively justified their request. While initial hearings en banc ordinarily are held only to resolve intra-circuit splits, Stein and Bone have not identified any inconsistency in Ninth Circuit precedent. In fact, the Ninth Circuit's law is uniform, as it has twice held that the first-to-file bar is jurisdictional, with *Hartpence* revisiting that decision en banc within the past eight years. And Stein and Bone point to no confusion among district courts in the Ninth Circuit over how to apply *Lujan* and *Hartpence* in this respect. The Court

should summarily reject the request for an initial hearing en banc. *See Washington*, 593 F.3d at 798; *Lerjanthuk*, 709 F. App'x at 507; *John*, 247 F.3d at 1033 (Reinhardt, J., concurring).

Stein and Bone argue in a footnote that the jurisdictional issue is "of great importance," AOB 21 n.11, but they do not explain how it has any effect on their appeal. Their primary argument is that if the bar is not jurisdictional, then their "pending amended complaint" would be the "subject of a first-to-file analysis" rather than their original complaint. *Id.* But that contention is patently incorrect. They ignore the plain text of the statute, which, as explained *supra* at 24–27, independently requires courts to examine the later-filing relator's original complaint in conducting the first-to-file analysis. Even courts that do not treat the bar as jurisdictional reach the same conclusion: the bar's text itself requires analyzing the original complaint. *Mohajer*, 525 F. Supp. 3d at 459; *Shea*, 160 F. Supp. 3d at 30; *see Hayes*, 853 F.3d at 86 (Second Circuit decision holding bar is not jurisdictional); *Heath*, 791 F.3d at 120 (D.C. Circuit decision holding bar is not jurisdictional).

Appellants' citation to the Third Circuit's *Plavix* decision does not change the analysis. AOB 21 n.11. They note that *Plavix* held that the bar does not prevent parties from "amending a complaint to add, remove, or swap relators." *Plavix*, 974 F.3d at 236. While the Third Circuit does not treat the first-to-file bar

as jurisdictional, the holding Stein and Bone cite from *Plavix* has nothing to do with jurisdiction. Rather, it concerns the part of the bar that prohibits a relator from intervening in an existing *qui tam* action. *Id.* Their appeal admittedly does not concern intervention.

Stein and Bone also contend that whether the bar is jurisdictional is important because, as a general matter, a plaintiff has the burden of persuasion when a complaint is subjected to a jurisdictional attack, while a defendant bears the burden otherwise on a motion to dismiss. *See* AOB 21 n.11. That may generally be true, but Stein and Bone fail to explain how a shift in burden would have had any bearing on the district court's analysis here, which was indistinguishable from an analysis under a traditional motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim. *See Ashcroft v. Iqbal*, 556 U.S. 662, 678–79 (2009) (court must accept factual allegations as true on motion to dismiss for failure to state a claim); *United States ex rel. Lee v. Corinthian Colls.*, 655 F.3d 984, 998 (9th Cir. 2011) (courts generally "may not consider any material beyond the pleadings in ruling on a Rule 12(b)(6) motion"). Indeed, the district court never doubted the truth of any complaint's allegations and affirmatively declined to consider "evidence outside of the complaints" in conducting the analysis, stating that "only the complaints should be considered in determining whether the first-to-file bar applies." 1-ER-33.

Finally, even if this Court does examine the amended *Stein* complaint in conducting the first-to-file analysis, it should affirm because the earlier-filed complaints encompass the AA fraud alleged in the amended complaint. *See infra* at 46–49. There is no scenario, then, in which the jurisdictional question materially affects the outcome of this appeal, further counseling in favor of denying the request for an initial hearing en banc.[12]

B. The FCA's first-to-file bar required the district court to dismiss *Stein*.

Regardless of whether the district court examined the original or amended complaint in its analysis, the first-to-file bar required dismissal of *Stein* because it is based on the same material elements of fraud as alleged in the earlier-filed complaints.

1. The first-to-file bar requires dismissal of *qui tam* suits that allege the same material elements of fraud as an earlier suit.

The FCA incentivizes private individuals to alert the United States to potential fraud by bringing a *qui tam* complaint. But Congress understood that only a single complaint is needed to serve this purpose—where two suits raise "essentially the same claims, permitting the second suit to go forward [i]s not necessary to alert the government to the underlying facts of a fraudulent scheme."

[12] Denying this extraordinary request also will not prejudice Stein and Bone in the least; they are free, of course, to petition for rehearing en banc if appropriate once the three-judge panel assigned to this case decides this appeal.

Campbell v. Redding Med. Ctr., 421 F.3d 817, 822 (9th Cir. 2005). Congress sought to preclude duplicative *qui tam* suits when it amended the FCA in 1986 to add the first-to-file bar. Under the bar, once a relator brings a *qui tam* action, "no person other than the Government may … bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5).

The first-to-file bar absolutely prohibits *qui tam* suits that allege "the ***same material elements*** of fraud" as an earlier *qui tam* suit, even if the allegations "incorporate somewhat different details." *Lujan*, 243 F.3d at 1189. The focus of the analysis is whether the United States "has enough information to discover related frauds" once it "knows the essential facts of a fraudulent scheme." *Id.*; *see United States ex rel. Batiste v. SLM Corp.*, 659 F.3d 1204, 1209 (D.C. Cir. 2011) (first-to-file bar applied where "the allegations of the first complaint [gave] the government grounds to investigate all that is in the second").

This Court has already rejected a more narrow test under § 3730(b)(5) that asks whether the two actions share "identical facts." *Hartpence*, 792 F.3d at 1130. Indeed, the statute speaks of "related," not "identical," actions. *Lujan*, 243 F.3d at 1189 (citing 31 U.S.C. § 3730(b)(5)). In *Lujan*, the Ninth Circuit found that a bar only of "identical" actions would "decrease incentives to promptly bring qui tam actions," allow "recovery for the same conduct," and permit FCA claims to proceed that "have no additional benefit for the government." *Id.*

Because the first-to-file bar is broad, "simply adding factual details … to the essential or material elements of a fraud claim" will not save a subsequent *qui tam* suit from dismissal. *Branch*, 560 F.3d at 378; *see also United States ex rel. Marion v. Heald Coll., LLC*, 2015 WL 4512843, at *3 (N.D. Cal. July 24, 2015). The relator in *Marion*, for example, was one of several whistleblowers who alleged that a for-profit college had defrauded the U.S. Department of Education. 2015 WL 4512843, at *2. She argued that the first-to-file bar should not apply to her later-filed complaint because, unlike any earlier complaint, it detailed a scheme to enroll "phantom students" without their consent and collect financial aid on their behalf. *Id.* at *3. Though her allegations on this point were admittedly "more detailed" than earlier *qui tam* complaints, the court held that the first-to-file bar required dismissal of her complaint because an earlier complaint had referenced the defendant's collection of student aid for "improperly enrolled students," and thus the "phantom student" allegation was just a factual variation on the same scheme. *See id.*

Nor will geographic or temporal differences between complaints suffice to overcome the bar. *Batiste*, 659 F.3d at 1209. In *Batiste*, the first relator alleged a company-wide fraud but argued that it stopped at his particular office. *Id.* A subsequent relator alleged an ongoing fraud at a different regional office of the company. *Id.* Such differences were "immaterial," the D.C. Circuit reasoned,

because if the United States had investigated the alleged fraud in the first-filed complaint "on a nationwide basis," it would have discovered continuing fraud at the second relator's office. *Id.* Although the relators worked for different subsidiaries, both alleged that the same fraudulent activities occurred at their respective offices and that the company's policies promoted the fraudulent behavior. *Id.*

Relators likewise cannot avoid dismissal under § 3730(b)(5) by naming "different members of the same corporate family," *In re Nat. Gas Royalties Qui Tam Litig.*, 566 F.3d 956, 962 (10th Cir. 2009), especially where the first-filed complaint alleges a "corporate-wide problem" that would give the United States grounds to investigate all corporate entities, *United States ex rel. Hampton v. Columbia/HCA Healthcare Corp.*, 318 F.3d 214, 218 (D.C. Cir. 2003).

2. The district court properly dismissed *Stein* based on the first-to-file bar's material-elements test.

The district court properly applied the Ninth Circuit's material-elements test in comparing Appellants' initial complaint to the earlier-filed *qui tam* complaints. *See* 1-ER-18–20. Notably, Stein and Bone do not contend that they have alleged a fraud scheme broader in geographic or temporal scope than that asserted in earlier-filed actions; rather, they contend that they have alleged methods of committing

fraud that the relators in *Osinek*, *Taylor*, and *Arefi* did not allege.[13] But Stein and Bone would make the first-to-file inquiry too granular. *Osinek*, *Taylor*, and *Arefi* all asserted a scheme to knowingly falsify diagnosis codes submitted to CMS to receive improper risk-adjustment payments from the Medicare Advantage program that would have put the United States on the trail of *Stein*'s similar upcoding allegations about specific medical conditions.

a. Sepsis

The district court correctly concluded that the first-to-file bar required dismissal of *Stein*'s cause of action based on the alleged submission of false

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[13] In a conclusory footnote, Stein and Bone contend that Kaiser is "collaterally estopped from arguing that *Arefi* can be a first-to-file bar because there was [a] judicial determination that *Arefi* was jurisdictionally defective." AOB 35 n.16. The *Arefi* Relators did not oppose the first-to-file motion, and the court dismissed their complaint in its entirety. 1-ER-48. Stein and Bone do not explain how collateral estoppel, which prevents relitigation of issues already decided, would apply here. *See McQuillion v. Schwarzenegger*, 369 F.3d 1091, 1096 (9th Cir. 2004) (explaining the three factors courts consider before applying collateral estoppel). Defendants are not attempting to relitigate whether the first-to-file bar applies to *Arefi*.

In addition, because *Arefi* was pending when *Stein* was filed, the fact that the *Arefi* Relators did not oppose the first-to-file motion and the district court dismissed their complaint does not mean the *Arefi* complaint could not bar the *Stein* complaint, or that the district court could not have so concluded. *See Lujan*, 243 F.3d at 1188 (concluding that subsequently dismissed *qui tam* action "should still be considered a 'pending' action for purposes of § 3730(b)(5)" because it had not yet been dismissed when the second *qui tam* action was filed); *United States ex rel. Shea v. Cellco P'ship*, 863 F.3d 923, 930 (D.C. Cir. 2017) (holding that a later-filed *qui tam* action was "incurably flawed from the moment [the relator] filed it" because the earlier-filed *qui tam* was "pending" at the time of the filing).

diagnosis codes for sepsis. The crux of *Stein*'s sepsis allegations is that Defendants inappropriately diagnosed sepsis, primarily in the hospital setting, by using a flawed diagnostic standard and then reported corresponding diagnosis codes for sepsis to CMS to support risk-adjustment payments. 7-ER-1515–18. The relevant inquiry is whether the United States would have had sufficient notice to investigate these allegations based on the earlier-filed *qui tam* complaints. *See Lujan*, 243 F.3d at 1189.

Osinek, *Taylor*, and *Arefi* all alleged fraud schemes about upcoding high-value medical conditions that would have led the government to discover the sepsis fraud alleged in *Stein*. Osinek alleged that Kaiser engaged in a widespread scheme to make Medicare Advantage members seem less healthy than they actually were, including by using internal guidance and policies to encourage diagnosis coding of medical conditions that should not have been coded and that members' symptoms did not reflect. 8-ER-1752, -1757–59, -1761–63. Taylor alleged that Defendants across the country flouted diagnosis coding guidelines, diagnosing members with medical conditions they did not have, that were not addressed in face-to-face visits with appropriate healthcare providers, and that were not supported by medical record documentation. 8-ER-1643, -1658. And the *Arefi* Relators asserted a fraud scheme against over ten Kaiser-affiliated entities across the country—including Kaiser Foundation Hospitals—based on their use of diagnostic criteria "that find

no support in medical literature or accepted standards of medical or coding practice." 8-ER-1548–50. Notably, the *Arefi* Relators ***specifically*** allege that Defendants' scheme resulted in improper diagnosing of both septicemia and sepsis. 8-ER-1550–51, -1574.

If the United States investigated these allegations about upcoding high-value medical conditions for Medicare Advantage members—including upcoding of medical conditions by using ***improper diagnostic criteria***, upcoding in ***hospital settings***, and upcoding of ***sepsis***—there is no question that the United States would have discovered the alleged sepsis upcoding fraud that *Stein* alleges occurred in the hospital setting by using improper diagnostic criteria. *Stein*'s sepsis allegations do not detail an independent fraud scheme based on materially different facts; rather, those allegations are "lesser-included conduct" of the broader upcoding scheme alleged in *Osinek*, *see* 1-ER-42, and then again in *Taylor* and *Arefi*. In other words, *Stein*'s sepsis allegations are no more than a "factual detail[]" that is indistinguishable from "the essential or material elements" of the same alleged scheme asserted in preceding *qui tam* actions. *See Branch*, 560 F.3d at 378; *Marion*, 2015 WL 4512843, at *3.

Appellants' arguments to the contrary are not persuasive. They insist that they were the first to allege a sepsis-related fraud, noting how their sepsis allegations "span 24 pages," whereas *Osinek* and *Taylor* do not explicitly reference

sepsis and *Arefi* mentioned sepsis only three times. AOB 34–36. They argue that this distinction "makes it very unlikely that *Stein*'s detailed sepsis fraud claims share the same or similar material elements" as the earlier-filed complaints. *Id.* at 36. But simply because the earlier-filed actions did not refer to sepsis or did not do so in the same detail as *Stein* does not mean they could not have put the United States on notice of facts that would have uncovered the alleged sepsis fraud. Tallying the number of times each complaint references "sepsis" is not a principled way to differentiate the allegations, but rather a transparent attempt to reduce the first-to-file analysis to an identical facts test, which the Ninth Circuit already has rejected. *See Lujan*, 243 F.3d at 1189.

Stein and Bone also argue that the alleged sepsis scheme occurred in the hospital setting, and did not turn on the use of "leading coding queries," "refresh," "addenda," or computer programs and "algorithms," AOB 37–39, all of which Osinek includes within the scope of her alleged upcoding scheme. As the district court expressly concluded, however, "nothing about *Osinek* excepts a hospital setting," and *Osinek* was not limited to these particular practices. 1-ER-43. Rather, "*Osinek* asserts that upcoding was improper because it was based on exploiting high-value [medical] conditions," 1-ER-42—precisely the fraud theory that Stein and Bone alleged with regard to sepsis diagnoses. In addition, *Arefi* specifically named Kaiser Foundation Hospitals as a defendant, 8-ER-1556, and

Taylor made clear that the alleged fraud applied to hospitals associated with the Defendants' health plans, *see* 8-ER-1647, -1666, -1679.

b. Malnutrition

For similar reasons, the first-to-file bar also required the district court to dismiss Appellants' cause of action based on a scheme to submit false diagnoses for malnutrition. Stein and Bone alleged that Defendants submitted malnutrition diagnosis codes to CMS that were not supported by an appropriate provider type—specifically, physicians "rubber stamped" diagnoses made by dieticians rather than diagnose members themselves after face-to-face visits. 7-ER-1524–27.

The upcoding schemes alleged in the earlier-filed actions gave the United States all the information it needed to discover the alleged malnutrition scheme in *Stein*. Osinek alleged a scheme to diagnose high-value medical conditions, specifically through means such as diagnosing conditions without necessary support or documentation. 8-ER-1761–62. And she specifically alleged that the scheme implicated two types of malnutrition conditions: cachexia and protein calorie malnutrition. 8-ER-1757–58. Taylor specifically accused Defendants of submitting diagnosis codes for medical conditions not diagnosed by the appropriate provider type and not diagnosed as a result of face-to-face visits, 8-ER-1643, 1676, 1680, just as *Stein* alleged occurred with malnutrition diagnoses. Taylor also specifically alleged that "false claim[s] resulted from Kaiser coders

and/or computer systems adding a malnutrition diagnosis where the treating [healthcare providers] had not." 8-ER-1676. The *Arefi* Relators raised concerns about malnutrition diagnosis coding in particular and alleged that Defendants' upcoding scheme resulted in the submission to CMS of inappropriate diagnosis codes for protein calorie malnutrition. 8-ER-1577.

Stein and Bone argue that they alleged an "independent fraud" related to malnutrition, AOB 42, but none of their arguments withstands scrutiny. Similar to their sepsis argument, they recount the number of times each of the earlier-filed complaints referenced malnutrition—three times in *Osinek*, three times in *Taylor*, and five times in *Arefi*—and tout how their complaint referenced malnutrition "54 times." AOB 39–40. But this counting argument proves too much: under the material-elements test, "simply adding factual details … to the essential or material elements of a fraud claim" will not save a later-filed *qui tam* action from dismissal. *Branch*, 560 F.3d at 378; *Marion*, 2015 WL 4512843, at *3.

Stein and Bone also assert that "none of the malnutrition references" in the earlier-filed complaints "relate[s] to the material elements of Stein's malnutrition claim." AOB 41. But aside from describing their allegations about how providers purportedly "rubber stamped" dieticians' malnutrition diagnoses, Stein and Bone fail to explain the "material elements" of this malnutrition scheme. If a material element is that the alleged malnutrition fraud occurred "contemporaneously with

the MA patient's hospital admission," AOB 42, then that detail is of no help. The district court properly found that the upcoding scheme alleged in *Osinek* is not limited to the outpatient setting. *See* 1-ER-43. And, as explained *supra* at 43–44, *Taylor* and *Arefi* both encompass fraud schemes that occurred in the hospital setting.

As the district court correctly found, Appellants' malnutrition allegations—which focus on a particular high-value medical condition but "implicate[] the same kind of conduct" as *Osinek*—are part and parcel of *Osinek*'s alleged upcoding scheme, 1-ER-42–43, which *Taylor* and *Arefi* then also alleged on an even broader geographic scale.

c. Aortic Atherosclerosis

Finally, Stein and Bone argue that their cause of action based on an alleged scheme to submit false diagnosis codes for AA survives the first-to-file bar. AOB at 43. This argument fails at the outset because Stein and Bone did not bring their AA allegations in their original complaint, and the district court correctly concluded that the first-to-file analysis must focus on their original complaint. *See supra* at 24–36. Even if the rule were otherwise, however, their AA allegations still would be barred because they are not materially different from the fraud alleged in the earlier-filed *qui tam* complaints.

Stein and Bone alleged that Defendants submitted diagnosis codes for AA to

CMS any time a healthcare provider noted the existence of AA in the medical record, which ran afoul of diagnosis coding rules requiring diagnoses to be made as a result of face-to-face visits and not solely as a result of, for example, findings from diagnostic tests such as x-rays. 6-ER-1097–1100.

As the district court properly concluded, those AA allegations "overlap with the *Osinek* complaint," and the "nature" of the AA allegations is "similar" to *Osinek*'s upcoding allegations "such that AA is a condition that the government likely would have investigated given *Osinek*'s description of Kaiser exploiting high-value conditions." 1-ER-43. Taylor also specifically faulted Defendants for submitting diagnosis codes to CMS in the absence of face-to-face visits and "where the only documentation to support the diagnosis was a radiologic or lab test." 8-ER-1680. The *Arefi* Relators similarly criticized Defendants for not complying with diagnosis coding guidelines that supposedly prohibited the reporting to CMS of diagnosis codes for medical "conditions that either did not exist at the time of a face-to-face physician encounter or were not being currently treated." 8-ER-1549–50.

Appellants' attempts to distinguish their AA allegations are to no avail. Their allegations that certain Defendants submitted AA diagnosis codes to CMS whenever AA was observed in an x-ray or listed in a medical record are, again, no more than a factual nuance encompassed by Osinek's broader allegation that

Defendants submitted diagnosis codes for complex medical conditions without proper support in the record. *Compare* 8-ER-1757–59, -1762–63, *with* 6-ER-1097–1100. Similarly, Appellants' allegation that AA was inappropriately coded based on test results is simply a variation on Osinek's allegation that Defendants instructed healthcare providers to review previous test results to support diagnoses, *compare* 8-ER-1760–61, *with* 6-ER-1098–99, as well as Taylor's allegation about diagnosing medical conditions based solely on diagnostic testing or radiologic exams, 8-ER-1680.

It also makes no difference that Appellants' AA allegations "do[] not utilize computer data mining of prior year's diagnoses," nor rely on "improper leading queries." AOB 43–44. The district court correctly found that *Osinek* was not limited to fraud based on "data mining" and "query" schemes. Instead, "*Osinek* asserts that upcoding was improper because it was based on exploiting high-value conditions," including by, "*e.g.*, exaggerating a patient's condition, diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a condition for which the patient was not treated, diagnosing without the necessary support/documentation, and the like." 1-ER-42. The district court correctly concluded that, "[b]ased on *Osinek*, the government was put on notice that high-value conditions"—such as AA—"often did not have proper support and were diagnosed even when a patient was not treated for that condition at the time

of service." 1-ER-37–38.

Stein and Bone also attempt to cast doubt on the district court's conclusions by arguing that *Osinek*, *Taylor*, and *Arefi* do not specifically mention AA with what Stein and Bone deem to be sufficient frequency. AOB 43. Again, a counting exercise is not meaningful to the first-to-file inquiry. As discussed with regard to the sepsis and malnutrition allegations, it also does not matter that Stein and Bone alleged that the purported AA scheme occurred in the hospital setting or that AA was not a target of the alleged "refresh" scheme. AOB 43–44. *Osinek*, *Taylor*, and *Arefi* do not except a hospital setting from the alleged upcoding scheme. *See supra* at 43–44, 45–46.

As with their sepsis and malnutrition allegations, Appellants' AA allegations are no more than a factual nuance encompassed by the earlier-filed actions' broader allegations that Defendants submitted diagnosis codes for complex medical conditions without proper support in order to obtain higher risk-adjustment payments from the Medicare Advantage program. The district court properly dismissed the AA allegations under the first-to-file bar.

3. The district court's application of the first-to-file bar's material-elements test was not "overly broad."

Throughout their Opening Brief, Stein and Bone repeatedly caution this Court against adopting an "overly broad application" of the first-to-file bar, contending that the district court engaged in an "extremely generalized" analysis

that is disfavored by Ninth Circuit precedent. AOB 23, 37, 41–42. They cite language in *Hartpence*, *Campbell*, and *United States ex rel. Mateski v. Raytheon Co.*, 816 F.3d 565 (9th Cir. 2016), to support their contention. AOB 23–24. But none of these cases suggests that the district court erred in applying the bar here.

Stein and Bone first point to *Hartpence*'s statement that "allowing claims for related but distinct fraud claims … increases the total potential for recovery," but that was tied to the Court's conclusion that the later-filing relator in that case "provided information about a ***different*** form of fraud," without which "the government might ***not*** have investigated" beyond the fraud alleged in the earlier-filed *qui tam* complaint. 792 F.3d at 1131–32. That is not the case here. The fraud alleged by Stein and Bone was ***not*** different from the scheme alleged in the earlier-filed complaints for all the reasons explained *supra* at 39–49.

Campbell's statement that "an overly broad interpretation of the first-to-file bar, allowing even sham complaints to preclude subsequent meritorious complaints in a public disclosure case," 421 F.3d at 821, also does not aid Stein and Bone. *Campbell* involved a factual situation not at issue here—whether an earlier-filed complaint that is barred by the FCA's public-disclosure bar can bar a later-filed complaint under the first-to-file bar. *Id.* at 818. The concern about overbreadth in *Campbell* related to the unfairness and bad policy of dismissing a later-filed lawsuit on the basis of a complaint filed by a non-original source, who by

definition "does not 'alert[] the government to the essential facts of a fraudulent scheme.'" *Id.* at 822 (quoting *Lujan*, 243 F.3d at 1188). That concern does not apply to a later-filed complaint based on the same material elements as an earlier-filed complaint—and particularly not here, where five relators in three earlier actions put the United States on notice of the same conduct that Stein and Bone later raised in their action.

Mateski is even further afield. There, the Ninth Circuit cautioned against viewing complaints "at the highest level of generality … in order to wipe out *qui tam* suits that rest on genuinely new and material information." 816 F.3d at 576. As Stein and Bone concede, that case also involved the public-disclosure bar, not the first-to-file bar. Stein and Bone argue, without explanation, that *Mateski*'s rationale should apply in first-to-file cases. AOB 24. But there is good reason to distinguish the two rules—they are different statutes with different purposes and serve different legislative objectives. The public-disclosure bar prevents opportunistic lawsuits based on publicly disclosed information from any relator who is not an "original source," and applies irrespective of whether one or more relators also bring FCA claims. *See Mateski*, 816 F.3d at 570. The first-to-file bar, on the other hand, prevents duplicative lawsuits filed by later-in-time relators to ensure that multiple relators do not expect recovery for alleging the same essential misconduct, "thereby decreasing the total amount each relator would potentially

receive and [decreasing] incentives to bring the suit." *See Lujan*, 243 F.3d at 1189.

In any event, the district court here did not view the complaints "at the highest level of generality." *See Mateski*, 816 F.3d at 576. It is not as if the court simply concluded that because *Osinek* alleged fraud on Medicare, the first-to-file bar required dismissal of all later-filed *qui tam* actions alleging fraud on Medicare. Rather, the court made its decision after comparing complaints that all involve a specific group of entities during a specific time period allegedly diagnosing and reporting to CMS risk-adjusting medical conditions for a specific group of patients under a specific part of the Medicare program. In addition, the district court recognized that the complaints had differences and evaluated those differences to determine whether they indeed qualified as distinct fraud schemes, sometimes concluding that they did (as with allegations about upcoding among external healthcare providers in *Taylor*, which survived the motion to dismiss), 1-ER-38–39, and sometimes concluding that they did not (as with upcoding allegations about sepsis and malnutrition in *Stein*, which did not survive the motion), 1-ER-42–43.

In arguing that the district court utilized too expansive a view of the allegations in the earlier-filed complaints, Stein and Bone essentially ask for the "identical facts" test rejected by this Court in *Lujan*. *See* 243 F.3d at 1188–89. But that is not the standard. *Id.* at 1189. The material-elements test governs the first-to-file analysis, and the district court correctly applied that test to the

allegations in the *qui tam* complaints before it. 1-ER-18–19 (quoting *Lujan*, 243 F.3d at 1188–89). This Court should affirm.

II. The Court Should Affirm the District Court's Denial of Leave to Amend

The district court properly dismissed *Stein* without leave to amend, in accord with the first-to-file bar's text and jurisdictional nature. Stein and Bone argue that the district court should have allowed them a chance to amend to "correct any deficiency" in their second amended complaint. AOB 46. But they failed to explain to the district court—as they fail to do here—how they would amend their complaint to cure their pleading defects. In the face of a statute requiring dismissal, amendment would be futile. *See Chinatown Neighborhood Ass'n v. Harris*, 794 F.3d 1136, 1144 (9th Cir. 2015) (district court may deny leave to amend when proposed amendments are "futile").

Appellants' "position that a violation of the first-to-file bar can be cured by the filing of an amended pleading is inconsistent with the language of the statute." *Wood*, 899 F.3d at 171. "As a general rule, if an action is barred by the terms of a statute, it must be dismissed." *Hallstrom*, 493 U.S. at 31. The first-to-file bar expressly states that no private individual may "bring a related action" when an FCA action is "pending." 31 U.S.C. § 3730(b)(5). The "clear import of the language is that dismissal is required. … [A]n action cannot be *brought* while a first-filed action is pending." *Wood*, 899 F.3d at 171–72 (emphasis in original).

The Supreme Court concurs, noting that the first-to-file bar is one of "a number of provisions [in the FCA] that do require, in express terms, the dismissal of a relator's action." *State Farm Fire & Cas. Co. v. United States ex rel. Rigsby*, 580 U.S. 26, 34 (2016).

Based on the bar's text, the D.C., Second, and Eleventh Circuits all have held that amendment cannot cure a first-to-file bar violation; the barred action must be dismissed. *Cho*, 30 F.4th at 1042 ("Relators cannot evade the first-to-file bar by amending their pleading[.]"); *Wood*, 899 F.3d at 175 ("a first-to-file violation cannot be cured by amending or supplementing a complaint"); *Shea*, 863 F.3d at 929 ("A supplemental or amended complaint … could not remedy Shea's violation of the first-to-file bar.").[14] The Seventh Circuit similarly has held that "a related action based on the facts underlying the pending action must be dismissed rather

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[14] In *United States ex rel. Gadbois v. PharMerica Corp.*, the First Circuit considered a district court's dismissal of a relator's action under the first-to-file bar. 809 F.3d 1, 3 (2015). While on appeal, the first-filed action settled and was dismissed, so there was no longer any first-filed "pending" action. *Id.* at 4. The First Circuit remanded the case with instructions for the district court to consider a motion for leave to file an amended and supplemental complaint, reasoning that to require dismissal and refiling would be a "pointless formality." *Id.* at 6. To the extent *Gadbois* suggests that a relator can cure a first-to-file violation through amendment, it is unpersuasive. First, *Osinek* and *Taylor* are still pending, so the procedural circumstances present in *Gadbois* are not present here. Second, after *Gadbois* was decided, the Supreme Court stated in *Rigsby* that the first-to-file bar requires dismissal of a relator's action, which *Gadbois* did not have occasion to consider. *Rigsby*, 580 U.S. at 34. Third, as the Eleventh Circuit recently observed, *Gadbois* is "unpersuasive" because "it did not explain how its reading comports with the plain language of the first-to-file bar." *Cho*, 30 F.4th at 1041 n.3.

than stayed." *Chovanec*, 606 F.3d at 362.

The jurisdictional nature of the bar also supports that a relator cannot attempt to amend itself out of a first-to-file violation. "Subject matter jurisdiction must exist as of the time the action is commenced," *Morongo Band of Mission Indians*, 858 F.2d at 1380, so a relator cannot amend a complaint in a jurisdictionally barred action to create jurisdiction that did not exist originally, *see Carter*, 144 F. Supp. 3d at 881.

In addition, all of the practical and policy reasons why a relator's amended complaint cannot govern the first-to-file analysis also demonstrate why a relator should not be able to cure first-to-file violations through amendment. *See supra* at 26–27. Indeed, allowing relators to cure first-to-file violations through amendment could "create problematic inefficiencies," leaving first-to-file determinations to depend largely on "idiosyncrasies of the judge the case is before or the district the case is in" and the timing of amendment. *Wood*, 899 F.3d at 173. And if an amended complaint could cure first-to-file violations, then relators "could simply file unlimited related actions and keep each one 'on ice' until the case before it is dismissed, allowing the next case to take its turn. That would force defendants to defend the same claim again and again." *Id.* at 173–74.

Stein and Bone fail to explain how the district court abused its discretion by denying leave to amend. They again fail to grapple with the bar's text or address

any of the practical challenges that would arise if the Court adopted their reasoning. *See* AOB 45–46. As they did below, they simply argue that the district court should have granted them leave to amend because such leave should be freely given under Federal Rule of Civil Procedure 15. AOB 45; 2-ER-161. They do not acknowledge that the great weight of authority already has concluded that a relator cannot cure first-to-file violations through amendment. *See id.* None of the cases they cite about leave to amend concerns amendment in the first-to-file context.[15] And Stein and Bone have never provided an explanation about how they would amend their complaint with factual allegations that avoid a first-to-file violation. Defendants submit that Stein and Bone have not done so because they cannot—given the bar's text and jurisdictional nature, amendment would be futile.

CONCLUSION

The Court should affirm the district court's dismissal of Appellants' FCA action pursuant to 31 U.S.C. § 3730(b)(5).

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[15] *See Lee*, 655 F.3d at 995–96 (considering whether trial court abused its discretion in denying FCA relator leave to amend to plead additional facts to allege a "false statement"); *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 701 (9th Cir. 1990) (considering whether trial court abused its discretion in denying plaintiff leave to amend to assert an equal protection cause of action); *Schreiber Distrib. Co. v. Serv-Well Furniture Co.*, 806 F.2d 1393, 1401 (9th Cir. 1986) (considering whether trial court abused its discretion in denying plaintiff leave to amend RICO causes of action).

Dated: February 24, 2023

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 17. Statement of Related Cases
Pursuant to Circuit Rule 28-2.6

9th Cir. Case Number 22-15862

The undersigned attorney or self-represented party states the following:

[X] I am unaware of any related cases currently pending in this court.

[ ] I am unaware of any related cases currently pending in this court other than the case(s) identified in the initial brief(s) filed by the other party or parties.

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Signature: */s/ K. Lee Blalack, II*
Date: February 24, 2023

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 8. Certificate of Compliance for Briefs

9th Cir. Case Number 22-15862

I am the attorney or self-represented party.

This brief contains 13,563 words, excluding the items exempted by Fed. R. App. P. 32(f). The brief's type size and typeface comply with Fed. R. App. P. 32(a)(5) and (6).

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Signature: */s/ K. Lee Blalack, II*
Date: February 24, 2023

ADDENDUM

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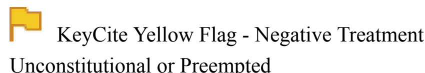
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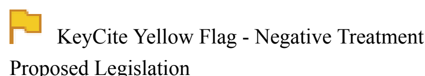
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Proposed Legislation

United States Code Annotated
Title 31. Money and Finance (Refs & Annos)
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31 U.S.C.A. § 3730

§ 3730. Civil actions for false claims

Effective: July 22, 2010
Currentness

(a) Responsibilities of the Attorney General.--The Attorney General diligently shall investigate a violation under section 3729. If the Attorney General finds that a person has violated or is violating section 3729, the Attorney General may bring a civil action under this section against the person.

(b) Actions by private persons.--(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure. [1] The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall--

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) Rights of the parties to qui tam actions.--(1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2)(A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as--

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the Government's expense). When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the Government to intervene at a later date upon a showing of good cause.

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(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the United States, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(d) Award to qui tam plaintiff.--(1) If the Government proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting [2] Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of section 3729, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

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(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) Certain Actions Barred.--(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2)(A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, “senior executive branch official” means any officer or employee listed in paragraphs (1) through (8) of section 101(f) of the Ethics in Government Act of 1978 (5 U.S.C. App.).

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed--

(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, “original source” means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

(f) Government not liable for certain expenses.--The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) Fees and expenses to prevailing defendant.--In civil actions brought under this section by the United States, the provisions of section 2412(d) of title 28 shall apply.

(h) Relief from retaliatory actions.--

(1) In general.--Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop 1 or more violations of this subchapter.

(2) Relief.--Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection.

(3) Limitation on bringing civil action.--A civil action under this subsection may not be brought more than 3 years after the date when the retaliation occurred.

CREDIT(S)

(Pub.L. 97-258, Sept. 13, 1982, 96 Stat. 978; Pub.L. 99-562, §§ 3, 4, Oct. 27, 1986, 100 Stat. 3154, 3157; Pub.L. 100-700, § 9, Nov. 19, 1988, 102 Stat. 4638; Pub.L. 101-280, § 10(a), May 4, 1990, 104 Stat. 162; Pub.L. 103-272, § 4(f)(1)(P), July 5, 1994, 108 Stat. 1362; Pub.L. 111-21, § 4(d), May 20, 2009, 123 Stat. 1624; Pub.L. 111-148, Title X, § 10104(j)(2), Mar. 23, 2010, 124 Stat. 901; Pub.L. 111-203, Title X, § 1079A(c), July 21, 2010, 124 Stat. 2079.)

Notes of Decisions (2635)

Footnotes

1 See, now, Rule 4(i) of the Federal Rules of Civil Procedure.

2 So in original. Probably should be “Accountability”.

31 U.S.C.A. § 3730, 31 USCA § 3730
Current through P.L. 117-262. Some statute sections may be more current, see credits for details.

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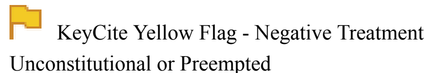
Enacted Legislation Note in PL 117-286, December 27, 2022, 136 Stat 4196,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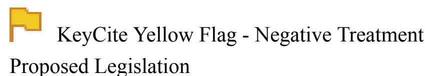
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Proposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XVIII. Health Insurance for Aged and Disabled (Refs & Annos)
Part C. Medicare+Choice Program (Refs & Annos)

42 U.S.C.A. § 1395w-23

§ 1395w-23. Payments to Medicare+Choice organizations

Effective: February 9, 2018
Currentness

(a) Payments to organizations

(1) Monthly payments

(A) In general

Under a contract under section 1395w-27 of this title and subject to subsections (e), (g), (i), and (l) and section 1395w-28(e)(4) of this title, the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

(i) Payment before 2006

For years before 2006, the payment amount shall be equal to $^{1}/_{12}$ of the annual MA capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1395w-24(f)(1)(E) of this title.

(ii) Payment for original fee-for-service benefits beginning with 2006

For years beginning with 2006, the amount specified in subparagraph (B).

(B) Payment amount for original fee-for-service benefits beginning with 2006

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(i) Payment of bid for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) Payment of benchmark for plans with bids at or above benchmark

In the case of a plan for which there are no average per capita monthly savings described in section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) Payment of benchmark for MSA plans

Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C).

(iv) Authority to apply frailty adjustment under PACE payment rules for certain specialized MA plans for special needs individuals

(I) In general

Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1395eee(d) of this title (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) Plan described

A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1395w-28(b)(6)(B)(ii) of this title that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.

(C) Demographic adjustment, including adjustment for health status

(i) In general

Subject to subparagraph (I), the Secretary shall adjust the payment amount under subparagraph (A)(i) and the amount specified under subparagraph (B)(i), (B)(ii), and (B)(iii) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status under

paragraph (3), so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

(ii) Application of coding adjustment

For 2006 and each subsequent year:

(I) In applying the adjustment under clause (i) for health status to payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part [1] A and B to the extent that the Secretary has identified such differences.

(II) In order to ensure payment accuracy, the Secretary shall annually conduct an analysis of the differences described in subclause (I). The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years. In conducting such analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

(III) In calculating each year's adjustment, the adjustment factor shall be for 2014, not less than the adjustment factor applied for 2010, plus 1.5 percentage points; for each of years 2015 through 2018, not less than the adjustment factor applied for the previous year, plus 0.25 percentage point; and for 2019 and each subsequent year, not less than 5.9 percent.

(IV) Such adjustment shall be applied to risk scores until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data.

(iii) Improvements to risk adjustment for special needs individuals with chronic health conditions

(I) In general

For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for special needs individuals (as defined in section 1395w-28(b)(6) of this title).

(II) Individuals described

An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(III) Evaluation

For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

(IV) Publication of evaluation and revisions

The Secretary shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.

(D) Separate payment for Federal drug subsidies

In the case of an enrollee in an MA-PD plan, the MA organization offering such plan also receives--

(i) subsidies under section 1395w-115 of this title (other than under subsection (g) [2]); and

(ii) reimbursement for premium and cost-sharing reductions for low-income individuals under section 1395w-114(c)(1)(C) of this title.

(E) Payment of rebate for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w-24(b)(3)(C) or 1395w-24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is the amount of the monthly rebate computed under section 1395w-24(b)(1)(C)(i) of this title for that plan and year (as reduced by the amount of any credit provided under section 1395w-24(b)(1)(C)(iv) of this title).

(F) Adjustment for intra-area variations

(i) Intra-regional variations

In the case of payment with respect to an MA regional plan for an MA region, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such region.

(ii) Intra-service area variations

In the case of payment with respect to an MA local plan for a service area that covers more than one MA local area, the Secretary shall also adjust the amounts specified under subparagraphs (B)(i) and (B)(ii) in a manner to take into account variations in MA local payment rates under this part among the different MA local areas included in such service area.

(G) Adjustment relating to risk adjustment

The Secretary shall adjust payments with respect to MA plans as necessary to ensure that--

(i) the sum of--

(I) the monthly payment made under subparagraph (A)(ii); and

(II) the MA monthly basic beneficiary premium under section 1395w-24(b)(2)(A) of this title; equals

(ii) the unadjusted MA statutory non-drug monthly bid amount, adjusted in the manner described in subparagraph (C) and, for an MA regional plan, subparagraph (F).

(H) Special rule for end-stage renal disease

The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before December 8, 2003. In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1395rr(b)(7) of this title to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease. The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

(I) Improvements to risk adjustment for 2019 and subsequent years

(i) In general

In order to determine the appropriate adjustment for health status under subparagraph (C)(i), the following shall apply:

(I) Taking into account total number of diseases or conditions

The Secretary shall take into account the total number of diseases or conditions of an individual enrolled in an MA plan. The Secretary shall make an additional adjustment under such subparagraph as the number of diseases or conditions of an individual increases.

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(II) Using at least 2 years of diagnostic data

The Secretary may use at least 2 years of diagnosis data.

(III) Providing separate adjustments for dual eligible individuals

With respect to individuals who are dually eligible for benefits under this subchapter and subchapter XIX, the Secretary shall make separate adjustments for each of the following:

(aa) Full-benefit dual eligible individuals (as defined in section 1396u-5(c)(6) of this title).

(bb) Such individuals not described in item (aa).

(IV) Evaluation of mental health and substance use disorders

The Secretary shall evaluate the impact of including additional diagnosis codes related to mental health and substance use disorders in the risk adjustment model.

(V) Evaluation of chronic kidney disease

The Secretary shall evaluate the impact of including the severity of chronic kidney disease in the risk adjustment model.

(VI) Evaluation of payment rates for end-stage renal disease

The Secretary shall evaluate whether other factors (in addition to those described in subparagraph (H)) should be taken into consideration when computing payment rates under such subparagraph.

(ii) Phased-in implementation

The Secretary shall phase-in any changes to risk adjustment payment amounts under subparagraph (C)(i) under this subparagraph over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.

(iii) Opportunity for review and public comment

The Secretary shall provide an opportunity for review of the proposed changes to such risk adjustment payment amounts under this subparagraph and a public comment period of not less than 60 days before implementing such changes.

(2) Adjustment to reflect number of enrollees

(A) In general

The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) Special rule for certain enrollees

(i) In general

Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare+Choice organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

(ii) Exception

No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1395w-22(c) of this title at the time the individual enrolled with the organization.

(3) Establishment of risk adjustment factors

(A) Report

The Secretary shall develop, and submit to Congress by not later than March 1, 1999, a report on the method of risk adjustment of payment rates under this section, to be implemented under subparagraph (C), that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) Data collection

In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) Initial implementation

(i) In general

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The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) Phase-in

Except as provided in clause (iv), such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to--

(I) 10 percent of $^{1}/_{12}$ of the annual Medicare+Choice capitation rate in 2000 and each succeeding year through 2003;

(II) 30 percent of such capitation rate in 2004;

(III) 50 percent of such capitation rate in 2005;

(IV) 75 percent of such capitation rate in 2006; and

(V) 100 percent of such capitation rate in 2007 and succeeding years.

(iii) Data for risk adjustment methodology

Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iv) Full implementation of risk adjustment for congestive heart failure enrollees for 2001

(I) Exemption from phase-in

Subject to subclause (II), the Secretary shall fully implement the risk adjustment methodology described in clause (i) with respect to each individual who has had a qualifying congestive heart failure inpatient diagnosis (as determined by the Secretary under such risk adjustment methodology) during the period beginning on July 1, 1999, and ending on June 30, 2000, and who is enrolled in a coordinated care plan that is the only coordinated care plan offered on January 1, 2001, in the service area of the individual.

(II) Period of application

Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.

(D) Uniform application to all types of plans

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Subject to section 1395w-28(e)(4) of this title, the methodology shall be applied uniformly without regard to the type of plan.

(4) Payment rule for federally qualified health center services

If an individual who is enrolled with an MA plan under this part receives a service from a federally qualified health center that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1395w-27(e)(3) of this title)--

(A) the Secretary shall pay the amount determined under section 1395*l*(a)(3)(B) of this title directly to the federally qualified health center not less frequently than quarterly; and

(B) the Secretary shall not reduce the amount of the monthly payments under this subsection as a result of the application of subparagraph (A).

(b) Annual announcement of payment rates

(1) Annual announcements

(A) For 2005

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the second Monday in May of 2004, with respect to each MA payment area, the following:

(i) MA capitation rates

The annual MA capitation rate for each MA payment area for 2005.

(ii) Adjustment factors

The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in 2005.

(B) For 2006 and subsequent years

For a year after 2005--

(i) Initial announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the first Monday in April before the calendar year concerned, with respect to each MA payment area, the following:

(I) MA capitation rates; MA local area benchmark

The annual MA capitation rate for each MA payment area for the year.

(II) Adjustment factors

The risk and other factors to be used in adjusting such rates under subsection (a)(1)(C) for payments for months in such year.

(ii) Regional benchmark announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each MA region and each MA regional plan for which a bid was submitted under section 1395w-24 of this title, the MA region-specific non-drug monthly benchmark amount for that region for the year involved.

(iii) Benchmark announcement for CCA local areas

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each CCA area (as defined in section 1395w-29(b)(1)(A) of this title), the CCA non-drug monthly benchmark amount under section 1395w-29(e)(1) of this title for that area for the year involved.

(2) Advance notice of methodological changes

At least 45 days (or, in 2017 and each subsequent year, at least 60 days) before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity (in 2017 and each subsequent year, of no less than 30 days) to comment on such proposed changes.

(3) Explanation of assumptions

In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in such announcement.

(4) Continued computation and publication of county-specific per capita fee-for-service expenditure information

The Secretary, through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 426-1 of this title) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

(A) Total expenditures per capita per month, computed separately for part A and for part B.

(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).

(c) Calculation of annual Medicare+Choice capitation rates

(1) In general

For purposes of this part, subject to paragraphs (6)(C) and (7), each annual Medicare+Choice capitation rate, for a Medicare +Choice payment area that is an MA local area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), (C), or (D):

(A) Blended capitation rate

For a year before 2005, the sum of--

(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare +Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year, and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied (for a year other than 2004) by the budget neutrality adjustment factor determined under paragraph (5).

(B) Minimum amount

12 multiplied by the following amount:

(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area).

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002, 2003, and 2004, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(C) Minimum percentage increase

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and 2003, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(v) For 2004 and each succeeding year, the greater of--

(I) 102 percent of the annual MA capitation rate under this paragraph for the area for the previous year; or

(II) the annual MA capitation rate under this paragraph for the area for the previous year increased by the national per capita MA growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.

(D) 100 percent of fee-for-service costs

(i) In general

For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under sections, [3] 1395w-4(o), and [3] 1395ww(n) and 1395ww(h) of this title.

(ii) Periodic rebasing

The provisions of clause (i) shall apply for 2004 and for subsequent years as the Secretary shall specify (but not less than once every 3 years).

(iii) Inclusion of costs of VA and DOD military facility services to medicare-eligible beneficiaries

In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(2) Area-specific and national percentages

For purposes of paragraph (1)(A)--

(A) for 1998, the “area-specific percentage” is 90 percent and the “national percentage” is 10 percent,

(B) for 1999, the “area-specific percentage” is 82 percent and the “national percentage” is 18 percent,

(C) for 2000, the “area-specific percentage” is 74 percent and the “national percentage” is 26 percent,

(D) for 2001, the “area-specific percentage” is 66 percent and the “national percentage” is 34 percent,

(E) for 2002, the “area-specific percentage” is 58 percent and the “national percentage” is 42 percent, and

(F) for a year after 2002, the “area-specific percentage” is 50 percent and the “national percentage” is 50 percent.

(3) Annual area-specific Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), subject to subparagraphs (B) and (E), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area--

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

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(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) Removal of medical education from calculation of adjusted average per capita cost

(i) In general

In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) Applicable percent

For purposes of clause (i), the applicable percent for--

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) Payment adjustment

(i) In general

Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997--

(I) for the indirect costs of medical education under section 1395ww(d)(5)(B) of this title, and

(II) for direct graduate medical education costs under section 1395ww(h) of this title.

(ii) Treatment of payments covered under State hospital reimbursement system

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To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1395f(b)(3) of this title, the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

(D) Treatment of areas with highly variable payment rates

In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1395mm(a)(1)(C) of this title for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(E) Inclusion of costs of DOD and VA military facility services to Medicare-eligible beneficiaries

In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) Input-price-adjusted annual national Medicare+Choice capitation rate

(A) In general

For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare +Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of--

(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this subchapter that are used in applying (or updating) national payment rates for specific areas and localities.

(B) National standardized annual Medicare+Choice capitation rate

In subparagraph (A)(i), the “national standardized annual Medicare+Choice capitation rate” for a year is equal to--

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(i) the sum (for all Medicare+Choice payment areas) of the product of--

(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) Special rules for 1998

In applying this paragraph for 1998--

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii)--

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1395ww(d)(3)(E) of this title to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services--

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1395w-4(e) of this title used to adjust payment rates for physicians' services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

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The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) Payment adjustment budget neutrality factor

For purposes of paragraph (1)(A), for each year (other than 2004), the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iv), (a)(4), and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) "National per capita Medicare+Choice growth percentage" defined

(A) In general

In this part, the "national per capita Medicare+Choice growth percentage" for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this subchapter for an individual entitled to benefits under part A and enrolled under part B, excluding expenditures attributable to subsections (a)(7) and (o) of section 1395w-4 of this title and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

(B) Adjustment

The number of percentage points specified in this subparagraph is--

(i) for 1998, 0.8 percentage points,

(ii) for 1999, 0.5 percentage points,

(iii) for 2000, 0.5 percentage points,

(iv) for 2001, 0.5 percentage points,

(v) for 2002, 0.3 percentage points, and

(vi) for a year after 2002, 0 percentage points.

(C) Adjustment for over or under projection of national per capita Medicare+Choice growth percentage

Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for

the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004.

(7) Adjustment for national coverage determinations and legislative changes in benefits

If the Secretary makes a determination with respect to coverage under this subchapter or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w-22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the new benefits.

(d) MA payment area; MA local area; MA region defined

(1) MA payment area

In this part, except as provided in this subsection, the term "MA payment area" means--

(A) with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and

(B) with respect to an MA regional plan, an MA region (as established under section 1395w-27a(a)(2) of this title).

(2) MA local area

The term "MA local area" means a county or equivalent area specified by the Secretary.

(3) Rule for ESRD beneficiaries

In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(4) Geographic adjustment

(A) In general

Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a Medicare+Choice payment area in the State otherwise determined under paragraph (1) for MA local plans--

(i) to a single statewide Medicare+Choice payment area,

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(ii) to the metropolitan based system described in subparagraph (C), or

(iii) to consolidating into a single Medicare+Choice payment area noncontiguous counties (or equivalent areas described in paragraph (1)(A)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) Budget neutrality adjustment

In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section with respect to MA local plans for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section for such plans in the State shall not exceed the aggregate payments that would have been made under this section for such plans for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.

(C) Metropolitan based system

The metropolitan based system described in this subparagraph is one in which--

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single Medicare+Choice payment area, and

(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single Medicare+Choice payment area.

(D) Areas

In subparagraph (C), the terms “metropolitan statistical area”, “consolidated metropolitan statistical area”, and “primary metropolitan statistical area” mean any area designated as such by the Secretary of Commerce.

(e) Special rules for individuals electing MSA plans

(1) In general

If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1395w-24(b)(2)(C) of this title) for an MSA plan for a year is less than $^{1}/_{12}$ of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

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(2) Establishment and designation of Medicare+Choice medical savings account as requirement for payment of contribution

In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual--

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare +Choice MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such Medicare+Choice MSA, has designated one of such accounts as the individual's Medicare+Choice MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) Lump-sum deposit of medical savings account contribution

In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the Medicare+Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) Payments from Trust Funds

The payment to a Medicare+Choice organization under this section for individuals enrolled under this part with the organization and for payments under subsection (l) and subsection (m) and payments to a Medicare+Choice MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this subchapter. Payments to MA organizations for statutory drug benefits provided under this subchapter are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) Special rule for certain inpatient hospital stays

In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title), a rehabilitation hospital described in section 1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v) of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title) as of the effective date of the individual's--

(1) election under this part of a Medicare+Choice plan offered by a Medicare+Choice organization--

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(A) payment for such services until the date of the individual's discharge shall be made under this subchapter through the Medicare+Choice plan or the original medicare fee-for-service program option described in section 1395w-21(a)(1)(A) of this title (as the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

(2) termination of election with respect to a Medicare+Choice organization under this part--

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1395ww(d) of this title or other payment provision under this subchapter for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be, or by any succeeding Medicare+Choice organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

(h) Special rule for hospice care

(1) Information

A contract under this part shall require the Medicare+Choice organization to inform each individual enrolled under this part with a Medicare+Choice plan offered by the organization about the availability of hospice care if--

(A) a hospice program participating under this subchapter is located within the organization's service area; or

(B) it is common practice to refer patients to hospice programs outside such service area.

(2) Payment

If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1395d(d)(1) of this title to receive hospice care from a particular hospice program--

(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1395d(d)(1) of this title, including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1395w-24(f)(1)(A) of this title.

(i) New entry bonus

(1) In general

Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000, or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001), the amount of the monthly payment otherwise made under this section shall be increased--

(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

(2) Period of application

Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

(3) Limitation to organization offering first plan in an area

Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) Construction

Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

(5) Offered defined

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In this subsection, the term "offered" means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

(j) Computation of benchmark amounts

For purposes of this part, subject to subsection (o), the term "MA area-specific non-drug monthly benchmark amount" means for a month in a year--

(1) with respect to--

(A) a service area that is entirely within an MA local area, subject to section 1395w-29(d)(2)(A) of this title, an amount equal to $^{1}/_{12}$ of the annual MA capitation rate under subsection (c)(1) for the area for the year (or, for 2007, 2008, 2009, and 2010, $^{1}/_{12}$ of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, $^{1}/_{12}$ of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, $^{1}/_{12}$ of the blended benchmark amount determined under subsection (n)(1) for the area for the year), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(B) a service area that includes more than one MA local area, an amount equal to the average of the amounts described in subparagraph (A) for each such local MA area, weighted by the projected number of enrollees in the plan residing in the respective local MA areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1395w-24(a)(6)(A)(iii) of this title), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(2) with respect to an MA region for a month in a year, the MA region-specific non-drug monthly benchmark amount, as defined in section 1395w-27a(f) of this title for the region for the year.

(k) Determination of applicable amount for purposes of calculating the benchmark amounts

(1) Applicable amount defined

For purposes of subsection (j), subject to paragraphs (2), (4), and (5), the term "applicable amount" means for an area--

(A) for 2007--

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount specified in subsection (c)(1)(C) for the area for 2006--

(I) first adjusted by the rescaling factor for 2006 for the area (as made available by the Secretary in the announcement of the rates on April 4, 2005, under subsection (b)(1), but excluding any national adjustment factors for coding intensity and risk adjustment budget neutrality that were included in such factor); and

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(II) then increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2007, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004;

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of--

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year; and

(B) for a subsequent year--

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year (determined without regard to paragraphs (2), (4), and (5)), increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of--

(I) the amount determined under clause (i) for the area for the year; or

(II) the amount specified in subsection (c)(1)(D) for the area for the year.

(2) Phase-out of budget neutrality factor

(A) In general

Except as provided in subparagraph (D), in the case of 2007 through 2010, the applicable amount determined under paragraph (1) shall be multiplied by a factor equal to 1 plus the product of--

(i) the percent determined under subparagraph (B) for the year; and

(ii) the applicable phase-out factor for the year under subparagraph (C).

(B) Percent determined

(i) In general

For purposes of subparagraph (A)(i), subject to clause (iv), the percent determined under this subparagraph for a year is a percent equal to a fraction the numerator of which is described in clause (ii) and the denominator of which is described in clause (iii).

(ii) Numerator based on difference between demographic rate and risk rate

(I) In general

The numerator described in this clause is an amount equal to the amount by which the demographic rate described in subclause (II) exceeds the risk rate described in subclause (III).

(II) Demographic rate

The demographic rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to $^{1}/_{12}$ of the annual MA capitation rate under subsection (c)(1) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(III) Risk rate

The risk rate described in this subclause is the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to the amount described in subsection (j)(1)(A) (determined as if this paragraph had not applied) under subsection (j) for the area and year, adjusted pursuant to subsection (a)(1)(C).

(iii) Denominator based on risk rate

The denominator described in this clause is equal to the total amount estimated for the year under clause (ii)(III).

(iv) Requirements

In estimating the amounts under the previous clauses, the Secretary shall--

(I) use a complete set of the most recent and representative Medicare Advantage risk scores under subsection (a)(3) that are available from the risk adjustment model announced for the year;

(II) adjust the risk scores to reflect changes in treatment and coding practices in the fee-for-service sector;

(III) adjust the risk scores for differences in coding patterns between Medicare Advantage plans and providers under the original Medicare fee-for-service program under parts A and B to the extent that the Secretary has identified such differences, as required in subsection (a)(1)(C);

(IV) as necessary, adjust the risk scores for late data submitted by Medicare Advantage organizations;

(V) as necessary, adjust the risk scores for lagged cohorts; and

(VI) as necessary, adjust the risk scores for changes in enrollment in Medicare Advantage plans during the year.

(v) Authority

In computing such amounts the Secretary may take into account the estimated health risk of enrollees in preferred provider organization plans (including MA regional plans) for the year.

(C) Applicable phase-out factor

For purposes of subparagraph (A)(ii), the term "applicable phase-out factor" means--

(i) for 2007, 0.55;

(ii) for 2008, 0.40;

(iii) for 2009, 0.25; and

(iv) for 2010, 0.05.

(D) Termination of application

Subparagraph (A) shall not apply in a year if the amount estimated under subparagraph (B)(ii)(III) for the year is equal to or greater than the amount estimated under subparagraph (B)(ii)(II) for the year.

(3) No revision in percent

(A) In general

The Secretary may not make any adjustment to the percent determined under paragraph (2)(B) for any year.

(B) Rule of construction

Nothing in this subsection shall be construed to limit the authority of the Secretary to make adjustments to the applicable amounts determined under paragraph (1) as appropriate for purposes of updating data or for purposes of adopting an improved risk adjustment methodology.

(4) Phase-out of the indirect costs of medical education from capitation rates

(A) In general

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary's estimate of the standardized costs for payments under section 1395ww(d)(5)(B) of this title in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

(B) Percentages defined

For purposes of this paragraph:

(i) Phase-in percentage

The term "phase-in percentage" means, for an area for a year, the ratio (expressed as a percentage, but in no case greater than 100 percent) of--

(I) the maximum cumulative adjustment percentage for the year (as defined in clause (ii)); to

(II) the standardized IME cost percentage (as defined in clause (iii)) for the area and year.

(ii) Maximum cumulative adjustment percentage

The term "maximum cumulative adjustment percentage" means, for--

(I) 2010, 0.60 percent; and

(II) a subsequent year, the maximum cumulative adjustment percentage for the previous year increased by 0.60 percentage points.

(iii) Standardized IME cost percentage

The term "standardized IME cost percentage" means, for an area for a year, the per capita costs for payments under section 1395ww(d)(5)(B) of this title (expressed as a percentage of the fee-for-service amount specified in subparagraph (C)) for the area and the year.

(C) Fee-for-service amount

The fee-for-service amount specified in this subparagraph for an area for a year is the amount specified under subsection (c)(1)(D) for the area and the year.

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(5) Exclusion of costs for kidney acquisitions from capitation rates

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2021), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this subchapter (including expenses covered under section 1395rr(d) of this title) in the area for the year.

(l) Application of eligible professional incentives for certain MA organizations for adoption and meaningful use of certified EHR technology

(1) In general

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395w-4(o) and 1395w-4(a)(7) of this title shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible professional described

With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1395w-4(o) of this title) who--

(A)(i) is employed by the organization; or

(ii)(I) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; and

(II) furnishes at least 80 percent of the professional services of the eligible professional covered under this subchapter to enrollees of the organization; and

(B) furnishes, on average, at least 20 hours per week of patient care services.

(3) Eligible professional incentive payments

(A) In general

In applying section 1395w-4(o) of this title under paragraph (1), instead of the additional payment amount under section 1395w-4(o)(1)(A) of this title and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.

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(B) Avoiding duplication of payments

(i) In general

In the case of an eligible professional described in paragraph (2)--

(I) that is eligible for the maximum incentive payment under section 1395w-4(o)(1)(A) of this title for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and

(II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1395w-4(o)(1)(A) of this title.

(ii) Methods

In the case of an eligible professional described in paragraph (2) who is eligible for an incentive payment under section 1395w-4(o)(1)(A) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process--

(I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1395w-4(o)(1)(A) of this title; and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(C) Fixed schedule for application of limitation on incentive payments for all eligible professionals

In applying section 1395w-4(o)(1)(B)(ii) of this title under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization.

(4) Payment adjustment

(A) In general

In applying section 1395w-4(a)(7) of this title under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year.

(B) Specified percent

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The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of--

(i) the number of percentage points by which the applicable percent (under section 1395w-4(a)(7)(A)(ii) of this title) for the year is less than 100 percent; and

(ii) the Medicare physician expenditure proportion specified in subparagraph (C) for the year.

(C) Medicare physician expenditure proportion

The Medicare physician expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for physicians' services.

(D) Application of payment adjustment

In the case that a qualifying MA organization attests that not all eligible professionals of the organization are meaningful EHR users with respect to a year, the Secretary shall apply the payment adjustment under this paragraph based on the proportion of all such eligible professionals of the organization that are not meaningful EHR users for such year.

(5) Qualifying MA organization defined

In this subsection and subsection (m), the term "qualifying MA organization" means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 300gg-91(b)(3) of this title).

(6) Meaningful EHR user attestation

For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1395w-24(a)(1)(A)(iv) [4] of this title, identifying--

(A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1395w-4(o)(2) of this title) for a year specified by the Secretary; and

(B) whether each eligible hospital described in subsection (m)(1), [5] with respect to such organization, is a meaningful EHR user (as defined in section 1395ww(n)(3) of this title) for an applicable period specified by the Secretary.

(7) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names, business addresses, and business phone numbers of--

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(A) each qualifying MA organization receiving an incentive payment under this subsection for eligible professionals of the organization; and

(B) the eligible professionals of such organization for which such incentive payment is based.

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of--

(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B) and the specification of rules for the fixed schedule for application of limitation on incentive payments for all eligible professionals under paragraph (3)(C);

(B) the methodology and standards for determining eligible professionals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1395w-4(o)(2) of this title, including specification of the means of demonstrating meaningful EHR use under section 1395w-4(o)(3)(C) [6] of this title and selection of measures under section 1395w-4(o)(3)(B) [7] of this title.

(m) Application of eligible hospital incentives for certain MA organizations for adoption and meaningful use of certified EHR technology

(1) Application

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395ww(n) and 1395ww(b)(3)(B)(ix) of this title shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (l)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible hospital described

With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1395ww(n)(6)(B) of this title) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

(3) Eligible hospital incentive payments

(A) In general

In applying section 1395ww(n)(2) of this title under paragraph (1), instead of the additional payment amount under section 1395ww(n)(2) of this title, there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary--

(i) shall, insofar as data to determine the discharge related amount under section 1395ww(n)(2)(C) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

(ii) shall, insofar as data to determine the medicare share described in section 1395ww(n)(2)(D) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient-bed-days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period.

(B) Avoiding duplication of payments

(i) In general

In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1395ww(n) of this title and not under this subsection.

(ii) Methods

In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1395ww(n) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process--

(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1395ww(n) of this title; and

(II) to collect data from Medicare Advantage organizations to ensure against such duplicate payments.

(4) Payment adjustment

(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in subsection (l)(5)), if, according to the attestation of the organization submitted under subsection (l)(6) for an applicable period, one or more eligible hospitals (as defined in section 1395ww(n)(6)(B) of this title) that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1395ww(n)(3) of this title) with respect to a period, the payment amount payable under this section for such

organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

(B) Specified percent

The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of--

(i) the number of the percentage point reduction effected under section 1395ww(b)(3)(B)(ix)(I) of this title for the period; and

(ii) the Medicare hospital expenditure proportion specified in subparagraph (C) for the year.

(C) Medicare hospital expenditure proportion

The Medicare hospital expenditure proportion under this subparagraph for a year is the Secretary's estimate of the proportion, of the expenditures under parts A and B that are not attributable to this part, that are attributable to expenditures for inpatient hospital services.

(D) Application of payment adjustment

In the case that a qualifying MA organization attests that not all eligible hospitals are meaningful EHR users with respect to an applicable period, the Secretary shall apply the payment adjustment under this paragraph based on a methodology specified by the Secretary, taking into account the proportion of such eligible hospitals, or discharges from such hospitals, that are not meaningful EHR users for such period.

(5) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format--

(A) a list of the names, business addresses, and business phone numbers of each qualifying MA organization receiving an incentive payment under this subsection for eligible hospitals described in paragraph (2); and

(B) a list of the names of the eligible hospitals for which such incentive payment is based.

(6) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of--

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(A) the methodology and standards for determining payment amounts and payment adjustments under this subsection, including avoiding duplication of payments under paragraph (3)(B);

(B) the methodology and standards for determining eligible hospitals under paragraph (2); and

(C) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title, including specification of the means of demonstrating meaningful EHR use under subparagraph (C) of such section and selection of measures under subparagraph (B) of such section.

(n) Determination of blended benchmark amount

(1) In general

For purposes of subsection (j), subject to paragraphs (3), (4), and (5), the term "blended benchmark amount" means for an area--

(A) for 2012 the sum of--

(i) ½ of the applicable amount for the area and year; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area and year; and

(B) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(2) Specified amount

(A) In general

The amount specified in this subparagraph for an area and year is the product of--

(i) the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4) and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5); and

(ii) the applicable percentage for the area for the year specified under subparagraph (B).

(B) Applicable percentage

Subject to subparagraph (D), the applicable percentage specified in this subparagraph for an area for a year in the case of an area that is ranked--

(i) in the highest quartile under subparagraph (C) for the previous year is 95 percent;

(ii) in the second highest quartile under such subparagraph for the previous year is 100 percent;

(iii) in the third highest quartile under such subparagraph for the previous year is 107.5 percent; or

(iv) in the lowest quartile under such subparagraph for the previous year is 115 percent.

(C) Periodic ranking

For purposes of this paragraph in the case of an area located--

(i) in 1 of the 50 States or the District of Columbia, the Secretary shall rank such area in each year specified under subsection (c)(1)(D)(ii) based upon the level of the amount specified in subparagraph (A)(i) for such areas; or

(ii) in a territory, the Secretary shall rank such areas in each such year based upon the level of the amount specified in subparagraph (A)(i) for such area relative to quartile rankings computed under clause (i).

(D) 1-year transition for changes in applicable percentage

If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year shall be the average of--

(i) the applicable percentage for the area for the previous year; and

(ii) the applicable percentage that would otherwise apply for the area for the year.

(E) Base payment amount

Subject to subparagraphs (F) and (G), the base payment amount specified in this subparagraph--

(i) for 2012 is the amount specified in subsection (c)(1)(D) for the area for the year; or

(ii) for a subsequent year that--

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(I) is not specified under subsection (c)(1)(D)(ii), is the base amount specified in this subparagraph for the area for the previous year, increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

(II) is specified under subsection (c)(1)(D)(ii), is the amount specified in subsection (c)(1)(D) for the area for the year.

(F) Application of indirect medical education phase-out

The base payment amount specified in subparagraph (E) for a year shall be adjusted in the same manner under paragraph (4) of subsection (k) as the applicable amount is adjusted under such subsection.

(G) Application of kidney acquisitions adjustment

The base payment amount specified in subparagraph (E) for a year (beginning with 2021) shall be adjusted in the same manner under paragraph (5) of subsection (k) as the applicable amount is adjusted under such subsection.

(3) Alternative phase-ins

(A) 4-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $30 but less than $50, the blended benchmark amount for the area is--

(i) for 2012 the sum of--

(I) ¾ of the applicable amount for the area and year; and

(II) ¼ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of--

(I) ½ of the applicable amount for the area and year; and

(II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of--

(I) ¼ of the applicable amount for the area and year; and

(II) ¾ of the amount specified in paragraph (2)(A) for the area and year; and

(iv) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(B) 6-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $50, the blended benchmark amount for the area is--

(i) for 2012 the sum of--

(I) $^5/_6$ of the applicable amount for the area and year; and

(II) $^1/_6$ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of--

(I) $^2/_3$ of the applicable amount for the area and year; and

(II) ⅓ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of--

(I) ½ of the applicable amount for the area and year; and

(II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iv) for 2015 the sum of--

(I) ⅓ of the applicable amount for the area and year; and

(II) $^2/_3$ of the amount specified in paragraph (2)(A) for the area and year; and

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(v) for 2016 the sum of--

(I) $^{1}/_{6}$ of the applicable amount for the area and year; and

(II) $^{5}/_{6}$ of the amount specified in paragraph (2)(A) for the area and year; and

(vi) for a subsequent year the amount specified in paragraph (2)(A) for the area and year.

(C) Projected 2010 benchmark amount

The projected 2010 benchmark amount described in this subparagraph for an area is equal to the sum of--

(i) ½ of the applicable amount (as defined in subsection (k)) for the area for 2010; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area for 2010 but determined as if there were substituted for the applicable percentage specified in clause (ii) of such paragraph the sum of--

(I) the applicable percent that would be specified under subparagraph (B) of paragraph (2) (determined without regard to subparagraph (D) of such paragraph) for the area for 2010 if any reference in such paragraph to "the previous year" were deemed a reference to 2010; and

(II) the applicable percentage increase that would apply to a qualifying plan in the area under subsection (o) as if any reference in such subsection to 2012 were deemed a reference to 2010 and as if the determination of a qualifying county under paragraph (3)(B) of such subsection were made for 2010.

(4) Cap on benchmark amount

In no case shall the blended benchmark amount for an area for a year (determined taking into account subsection (o)) be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the year.

(5) Non-application to PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

(o) Applicable percentage quality increases

(1) In general

Subject to the succeeding paragraphs, in the case of a qualifying plan with respect to a year beginning with 2012, the applicable percentage under subsection (n)(2)(B) shall be increased on a plan or contract level, as determined by the Secretary--

(A) for 2012, by 1.5 percentage points;

(B) for 2013, by 3.0 percentage points; and

(C) for 2014 or a subsequent year, by 5.0 percentage points.

(2) Increase for qualifying plans in qualifying counties

The increase applied under paragraph (1) for a qualifying plan located in a qualifying county for a year shall be doubled.

(3) Qualifying plans and qualifying county defined; application of increases to low enrollment and new plans

For purposes of this subsection:

(A) Qualifying plan

(i) In general

The term "qualifying plan" means, for a year and subject to paragraph (4), a plan that had a quality rating under paragraph (4) of 4 stars or higher based on the most recent data available for such year.

(ii) Application of increases to low enrollment plans

(I) 2012

For 2012, the term "qualifying plan" includes an MA plan that the Secretary determines is not able to have a quality rating under paragraph (4) because of low enrollment.

(II) 2013 and subsequent years

For 2013 and subsequent years, for purposes of determining whether an MA plan with low enrollment (as defined by the Secretary) is included as a qualifying plan, the Secretary shall establish a method to apply to MA plans with low enrollment (as defined by the Secretary) the computation of quality rating and the rating system under paragraph (4).

(iii) Application of increases to new plans

(I) In general

A new MA plan that meets criteria specified by the Secretary shall be treated as a qualifying plan, except that in applying paragraph (1), the applicable percentage under subsection (n)(2)(B) shall be increased--

(aa) for 2012, by 1.5 percentage points;

(bb) for 2013, by 2.5 percentage points; and

(cc) for 2014 or a subsequent year, by 3.5 percentage points.

(II) New MA plan defined

The term "new MA plan" means, with respect to a year, a plan offered by an organization or sponsor that has not had a contract as a Medicare Advantage organization in the preceding 3-year period.

(B) Qualifying county

The term "qualifying county" means, for a year, a county--

(i) that has an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(ii) for which, as of December 2009, of the Medicare Advantage eligible individuals residing in the county at least 25 percent of such individuals were enrolled in Medicare Advantage plans; and

(iii) that has per capita fee-for-service spending that is lower than the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year.

(4) Quality determinations for application of increase

(A) Quality determination

The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w-22(e) of this title).

(B) Plans that failed to report

An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(C) Special rule for first 3 plan years for plans that were converted from a reasonable cost reimbursement contract

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For purposes of applying paragraph (1) and section 1395w-24(b)(1)(C) of this title for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1395w-21(c)(4) of this title--

(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.

(D) Special rule to prevent the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by a single organization

(i) In general

If--

(I) a Medicare Advantage organization has entered into more than one contract with the Secretary with respect to the offering of Medicare Advantage plans; and

(II) on or after January 1, 2019, the Secretary approves a request from the organization to consolidate the plans under one or more contract (in this subparagraph referred to as a "closed contract") with the plans offered under a separate contract (in this subparagraph referred to as the "continuing contract");

with respect to the continuing contract, the Secretary shall adjust the quality rating under the 5-star rating system and any quality increase under this subsection and rebate amounts under section 1395w-24 of this title to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts, as determined appropriate by the Secretary.

(ii) Application

An adjustment under clause (i) shall apply for any year for which the quality rating of the continuing contract is based primarily on a measurement period that is prior to the first year in which a closed contract is no longer offered.

(5) Exception for PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

(6) Quality measurement at the plan level for SNPs

(A) In general

Subject to subparagraph (B), the Secretary may require reporting of data under section 1395w-22(e) of this title for, and apply under this subsection, quality measures at the plan level for specialized MA plans for special needs individuals instead of at the contract level.

(B) Considerations

Prior to applying quality measurement at the plan level under this paragraph, the Secretary shall--

(i) take into consideration the minimum number of enrollees in a specialized MA plan for special needs individuals in order to determine if a statistically significant or valid measurement of quality at the plan level is possible under this paragraph;

(ii) take into consideration the impact of such application on plans that serve a disproportionate number of individuals dually eligible for benefits under this subchapter and under subchapter XIX;

(iii) if quality measures are reported at the plan level, ensure that MA plans are not required to provide duplicative information; and

(iv) ensure that such reporting does not interfere with the collection of encounter data submitted by MA organizations or the administration of any changes to the program under this part as a result of the collection of such data.

(C) Application

If the Secretary applies quality measurement at the plan level under this paragraph--

(i) such quality measurement may include Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and quality measures under part D; and

(ii) the Secretary shall consider applying administrative actions, such as remedies described in section 1395w-27(g)(2) of this title, at the plan level.

(7) Determination of feasibility of quality measurement at the plan level for all MA plans

(A) Determination of feasibility

The Secretary shall determine the feasibility of requiring reporting of data under section 1395w-22(e) of this title for, and applying under this subsection, quality measures at the plan level for all MA plans under this part.

(B) Consideration of change

After making a determination under subparagraph (A), the Secretary shall consider requiring such reporting and applying such quality measures at the plan level as described in such subparagraph

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVIII, § 1853, as added Pub.L. 105-33, Title IV, § 4001, Aug. 5, 1997, 111 Stat. 299; amended Pub.L. 106-113, Div. B, § 1000(a)(6) [Title V, §§ 511(a), 512, 514(a), 517], Nov. 29, 1999, 113 Stat. 1536, 1501A-380, 1501A-382, 1501A-383, 1501A-384; Pub.L. 106-554, § 1(a)(6) [Title VI, §§ 601(a), 602(a), 603, 605(a), 606(a)(2)(A), 607, 608(a), 611(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A-554, 2763A-555, 2763A-556 to 2763A-559; Pub.L. 107-188, Title V, § 532(d)(1), June 12, 2002, 116 Stat. 696; Pub.L. 108-173, Title I, § 101(e)(3)(D), Title II, §§ 211(a) to (e)(1), 221(d)(1), (4), 222(d), (e)(1), (f), (i), 237(b)(1), (2)(B), 241(b)(1), Title VII, § 736(d)(1), Title IX, § 900(e)(1)(G), Dec. 8, 2003, 117 Stat. 2151, 2176 to 2178, 2192, 2193, 2200, 2202, 2204, 2212, 2213, 2220, 2357, 2371; Pub.L. 109-171, Title V, § 5301, Feb. 8, 2006, 120 Stat. 48; Pub.L. 110-275, Title I, § 161(a), (b), July 15, 2008, 122 Stat. 2568; Pub.L. 111-5, Div. B, Title IV, §§ 4101(c), (e), 4102(c), (d)(3), Feb. 17, 2009, 123 Stat. 473, 476, 484, 486; Pub.L. 111-148, Title III, §§ 3201(a)(1), (2)(A), (b), (e)(1), (2)(A)(ii) to (iv), (f)(1), (g), (h), (i)(2), 3202(b)(2), 3203, 3205(b), (f), Title X, § 10318, Mar. 23, 2010, 124 Stat. 442, 444 to 447, 450, 454, 455, 456, 457, 458, 948; Pub.L. 111-152, Title I, § 1102(a) to (c)(3), (e), Mar. 30, 2010, 124 Stat. 1040, 1046; Pub.L. 112-240, Title VI, § 639, Jan. 2, 2013, 126 Stat. 2357; Pub.L. 114-10, Title II, § 209(d), Apr. 16, 2015, 129 Stat. 150; Pub.L. 114-106, § 2, Dec. 18, 2015, 129 Stat. 2222; Pub.L. 114-113, Div. O, Title VI, § 602(b)(2), Dec. 18, 2015, 129 Stat. 3024; Pub.L. 114-255, Div. C, Title XVII, § 17006(b), (f)(1), Dec. 13, 2016, 130 Stat. 1334, 1336; Pub.L. 115-123, Div. E, Title III, § 50311(d), Title XII, § 53112, Feb. 9, 2018, 132 Stat. 198, 305.)

Notes of Decisions (5)

Footnotes

1 So in original. Probably should be "parts".

2 So in original. Probably means "subsection (g) of 1395w-115 of this title".

3 So in original. Probably should be "section 1395w-4(o), 1395ww(h), and 1395ww(n) of this title."

4 So in original. Section 1395w-24(a)(1)(A) of this title does not contain a cl. (iv).

5 So in original. Probably should be "(m)(2),".

6 So in original. Probably should be "1395w-4(o)(2)(C)".

7 So in original. Probably should be "1395w-4(o)(2)(B)".

42 U.S.C.A. § 1395w-23, 42 USCA § 1395w-23
Current through P.L. 117-262. Some statute sections may be more current, see credits for details.

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United States Code Annotated
Federal Rules of Appellate Procedure (Refs & Annos)
Title VII. General Provisions

Federal Rules of Appellate Procedure Rule 35, 28 U.S.C.A.

Rule 35. En Banc Determination

Currentness

(a) When Hearing or Rehearing En Banc May Be Ordered. A majority of the circuit judges who are in regular active service and who are not disqualified may order that an appeal or other proceeding be heard or reheard by the court of appeals en banc. An en banc hearing or rehearing is not favored and ordinarily will not be ordered unless:

(1) en banc consideration is necessary to secure or maintain uniformity of the court's decisions; or

(2) the proceeding involves a question of exceptional importance.

(b) Petition for Hearing or Rehearing En Banc. A party may petition for a hearing or rehearing en banc.

(1) The petition must begin with a statement that either:

(A) the panel decision conflicts with a decision of the United States Supreme Court or of the court to which the petition is addressed (with citation to the conflicting case or cases) and consideration by the full court is therefore necessary to secure and maintain uniformity of the court's decisions; or

(B) the proceeding involves one or more questions of exceptional importance, each of which must be concisely stated; for example, a petition may assert that a proceeding presents a question of exceptional importance if it involves an issue on which the panel decision conflicts with the authoritative decisions of other United States Courts of Appeals that have addressed the issue.

(2) Except by the court's permission:

(A) a petition for an en banc hearing or rehearing produced using a computer must not exceed 3,900 words; and

(B) a handwritten or typewritten petition for an en banc hearing or rehearing must not exceed 15 pages.

(3) For purposes of the limits in Rule 35(b)(2), if a party files both a petition for panel rehearing and a petition for rehearing en banc, they are considered a single document even if they are filed separately, unless separate filing is required by local rule.

(c) Time for Petition for Hearing or Rehearing En Banc. A petition that an appeal be heard initially en banc must be filed by the date when the appellee's brief is due. A petition for a rehearing en banc must be filed within the time prescribed by Rule 40 for filing a petition for rehearing.

(d) Number of Copies. The number of copies to be filed must be prescribed by local rule and may be altered by order in a particular case.

(e) Response. No response may be filed to a petition for an en banc consideration unless the court orders a response. The length limits in Rule 35(b)(2) apply to a response.

(f) Call for a Vote. A vote need not be taken to determine whether the case will be heard or reheard en banc unless a judge calls for a vote.

CREDIT(S)

(As amended Apr. 1, 1979, eff. Aug. 1, 1979; Apr. 29, 1994, eff. Dec. 1, 1994; Apr. 24, 1998, eff. Dec. 1, 1998; Apr. 25, 2005, eff. Dec. 1, 2005; Apr. 28, 2016, eff. Dec. 1, 2016; Apr. 27, 2020, eff. Dec. 1, 2020.)

ADVISORY COMMITTEE NOTES
1967 Adoption

Statutory authority for in banc hearings is found in 28 U.S.C. § 46(c). The proposed rule is responsive to the Supreme Court's view in *Western Pacific Ry. Corp. v. Western Pacific Ry. Co.*, 345 U.S. 247, 73 S.Ct. 656, 97 L.Ed. 986 (1953), that litigants should be free to suggest that a particular case is appropriate for consideration by all the judges of a court of appeals. The rule is addressed to the procedure whereby a party may suggest the appropriateness of convening the court in banc. It does not affect the power of a court of appeals to initiate in banc hearings *sua sponte*.

The provision that a vote will not be taken as a result of the suggestion of the party unless requested by a judge of the court in regular active service or by a judge who was a member of the panel that rendered a decision sought to be reheard is intended to make it clear that a suggestion of a party as such does not require any action by the court. See *Western Pacific Ry. Corp. v. Western Pacific Ry. Co.*, supra, 345 U.S. at 262, 73 S.Ct. 656. The rule merely authorizes a suggestion, imposes a time limit on suggestions for rehearings in banc, and provides that suggestions will be directed to the judges of the court in regular active service.

In practice, the suggestion of a party that a case be reheard in banc is frequently contained in a petition for rehearing, commonly styled "petition for rehearing in banc." Such a petition is in fact merely a petition for a rehearing, with a suggestion that the case be reheard in banc. Since no response to the suggestion, as distinguished from the petition for rehearing, is required, the panel which heard the case may quite properly dispose of the petition without reference to the suggestion. In such a case the fact that no response has been made to the suggestion does not affect the finality of the judgment or the issuance of the mandate, and the final sentence of the rule expressly so provides.

1979 Amendment

Under the present rule there is no specific provision for a response to a suggestion that an appeal be heard in banc. This has led to some uncertainty as to whether such a response may be filed. The proposed amendment would resolve this uncertainty.

While the present rule provides a time limit for suggestions for rehearing in banc, it does not deal with the timing of a request that the appeal be heard in banc initially. The proposed amendment fills this gap as well, providing that the suggestion must be made by the date of which the appellee's brief is filed.

Provision is made for circulating the suggestions to members of the panel despite the fact that senior judges on the panel would not be entitled to vote on whether a suggestion will be granted.

1994 Amendment

Subdivision (d). Subdivision (d) is added; it authorizes the courts of appeals to prescribe the number of copies of suggestions for hearing or rehearing in banc that must be filed. Because the number of copies needed depends directly upon the number of judges in the circuit, local rules are the best vehicle for setting the required number of copies.

1998 Amendments

The language and organization of the rule are amended to make the rule more easily understood. In addition to changes made to improve the understanding, the Advisory Committee has changed language to make style and terminology consistent throughout the appellate rules. These changes are intended to be stylistic only.

Several substantive changes are made to this rule, however.

One of the purposes of the substantive amendments is to treat a request for a rehearing en banc like a petition for panel rehearing so that a request for a rehearing en banc will suspend the finality of the court of appeals' judgment and delay the running of the period for filing a petition for writ of certiorari. Companion amendments are made to Rule 41.

Subdivision (a). The title of this subdivision is changed from “When hearing or rehearing in banc *will* be ordered” to “When Hearing or Rehearing En Banc *May* Be Ordered.” The change emphasizes the discretion a court has with regard to granting en banc review.

Subdivision (b). The term “petition” for rehearing en banc is substituted for the term “suggestion” for rehearing en banc. The terminology change reflects the Committee's intent to treat similarly a petition for panel rehearing and a request for a rehearing en banc. The terminology change also delays the running of the time for filing a petition for a writ of certiorari because Sur. Ct. R. 13.3 says:

> if a petition for rehearing is timely filed in the lower court by any party, the time to file the petition for a writ of certiorari for all parties...runs from the date of the denial of the petition for rehearing or, if the petition for rehearing is granted, the subsequent entry of judgment.

The amendments also require each petition for en banc consideration to begin with a statement concisely demonstrating that the case meets the usual criteria for en banc consideration. It is the Committee's hope that requiring such a statement will cause the drafter of a petition to focus on the narrow grounds that support en banc consideration and to realize that a petition should not be filed unless the case meets those rigid standards.

Intercircuit conflict is cited as one reason for asserting that a proceeding involves a question of “exceptional importance.” Intercircuit conflicts create problems. When the circuits construe the same federal law differently, parties' rights and duties depend upon where a case is litigated. Given the increase in the number of cases decided by the federal courts and the limitation on the number of cases the Supreme Court can hear, conflicts between the circuits may remain unresolved by the Supreme Court for an extended period of time. The existence of an intercircuit conflict often generates additional litigation in the other circuits

as well as in the circuits that are already in conflict. Although an en banc proceeding will not necessarily prevent intercircuit conflicts, an en banc proceeding provides a safeguard against unnecessary intercircuit conflicts.

Some circuits have had rules or internal operating procedures that recognize a conflict with another circuit as a legitimate basis for granting a rehearing en banc. An intercircuit conflict may present a question of "exceptional importance" because of the costs that intercircuit conflicts impose on the system as a whole, in addition to the significance of the issues involved. It is not, however, the Committee's intent to make the granting of a hearing or rehearing en banc mandatory whenever there is an intercircuit conflict.

The amendment states that "a petition may assert that a proceeding presents a question of exceptional importance if it involves an issue on which the panel decision conflicts with the authoritative decisions of every other United States Court of Appeals that has addressed the issue." That language contemplates two situations in which a rehearing en banc may be appropriate. The first is when a panel decision creates a conflict. A panel decision creates a conflict when it conflicts with the decisions of all other circuits that have considered the issue. If a panel decision simply joins one side of an already existing conflict, a rehearing en banc may not be as important because it cannot avoid the conflict. The Second situation that may be a strong candidate for a rehearing en banc is one in which the circuit persists in a conflict created by a pre-existing decision of the same circuit and no other circuits have joined on that side of the conflict. The amendment states that the conflict must be with an "authoritative" decision of another circuit. "Authoritative" is used rather than "published" because in some circuits unpublished opinions may be treated as authoritative.

Counsel are reminded that their duty is fully discharged without filing a petition for rehearing en banc unless the case meets the rigid standards of subdivision (a) of this rule and even then the granting of a petition is entirely within the court's discretion.

Paragraph (2) of this subdivision establishes a maximum length for a petition. Fifteen pages is the length currently used in several circuits. Each request for en banc consideration must be studied by every active judge of the court and is a serious call on limited judicial resources. The extraordinary nature of the issue or the threat to uniformity of the court's decision can be established in most cases in less than fifteen pages. A court may shorten the maximum length on a case by case basis but the rule does not permit a circuit to shorten the length by local rule. The Committee has retained page limits rather than using word or line counts similar to those in amended Rule 32 because there has not been a serious enough problem to justify importing the word and line-count and typeface requirement that are applicable to briefs into other contexts.

Paragraph (3), although similar to (2), is separate because it deals with those instances in which a party files both a petition for rehearing en banc under this rule and a petition for panel rehearing under Rule 40.

To improve the clarity of the rule, the material dealing with filing a response to a petition and with voting on a petition have been moved to new subdivisions (e) and (f).

Subdivision (c). Two changes are made in this subdivision. First, the sentence stating that a request for a rehearing en banc does not affect the finality of the judgment or stay the issuance of the mandate is deleted. Second, the language permitting a party to include a request for rehearing en banc in a petition for panel rehearing is deleted. The Committee believes that those circuits that want to require two separate documents should have the option to do so.

Subdivision (e). This is a new subdivision. The substance of the subdivision, however, was drawn from former subdivision (b). The only changes are stylistic; no substantive changes are intended.

Subdivision (f). This is a new subdivision. The substance of the subdivision, however, was drawn from former subdivision (b).

Because of the discretionary nature of the en banc procedure, the filing of a suggestion for rehearing en banc has not required a vote; a vote is taken only when requested by a judge. It is not the Committee's intent to change the discretionary nature of the

procedure or to require a vote on a petition for rehearing en banc. The rule continues, therefore, to provide that a court is not obligated to vote on such petitions. It is necessary, however, that each court develop a procedure for disposing of such petitions because they will suspend the finality of the court's judgment and toll the time for filing a petition for certiorari.

Former subdivision (b) contained language directing the clerk to distribute a "suggestion" to certain judges and indicating which judges may call for a vote. New subdivision (f) does not address those issues because they deal with internal court procedures.

2005 Amendments

Subdivision (a). Two national standards--28 U.S.C. § 46(c) and Rule 35(a)--provide that a hearing or rehearing en banc may be ordered by "a majority of the circuit judges who are in regular active service." Although these standards apply to all of the courts of appeals, the circuits are deeply divided over the interpretation of this language when one or more active judges are disqualified.

The Supreme Court has never addressed this issue. In *Shenker v. Baltimore & Ohio R.R. Co.*, 374 U.S. 1 (1963), the Court rejected a petitioner's claim that his rights under § 46(c) had been violated when the Third Circuit refused to rehear his case en banc. The Third Circuit had 8 active judges at the time; 4 voted in favor of rehearing the case, 2 against, and 2 abstained. No judge was disqualified. The Supreme Court ruled against the petitioner, holding, in essence, that § 46(c) did not provide a cause of action, but instead simply gave litigants "the right to know the administrative machinery that will be followed and the right to suggest that the *en banc* procedure be set in motion in his case." *Id.* at 5. *Shenker* did stress that a court of appeals has broad discretion in establishing internal procedures to handle requests for rehearings--or, as *Shenker* put it, " 'to devise its own administrative machinery to provide the *means* whereby a majority may order such a hearing.' " *Id.* (quoting *Western Pac. R.R. Corp. v. Western Pac. R.R. Co.*, 345 U.S. 247, 250 (1953) (emphasis added)). But *Shenker* did not address what is meant by "a majority" in § 46(c) (or Rule 35(a), which did not yet exist)--and *Shenker* certainly did not suggest that the phrase should have different meanings in different circuits.

In interpreting that phrase, 7 of the courts of appeals follow the "absolute majority" approach. *See* Marie Leary, Defining the "Majority" Vote Requirement in Federal Rule of Appellate Procedure 35(a) for Rehearings En Banc in the United States Courts of Appeals 8 tbl.1 (Federal Judicial Center 2002). Under this approach, disqualified judges are counted in the base in calculating whether a majority of judges have voted to hear a case en banc. Thus, in a circuit with 12 active judges, 7 must vote to hear a case en banc. If 5 of the 12 active judges are disqualified, all 7 non-disqualified judges must vote to hear the case en banc. The votes of 6 of the 7 non-disqualified judges are not enough, as 6 is not a majority of 12.

Six of the courts of appeals follow the "case majority" approach. *Id.* Under this approach, disqualified judges are not counted in the base in calculating whether a majority of judges have voted to hear a case en banc. Thus, in a case in which 5 of a circuit's 12 active judges are disqualified, only 4 judges (a majority of the 7 non-disqualified judges) must vote to hear a case en banc. (The First and Third Circuits explicitly qualify the case majority approach by providing that a case cannot be heard en banc unless a majority of all active judges--disqualified and non-disqualified--are eligible to participate.)

Rule 35(a) has been amended to adopt the case majority approach as a uniform national interpretation of § 46(c). The federal rules of practice and procedure exist to "maintain consistency," which Congress has equated with "promot[ing] the interest of justice." 28 U.S.C. § 2073(b). The courts of appeals should not follow two inconsistent approaches in deciding whether sufficient votes exist to hear a case en banc, especially when there is a governing statute and governing rule that apply to all circuits and that use identical terms, and especially when there is nothing about the local conditions of each circuit that justifies conflicting approaches.

The case majority approach represents the better interpretation of the phrase "the circuit judges ... in regular active service" in the first sentence of § 46(c). The second sentence of § 46(c)--which defines which judges are eligible to participate in a case being heard or reheard en banc--uses the similar expression "all circuit judges in regular active service." It is clear that "all

circuit judges in regular active service" in the second sentence does not include disqualified judges, as disqualified judges clearly cannot participate in a case being heard or reheard en banc. Therefore, assuming that two nearly identical phrases appearing in adjacent sentences in a statute should be interpreted in the same way, the best reading of "the circuit judges ... in regular active service" in the first sentence of § 46(c) is that it, too, does not include disqualified judges.

This interpretation of § 46(c) is bolstered by the fact that the case majority approach has at least two major advantages over the absolute majority approach:

First, under the absolute majority approach, a disqualified judge is, as a practical matter, counted as voting against hearing a case en banc. This defeats the purpose of recusal. To the extent possible, the disqualification of a judge should not result in the equivalent of a vote for or against hearing a case en banc.

Second, the absolute majority approach can leave the en banc court helpless to overturn a panel decision with which almost all of the circuit's active judges disagree. For example, in a case in which 5 of a circuit's 12 active judges are disqualified, the case cannot be heard en banc even if 6 of the 7 non-disqualified judges strongly disagree with the panel opinion. This permits one active judge--perhaps sitting on a panel with a visiting judge--effectively to control circuit precedent, even over the objection of all of his or her colleagues. *See Gulf Power Co. v. FCC*, 226 F.3d 1220, 1222-23 (11th Cir. 2000) (Carnes, J., concerning the denial of reh'g en banc), *rev'd sub nom. National Cable & Telecomm. Ass'n, Inc. v. Gulf Power Co.*, 534 U.S. 327 (2002). Even though the en banc court may, in a future case, be able to correct an erroneous legal interpretation, the en banc court will never be able to correct the injustice inflicted by the panel on the parties to the case. Moreover, it may take many years before sufficient non-disqualified judges can be mustered to overturn the panel's erroneous legal interpretation. In the meantime, the lower courts of the circuit must apply--and the citizens of the circuit must conform their behavior to--an interpretation of the law that almost all of the circuit's active judges believe is incorrect.

The amendment to Rule 35(a) is not meant to alter or affect the quorum requirement of 28 U.S.C. § 46(d). In particular, the amendment is not intended to foreclose the possibility that § 46(d) might be read to require that more than half of all circuit judges in regular active service be eligible to participate in order for the court to hear or rehear a case en banc.

2016 Amendments

The page limits previously employed in Rules 5, 21, 27, 35, and 40 have been largely overtaken by changes in technology. For papers produced using a computer, those page limits are now replaced by word limits. The word limits were derived from the current page limits using the assumption that one page is equivalent to 260 words. Papers produced using a computer must include the certificate of compliance required by Rule 32(g); Form 6 in the Appendix of Forms suffices to meet that requirement. Page limits are retained for papers prepared without the aid of a computer (i.e., handwritten or typewritten papers). For both the word limit and the page limit, the calculation excludes any items listed in Rule 32(f).

2020 Amendments

The amendment to Rule 35(e) clarifies that the length limits applicable to a petition for hearing or rehearing en banc also apply to a response to such a petition, if the court orders one.

Notes of Decisions (52)

F. R. A. P. Rule 35, 28 U.S.C.A., FRAP Rule 35
Including Amendments Received Through 2-1-23

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United States Code Annotated
Federal Rules of Civil Procedure for the United States District Courts (Refs & Annos)
Title III. Pleadings and Motions

Federal Rules of Civil Procedure Rule 15

Rule 15. Amended and Supplemental Pleadings

Currentness

(a) Amendments Before Trial.

(1) ***Amending as a Matter of Course.*** A party may amend its pleading once as a matter of course within:

(A) 21 days after serving it, or

(B) if the pleading is one to which a responsive pleading is required, 21 days after service of a responsive pleading or 21 days after service of a motion under Rule 12(b), (e), or (f), whichever is earlier.

(2) ***Other Amendments.*** In all other cases, a party may amend its pleading only with the opposing party's written consent or the court's leave. The court should freely give leave when justice so requires.

(3) ***Time to Respond.*** Unless the court orders otherwise, any required response to an amended pleading must be made within the time remaining to respond to the original pleading or within 14 days after service of the amended pleading, whichever is later.

(b) Amendments During and After Trial.

(1) ***Based on an Objection at Trial.*** If, at trial, a party objects that evidence is not within the issues raised in the pleadings, the court may permit the pleadings to be amended. The court should freely permit an amendment when doing so will aid in presenting the merits and the objecting party fails to satisfy the court that the evidence would prejudice that party's action or defense on the merits. The court may grant a continuance to enable the objecting party to meet the evidence.

(2) ***For Issues Tried by Consent.*** When an issue not raised by the pleadings is tried by the parties' express or implied consent, it must be treated in all respects as if raised in the pleadings. A party may move--at any time, even after judgment--to amend the pleadings to conform them to the evidence and to raise an unpleaded issue. But failure to amend does not affect the result of the trial of that issue.

(c) Relation Back of Amendments.

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(1) ***When an Amendment Relates Back.*** An amendment to a pleading relates back to the date of the original pleading when:

(A) the law that provides the applicable statute of limitations allows relation back;

(B) the amendment asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out--or attempted to be set out--in the original pleading; or

(C) the amendment changes the party or the naming of the party against whom a claim is asserted, if Rule 15(c)(1)(B) is satisfied and if, within the period provided by Rule 4(m) for serving the summons and complaint, the party to be brought in by amendment:

(i) received such notice of the action that it will not be prejudiced in defending on the merits; and

(ii) knew or should have known that the action would have been brought against it, but for a mistake concerning the proper party's identity.

(2) ***Notice to the United States.*** When the United States or a United States officer or agency is added as a defendant by amendment, the notice requirements of Rule 15(c)(1)(C)(i) and (ii) are satisfied if, during the stated period, process was delivered or mailed to the United States attorney or the United States attorney's designee, to the Attorney General of the United States, or to the officer or agency.

(d) Supplemental Pleadings. On motion and reasonable notice, the court may, on just terms, permit a party to serve a supplemental pleading setting out any transaction, occurrence, or event that happened after the date of the pleading to be supplemented. The court may permit supplementation even though the original pleading is defective in stating a claim or defense. The court may order that the opposing party plead to the supplemental pleading within a specified time.

CREDIT(S)

(Amended January 21, 1963, effective July 1, 1963; February 28, 1966, effective July 1, 1966; March 2, 1987, effective August 1, 1987; April 30, 1991, effective December 1, 1991; amended by Pub.L. 102-198, § 11, December 9, 1991, 105 Stat. 1626; amended April 22, 1993, effective December 1, 1993; April 30, 2007, effective December 1, 2007; March 26, 2009, effective December 1, 2009.)

ADVISORY COMMITTEE NOTES

1937 Adoption

See generally for the present federal practice, [former] Equity Rules 19 (Amendments Generally), 28 (Amendment of Bill as of Course), 32 (Answer to Amended Bill), 34 (Supplemental Pleading), and 35 (Bills of Revivor and Supplemental Bills--Form); U.S.C. Title 28, § 399 [now 1653] (Amendments to show diverse citizenship) and [former] 777 (Defects of form; amendments). See *English Rules Under the Judicature Act* (The Annual Practice, 1937) O. 28, r. r. 1-13; O. 20, r. 4; O. 24, r. r. 1-3.

Note to Subdivision (a). The right to serve an amended pleading once as of course is common. 4 Mont.Rev.Codes Ann. (1935) § 9186; 1 Ore.Code Ann. (1930) § 1-904; 1 S.C.Code (Michie, 1932) § 493; *English Rules Under the Judicature Act* (The

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Annual Practice, 1937) O. 28, r. 2. Provision for amendment of pleading before trial, by leave of court, is in almost every code. If there is no statute the power of the court to grant leave is said to be inherent. Clark, *Code Pleading* (1928), pp. 498, 509.

Note to Subdivision (b). Compare [former] Equity Rule 19 (Amendments Generally) and code provisions which allow an amendment "at any time in furtherance of justice," (e.g., Ark.Civ.Code (Crawford, 1934) § 155) and which allow an amendment of pleadings to conform to the evidence, where the adverse party has not been misled and prejudiced (e.g., N.M.Stat.Ann. (Courtright, 1929) §§ 105-601, 105-602).

Note to Subdivision (c). "Relation back" is a well recognized doctrine of recent and now more frequent application. Compare Ala.Code Ann. (Michie, 1928) § 9513; Smith-Hurd Ill.Stats. ch. 110, § 170(2); 2 Wash.Rev.Stat.Ann. (Remington, 1932) § 308-3(4). See U.S.C., Title 28, § 399 [now 1653] (Amendments to show diverse citizenship) for a provision for "relation back."

Note to Subdivision (d). This is an adaptation of former Equity Rule 34 (Supplemental Pleading).

1963 Amendment

Rule 15(d) is intended to give the court broad discretion in allowing a supplemental pleading. However, some cases, opposed by other cases and criticized by the commentators, have taken the rigid and formalistic view that where the original complaint fails to state a claim upon which relief can be granted, leave to serve a supplemental complaint must be denied. See *Bonner v. Elizabeth Arden, Inc.,* 177 F.2d 703 (2d Cir. 1949); *Bowles v. Senderowitz,* 65 F.Supp. 548 (E.D.Pa.), rev'd on other grounds, 158 F.2d 435 (3d Cir. 1946), cert. denied, *Senderowitz v. Fleming,* 330 U.S. 848, 67 S.Ct. 1091, 91 L.Ed. 1292 (1947); cf. *LaSalle Nat. Bank v. 222 East Chestnut St. Corp.,* 267 F.2d 247 (7th Cir.), cert. denied, 361 U.S. 836, 80 S.Ct. 88, 4 L.Ed.2d 77 (1959). But see *Camilla Cotton Oil Co. v. Spencer Kellogg & Sons,* 257 F.2d 162 (5th Cir. 1958); *Genuth v. National Biscuit Co.,* 81 F.Supp. 213 (S.D.N.Y.1948), app. dism., 177 F.2d 962 (2d Cir. 1949); 3 Moore's *Federal Practice* ¶15.01[5] (Supp.1960); 1A Barron & Holtzoff, *Federal Practice & Procedure* 820-21 (Wright ed. 1960). Thus plaintiffs have sometimes been needlessly remitted to the difficulties of commencing a new action even though events occurring after the commencement of the original action have made clear the right to relief.

Under the amendment the court has discretion to permit a supplemental pleading despite the fact that the original pleading is defective. As in other situations where a supplemental pleading is offered, the court is to determine in the light of the particular circumstances whether filing should be permitted, and if so, upon what terms. The amendment does not attempt to deal with such questions as the relation of the statute of limitations to supplemental pleadings, the operation of the doctrine of laches, or the availability of other defenses. All these questions are for decision in accordance with the principles applicable to supplemental pleadings generally. Cf. *Blau v. Lamb,* 191 F.Supp. 906 (S.D.N.Y.1961); *Lendonsol Amusement Corp. v. B. & Q. Assoc., Inc.,* 23 F.R.Serv. 15d.3, Case 1 (D.Mass.1957).

1966 Amendment

Rule 15(c) is amplified to state more clearly when an amendment of a pleading changing the party against whom a claim is asserted (including an amendment to correct a misnomer or misdescription of a defendant) shall "relate back" to the date of the original pleading.

The problem has arisen most acutely in certain actions by private parties against officers or agencies of the United States. Thus an individual denied social security benefits by the Secretary of Health, Education, and Welfare may secure review of the decision by bringing a civil action against that officer within sixty days. 42 U.S.C. § 405(g) (Supp. III, 1962). In several recent cases the claimants instituted timely action but mistakenly named as defendant the United States, the Department of HEW, the "Federal Security Administration" (a nonexistent agency), and a Secretary who had retired from the office nineteen days before. Discovering their mistakes, the claimants moved to amend their complaints to name the proper defendant; by this time the statutory sixty-day period had expired. The motions were denied on the ground that the amendment "would amount to the

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commencement of a new proceeding and would not relate back in time so as to avoid the statutory provision * * * that suit be brought within sixty days * * *" *Cohn v. Federal Security Adm.,* 199 F.Supp. 884, 885 (W.D.N.Y.1961); see also *Cunningham v. United States,* 199 F.Supp. 541 (W.D.Mo.1958); *Hall v. Department of HEW,* 199 F.Supp. 833 (S.D.Tex.1960); *Sandridge v. Folsom, Secretary of HEW,* 200 F.Supp. 25 (M.D.Tenn.1959). [The Secretary of Health, Education, and Welfare has approved certain ameliorative regulations under 42 U.S.C. § 405(g). See 29 Fed.Reg. 8209 (June 30, 1964); Jacoby, *The Effect of Recent Changes in the Law of "Nonstatutory" Judicial Review,* 53 Geo.L.J. 19, 42-43 (1964); see also *Simmons v. United States Dept. HEW,* 328 F.2d 86 (3d Cir. 1964).]

Analysis in terms of "new proceeding" is traceable to *Davis v. L. L. Cohen & Co.,* 268 U.S. 638 (1925), and *Mellon v. Arkansas Land & Lumber Co.,* 275 U.S. 460 (1928), but those cases antedate the adoption of the Rules which import different criteria for determining when an amendment is to "relate back". As lower courts have continued to rely on the *Davis* and *Mellon* cases despite the contrary intent of the Rules, clarification of Rule 15(c) is considered advisable.

Relation back is intimately connected with the policy of the statute of limitations. The policy of the statute limiting the time for suit against the Secretary of HEW would not have been offended by allowing relation back in the situations described above. For the government was put on notice of the claim within the stated period--in the particular instances, by means of the initial delivery of process to a responsible government official (see Rule 4(d)(4) and (5)). In these circumstances, characterization of the amendment as a new proceeding is not responsive to the realty [sic], but is merely question-begging; and to deny relation back is to defeat unjustly the claimant's opportunity to prove his case. See the full discussion by Byse, *Suing the "Wrong" Defendant in Judicial Review of Federal Administrative Action: Proposals for Reform,* 77 Harv.L.Rev. 40 (1963); see also Ill.Civ.P. Act § 46(4).

Much the same question arises in other types of actions against the government (see *Byse,* supra, at 45 n. 15). In actions between private parties, the problem of relation back of amendments changing defendants has generally been better handled by the courts, but incorrect criteria have sometimes been applied, leading sporadically to doubtful results. See 1A Barron & Holtzoff, *Federal Practice & Procedure* § 451 (Wright ed. 1960); 1 id. § 186 (1960); 2 id. § 543 (1961); 3 *Moore's Federal Practice,* par. 15.15 (Cum.Supp.1962); Annot., *Change in Party After Statute of Limitations Has Run,* 8 A.L.R.2d 6 (1949). Rule 15(c) has been amplified to provide a general solution. An amendment changing the party against whom a claim is asserted relates back if the amendment satisfies the usual condition of Rule 15(c) of "arising out of the conduct * * * set forth * * * in the original pleading," and if, within the applicable limitations period, the party brought in by amendment, first, received such notice of the institution of the action--the notice need not be formal--that he would not be prejudiced in defending the action, and, second, knew or should have known that the action would have been brought against him initially had there not been a mistake concerning the identity of the proper party. Revised Rule 15(c) goes on to provide specifically in the government cases that the first and second requirements are satisfied when the government has been notified in the manner there described (see Rule 4(d)(4) and (5)). As applied to the government cases, revised Rule 15(c) further advances the objectives of the 1961 amendment of Rule 25(d) (substitution of public officers).

The relation back of amendments changing plaintiffs is not expressly treated in revised Rule 15(c) since the problem is generally easier. Again the chief consideration of policy is that of the statute of limitations, and the attitude taken in revised Rule 15(c) toward change of defendants extends by analogy to amendments changing plaintiffs. Also relevant is the amendment of Rule 17(a) (real party in interest). To avoid forfeitures of just claims, revised Rule 17(a) would provide that no action shall be dismissed on the ground that it is not prosecuted in the name of the real party in interest until a reasonable time has been allowed for correction of the defect in the manner there stated.

1987 Amendment

The amendments are technical. No substantive change is intended.

1991 Amendment

The rule has been revised to prevent parties against whom claims are made from taking unjust advantage of otherwise inconsequential pleading errors to sustain a limitations defense.

Paragraph (c)(1). This provision is new. It is intended to make it clear that the rule does not apply to preclude any relation back that may be permitted under the applicable limitations law. Generally, the applicable limitations law will be state law. If federal jurisdiction is based on the citizenship of the parties, the primary reference is the law of the state in which the district court sits. *Walker v. Armco Steel Corp.,* 446 U.S. 740 (1980). If federal jurisdiction is based on a federal question, the reference may be to the law of the state governing relations between the parties. *E.g., Board of Regents v. Tomanio,* 446 U.S. 478 (1980). In some circumstances, the controlling limitations law may be federal law. *E.g., West v. Conrail, Inc.,* 107 S.Ct. 1538 (1987). Cf. *Burlington Northern R. Co. v. Woods,* 480 U.S. 1 (1987); *Stewart Organization v. Ricoh,* 108 S.Ct. 2239 (1988). Whatever may be the controlling body of limitations law, if that law affords a more forgiving principle of relation back than the one provided in this rule, it should be available to save the claim. Accord, *Marshall v. Mulrenin,* 508 F.2d 39 (1st Cir.1974). If *Schiavone v. Fortune,* 106 S.Ct. 2379 (1986) implies the contrary, this paragraph is intended to make a material change in the rule.

Paragraph (c)(3). This paragraph has been revised to change the result in *Schiavone v. Fortune, supra,* with respect to the problem of a misnamed defendant. An intended defendant who is notified of an action within the period allowed by Rule 4(m) [subdivision (m) in Rule 4 was a proposed subdivision which was withdrawn by the Supreme Court] for service of a summons and complaint may not under the revised rule defeat the action on account of a defect in the pleading with respect to the defendant's name, provided that the requirements of clauses (A) and (B) have been met. If the notice requirement is met within the Rule 4(m) [subdivision (m) in Rule 4 was a proposed subdivision which was withdrawn by the Supreme Court] period, a complaint may be amended at any time to correct a formal defect such as a misnomer or misidentification. On the basis of the text of the former rule, the Court reached a result in *Schiavone v. Fortune* that was inconsistent with the liberal pleading practices secured by Rule 8. See Bauer, Schiavone: *An Un-Fortune-ate Illustration of the Supreme Court's Role as Interpreter of the Federal Rules of Civil Procedure,* 63 Notre Dame L.Rev. 720 (1988); Brussack, *Outrageous Fortune: The Case for Amending Rule 15(c) Again,* 61 S.Cal.L.Rev. 671 (1988); Lewis, *The Excessive History of Federal Rule 15(c) and Its Lessons for Civil Rules Revision,* 86 Mich.L.Rev. 1507 (1987).

In allowing a name-correcting amendment within the time allowed by Rule 4(m), this rule allows not only the 120 days specified in that rule, but also any additional time resulting from any extension ordered by the court pursuant to that rule, as may be granted, for example, if the defendant is a fugitive from service of the summons.

This revision, together with the revision of Rule 4(i) with respect to the failure of a plaintiff in an action against the United States to effect timely service on all the appropriate officials, is intended to produce results contrary to those reached in *Gardner v. Gartman,* 880 F.2d 797 (4th Cir. 1989), *Rys v. U.S. Postal Service,* 886 F.2d 443 (1st Cir. 1989), *Martin's Food & Liquor, Inc. v. U.S. Dept. of Agriculture,* 14 F.R.D.3d 86 (N.D.Ill.1988). *But cf. Montgomery v. United States Postal Service,* 867 F.2d 900 (5th Cir. 1989), *Warren v. Department of the Army,* 867 F.2d 1156 (8th Cir. 1989); *Miles v. Department of the Army,* 881 F.2d 777 (9th Cir. 1989), *Barsten v. Department of the Interior,* 896 F.2d 422 (9th Cir. 1990); *Brown v. Georgia Dept. of Revenue,* 881 F.2d 1018 (11th Cir. 1989).

1993 Amendment

The amendment conforms the cross reference to Rule 4 to the revision of that rule.

2007 Amendment

The language of Rule 15 has been amended as part of the general restyling of the Civil Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only.

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Former Rule 15(c)(3)(A) called for notice of the “institution” of the action. Rule 15(c)(1)(C)(i) omits the reference to “institution” as potentially confusing. What counts is that the party to be brought in have notice of the existence of the action, whether or not the notice includes details as to its “institution.”

2009 Amendment

Rule 15(a)(1) is amended to make three changes in the time allowed to make one amendment as a matter of course.

Former Rule 15(a) addressed amendment of a pleading to which a responsive pleading is required by distinguishing between the means used to challenge the pleading. Serving a responsive pleading terminated the right to amend. Serving a motion attacking the pleading did not terminate the right to amend, because a motion is not a “pleading” as defined in Rule 7. The right to amend survived beyond decision of the motion unless the decision expressly cut off the right to amend.

The distinction drawn in former Rule 15(a) is changed in two ways. First, the right to amend once as a matter of course terminates 21 days after service of a motion under Rule 12(b), (e), or (f). This provision will force the pleader to consider carefully and promptly the wisdom of amending to meet the arguments in the motion. A responsive amendment may avoid the need to decide the motion or reduce the number of issues to be decided, and will expedite determination of issues that otherwise might be raised seriatim. It also should advance other pretrial proceedings.

Second, the right to amend once as a matter of course is no longer terminated by service of a responsive pleading. The responsive pleading may point out issues that the original pleader had not considered and persuade the pleader that amendment is wise. Just as amendment was permitted by former Rule 15(a) in response to a motion, so the amended rule permits one amendment as a matter of course in response to a responsive pleading. The right is subject to the same 21-day limit as the right to amend in response to a motion.

The 21-day periods to amend once as a matter of course after service of a responsive pleading or after service of a designated motion are not cumulative. If a responsive pleading is served after one of the designated motions is served, for example, there is no new 21-day period.

Finally, amended Rule 15(a)(1) extends from 20 to 21 days the period to amend a pleading to which no responsive pleading is allowed and omits the provision that cuts off the right if the action is on the trial calendar. Rule 40 no longer refers to a trial calendar, and many courts have abandoned formal trial calendars. It is more effective to rely on scheduling orders or other pretrial directions to establish time limits for amendment in the few situations that otherwise might allow one amendment as a matter of course at a time that would disrupt trial preparations. Leave to amend still can be sought under Rule 15(a)(2), or at and after trial under Rule 15(b). [1]

Abrogation of Rule 13(f) establishes Rule 15 as the sole rule governing amendment of a pleading to add a counterclaim.

The times set in the former rule at 10 or 20 days have been revised to 14 or 21 days. See the Note to Rule 6.

Notes of Decisions (5713)

Footnotes

1 If the proposed amendment to Rule 15(a)(3) ... changing the time period is approved by the Judicial Conference, the following additional sentence will be added to the Committee Note: "Amended Rule 15(a)(3) extends from 10 to 14 days the period to respond to an amended pleading."

Fed. Rules Civ. Proc. Rule 15, 28 U.S.C.A., FRCP Rule 15
Including Amendments Received Through 2-1-23

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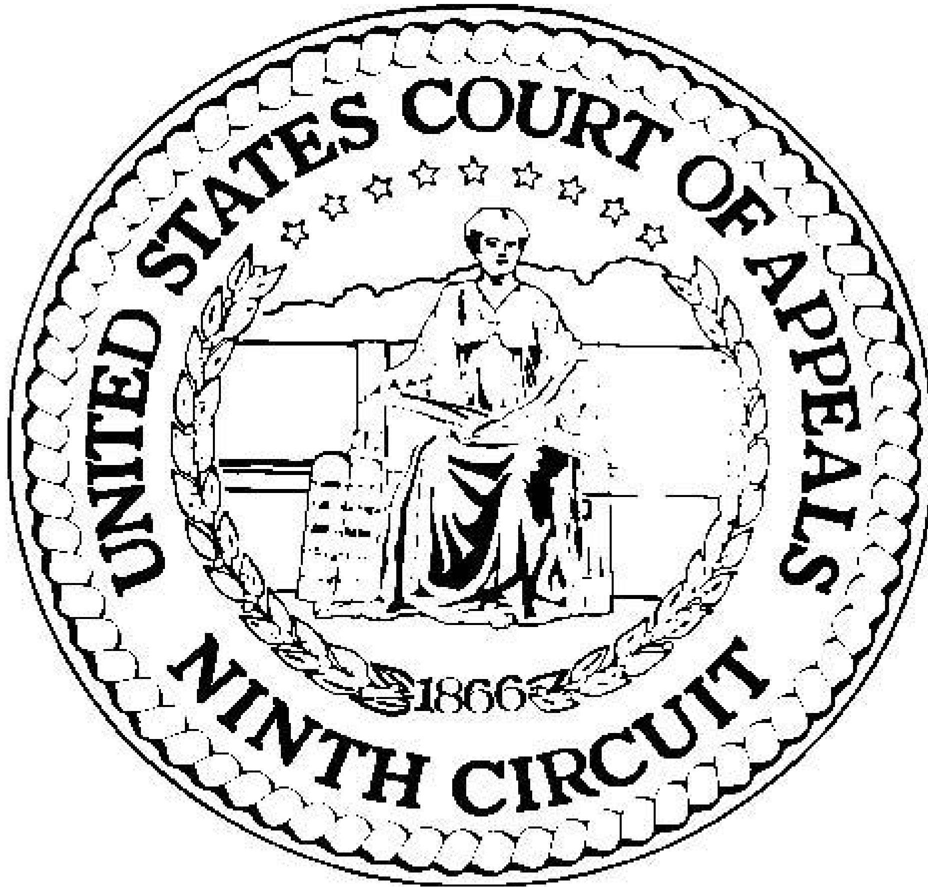
UNITED STATES COURT OF APPEALS

for the NINTH CIRCUIT



GENERAL ORDERS

Revised as of September 8, 2022

6. <u>Notification to En Banc Coordinator</u>

Judges should direct copies of all en banc correspondence under this Chapter to the En Banc Coordinator and the Clerk of Court or any person the Clerk may designate until a final en banc vote is tallied.

7. <u>Death Penalty Cases</u>

En banc procedures in death penalty cases, when a date for execution has been set, are contained in Circuit Rule 22 and shall be supervised by the Capital Case Coordinator.

8. <u>Stay of Mandate</u>

Whenever an off-panel judge timely invokes the procedures set forth in this Chapter, the mandate shall automatically be stayed. *(Rev. 10/26/21)*

5.2. <u>Initial Hearing En Banc</u>

Pursuant to Fed. R. App. P. 35(c), a petition requesting that an appeal be heard initially en banc must be filed by the date when the appellee's brief is due. The petition shall be referred to the three-judge panel assigned to the case for resolution. The panel may deny the petition on behalf of the Court or request that the Court vote on whether to hear the case initially en banc.

A three-judge panel may also, *sua sponte*, and in accordance with the rules

pertaining to *sua sponte* en banc calls, request a vote on whether a case assigned to that panel should be heard initially en banc. *(Rev. 10/26/21)*

5.3. Amendment of Disposition; Proposal by Judge

a. Amendment of Disposition

If a panel amends its disposition, the panel shall set forth in its amended disposition or separate order: (1) the ruling on the petition for rehearing or petition for rehearing en banc; (2) whether subsequent petitions for rehearing or rehearing en banc may be filed; and (3) the status of any pending petitions for rehearing or rehearing en banc not ruled on. The Clerk's Office shall contact the authoring judge if the amended disposition does not so specify. *(New 7/1/02)*

If a panel substantively amends its disposition, any off-panel judge may, within 7 days of the filing of the amended disposition, notify the panel and the other members of the Court that he or she is considering making an en banc call on the basis of the substantive amendment. Such notification shall extend the time to make an en banc call by 14 days. Thereafter, the provisions of this Chapter relating to a sua sponte en banc calls shall apply. *(New 12/1/02; Rev. 10/26/21)*

b. Proposal by Judge

Any active or senior judge may, before an en banc call is made or before the time for calling for en banc expires, propose to the panel that it amend its

Code of Federal Regulations
Title 42. Public Health
Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)
Subchapter B. Medicare Program
Part 422. Medicare Advantage Program (Refs & Annos)
Subpart G. Payments to Medicare Advantage Organizations (Refs & Annos)

42 C.F.R. § 422.308

§ 422.308 Adjustments to capitation rates, benchmarks, bids, and payments.

Effective: June 6, 2011
Currentness

CMS performs the following calculations and adjustments to determine rates and payments:

(a) National per capita growth percentage.

(1) The national per capita growth percentage for a year, applied under § 422.306, is CMS' estimate of the rate of growth in per capita expenditures under this title for an individual entitled to benefits under Part A and enrolled under Part B. CMS may make separate estimates for aged enrollees, disabled enrollees, and enrollees who have ESRD.

(2) The amount calculated in paragraph (a)(1) of this section must exclude expenditures attributable to sections 1848(a)(7) and (o) and sections 1886(b)(3)(B)(ix) and (n) of the Act.

(b) Adjustment for over or under projection of national per capita growth percentages. CMS will adjust the minimum percentage increase rate at § 422.306(a)(2) and the adjusted average per capita cost rate at § 422.306(b)(2) for the previous year to reflect any differences between the projected national per capita growth percentages for that year and previous years, and the current estimates of those percentages for those years. CMS will not make this adjustment for years before 2004.

(c) Risk adjustment—

(1) General rule. CMS will adjust the payment amounts under § 422.304(a)(1), (a)(2), and (a)(3) for age, gender, disability status, institutional status, and other factors CMS determines to be appropriate, including health status, in order to ensure actuarial equivalence. CMS may add to, modify, or substitute for risk adjustment factors if those changes will improve the determination of actuarial equivalence.

(2) Risk adjustment: Health status—

(i) Data collection. To adjust for health status, CMS applies a risk factor based on data obtained in accordance with § 422.310.

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(ii) Implementation. CMS applies a risk factor that incorporates inpatient hospital and ambulatory risk adjustment data. This factor is phased as follows:

(A) 100 percent of payments for ESRD MA enrollees in 2005 and succeeding years.

(B) 75 percent of payments for aged and disabled enrollees in 2006.

(C) 100 percent of payments for aged and disabled enrollees in 2007 and succeeding years.

(3) Uniform application. Except as provided for MA RFB plans under § 422.304(c)(3), CMS applies this adjustment factor to all types of plans.

(4) Authority to apply frailty adjustment under PACE payment rules for certain specialized MA plans for special needs individuals.

(i) Application of payment rules. For plan year 2011 and subsequent plan years, in the case of a plan described in paragraph (c)(4)(ii) of this section, the Secretary may apply the payment rules under section 1894(d) of the Act (other than paragraph (3) of that section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(ii) Plan described. A plan described in this paragraph is a fully integrated dual-eligible special needs plan, as defined at § 422.2, and has a similar average level of frailty (as determined by the Secretary) as the PACE program.

(5) Application of coding adjustment.

(i) In applying the adjustment under paragraph (c)(1) of this section for health status to payment amounts, the Secretary ensures that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between MA plans and providers under Part A and B to the extent that the Secretary has identified such differences.

(ii) In order to ensure payment accuracy, the Secretary annually conducts an analysis of the differences described in paragraph (c)(5)(i) of this section.

(A) The Secretary completes such analysis by a date necessary to ensure that the results of such analysis are incorporated on a timely basis into the risk scores for 2008 and subsequent years.

(B) In conducting such analysis, the Secretary uses data submitted with respect to 2004 and subsequent years, as available and updated as appropriate.

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(iii) In calculating each year's adjustment, the adjustment factor is as follows:

(A) For 2014, not less than the adjustment factor applied for 2010, plus 1.3 percentage points.

(B) For each of the years 2015 through 2018, not less than the adjustment factor applied for the previous year, plus 0.25 percentage points.

(C) For 2019 and each subsequent year, not less than 5.7 percent.

(iv) Such adjustment is applied to risk scores until the Secretary implements risk adjustment using MA diagnostic, cost, and use data.

(6) Improvements to risk adjustment for special needs individuals with chronic health conditions—

(i) General rule. For 2011 and subsequent years, for purposes of the adjustment under paragraph (c)(1) of this section with respect to individuals described in paragraph (c)(6)(ii) of the section, the Secretary uses a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score is used instead of the default risk score for new enrollees in MA plans that are not specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Act).

(ii) Individuals described. An individual described in this clause is a special needs individual described in section 1859(b)(6)(B)(iii) of the Act who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(iii) Evaluation. For 2011 and periodically thereafter, the Secretary evaluates and revises the risk adjustment system under this paragraph in order to, as accurately as possible, account for—

(A) Higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness; and

(B) Costs that may be associated with higher concentrations of beneficiaries with the conditions specified in paragraph (c)(6)(iii)(A) of this section.

(iv) Publication of evaluation and revisions. The Secretary publishes, as part of an announcement under section 1853(b) of the Act, a description of any evaluation conducted under paragraph (c)(6)(iii) of this section during the preceding year and any revisions made under paragraph (c)(6)(iii) of this section as a result of such evaluation.

(d) Adjustment for intra-area variations. CMS makes the following adjustments to payments.

(1) Intra-regional variations. For payments for an MA regional plan for an MA region, CMS will adjust the payment amount specified at § 422.304(a)(1) and (a)(2) to take into account variations in local payment rates among the different MA local areas included in the region.

(2) Intra-service area variations. For payments to an MA local plan with a service area covering more than one MA local area (county), CMS will adjust the payment amount specified in § 422.304(a)(1) and (a)(2) to take into account variations in local payment rates among the different MA local areas included in the plan's service area.

(e) Adjustment relating to risk adjustment: the government premium adjustment. CMS will adjust payments to an MA plan as necessary to ensure that the sum of CMS' monthly payment made under § 422.304(a) and the plan's monthly basic beneficiary premium equals the unadjusted MA statutory non-drug bid amount, adjusted for risk and for intra-area or intra-regional payment variation.

(f) Adjustment of payments to reflect number of Medicare enrollees—

(1) General rule. CMS adjusts payments retroactively to take into account any difference between the actual number of Medicare enrollees and the number on which it based an advance monthly payment.

(2) Special rules for certain enrollees.

(i) Subject to paragraph (f)(2)(ii) of this section, CMS may make adjustments, for a period (not to exceed 90 days) that begins when a beneficiary elects a group health plan (as defined in § 411.1010) offered by an MA organization, and ends when the beneficiary is enrolled in an MA plan offered by the MA organization.

(ii) CMS does not make an adjustment unless the beneficiary certifies that, at the time of enrollment under the MA plan, he or she received from the organization the disclosure statement specified in § 422.111.

(g) Adjustment for national coverage determination (NCD) services and legislative changes in benefits. If CMS determines that the cost of furnishing an NCD service or legislative change in benefits is significant, as defined in § 422.109, CMS will adjust capitation rates, or make other payment adjustments, to account for the cost of the service or legislative change in benefits. Until the new capitation rates are in effect, the MA organization will be paid for the significant cost NCD service or legislative change in benefits on a fee-for-service basis as provided under § 422.109(b).

(h) Adjustments to payments to regional MA plans for purposes of risk corridor payments. For the purpose of calculation of risk corridors under § 422.458, MA organizations offering regional MA plans in 2006 and/or 2007 must submit, after the end of a contract year and before a date CMS specifies, the following information:

(1) Actual allowable costs (defined in § 422.458(a)) for the previous contract year.

(2) The portion of the costs attributable to administrative expenses incurred in providing these benefits.

(3) The total costs for providing rebatable integrated benefits (as defined in § 422.458(a)) and the portion of the costs that is attributable to administrative expenses in addition to the administrative expenses described in paragraph (h)(2) of this section.

Credits

[70 FR 4729, Jan. 28, 2005, as amended at 75 FR 44564, July 28, 2010; 76 FR 21567, April 15, 2011]

SOURCE: 70 FR 4714, Jan. 28, 2005; 70 FR 4729, Jan. 28, 2005; 77 FR 29028, May 16, 2012; 84 FR 15827, April 16, 2019; 84 FR 23879, May 23, 2019, unless otherwise noted.

AUTHORITY: 42 U.S.C. 1302 and 1395hh.

Current through Feb. 22, 2023, 88 FR 10855. Some sections may be more current. See credits for details.

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