UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, v. ANTHEM, INC., Defendant.	Case No. 1:20-cv-02593-ALC **NOTICE OF DEFENDANT ANTHEM, INC.'S (1) MOTION TO TRANSFER VENUE, (2) MOTION TO DISMISS, AND (3) MOTION TO STRIKE** **Oral Argument Requested**

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that Defendant Anthem, Inc. ("Anthem"), hereby respectfully moves this Court for an order transferring this action to the United States District Court for the Southern District of Ohio pursuant to 28 U.S.C. § 1404(a). In the event the Court does not transfer this action, Anthem respectfully moves this Court for an order dismissing, pursuant to Federal Rule of Civil Procedure 12(b)(6), the First and Second Claims for Relief in Plaintiff's Amended Complaint, as well as the portion of the Third Claim for Relief that is based on Anthem's Medicare risk adjustment data attestations, and striking, pursuant to Federal Rule of Civil Procedure 12(f), paragraphs 99 through 105 of the Amended Complaint.

Anthem's motion to transfer is based upon the accompanying Memorandum of Law and the Declarations of James A. Bowman and Brian M. Cogdill, filed concurrently herewith, as well as the Amended Complaint on file in this matter (Dkt. #26) and any argument presented in connection with the hearing of these motions. Anthem's motion to dismiss and motion to strike are based upon the accompanying Memorandum of Law, filed concurrently herewith, as well as

the Amended Complaint on file in this matter (Dkt. #26) and any argument presented in connection with the hearing of these motions.

Dated: September 17, 2020

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,

Plaintiff,

v.

ANTHEM, INC.,

Defendant.

Case No. 1:20-cv-02593-ALC

MEMORANDUM OF LAW IN SUPPORT OF DEFENDANT ANTHEM, INC.'S (1) MOTION TO TRANSFER VENUE, (2) MOTION TO DISMISS, AND (3) MOTION TO STRIKE

Oral Argument Requested

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page(s)

Cases

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

Statutes

TABLE OF AUTHORITIES
(continued)

Page(s)

Other Authorities

Rules

TABLE OF AUTHORITIES
(continued)

Page(s)

Regulations

INTRODUCTION

Pursuant to the Court's August 8, 2020 order, Defendant Anthem, Inc. ("Anthem" or "the Company") submits this memorandum of law in support of three concurrently-filed motions: (1) a motion to transfer this action to the Southern District of Ohio, where the most relevant Anthem business operations were based, and where the witnesses who will be most material to this litigation are located; (2) a motion to dismiss Plaintiff's First and Second Claims for Relief (referred to herein as "Claims") in the Amended Complaint, and part of the Third Claim, for failure to allege materiality under the False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq.*; and (3) a motion to strike from the Amended Complaint irrelevant and prejudicial allegations regarding Plaintiff's prior settlements with non-parties.

This lawsuit relates to the Medicare Advantage ("MA") program, in which Medicare beneficiaries receive their health benefits through private insurance companies like Anthem—commonly referred to as Medicare Advantage Organizations ("MAOs")—rather than through traditional Medicare. Unlike traditional Medicare, where the Centers for Medicare and Medicaid Services ("CMS") reimburses healthcare providers based on the services they render to beneficiaries, CMS compensates MAOs prospectively based on the financial risk that the MAOs assume to provide Medicare benefits to their members. This risk is determined, in part, based on diagnosis codes that healthcare providers report from their encounters with the MAOs' members.

Plaintiff's Claims fundamentally concern a specific business process, Anthem's retrospective chart review program. As part of this program, Anthem (1) reviewed medical records from healthcare providers who rendered medical care to its MA members, (2) identified diagnosis codes for medical conditions that were documented in the medical records for those members, and then (3) submitted those diagnosis codes to CMS if the codes had not previously

been provided to the agency. Chart review programs like the one at issue in this case are common in the MA industry. CMS not only knows that Anthem and other MAOs submit additional diagnosis codes identified from these medical record reviews, but CMS program guidance explicitly authorizes the submission of diagnosis codes identified from chart reviews.

Plaintiff contends that when Anthem reviewed medical records to determine if any diagnosis codes that should be on file with CMS had not been previously submitted, Anthem was ***also*** required to review those medical records to verify the accuracy of diagnosis codes that healthcare providers had previously reported to Anthem—and by extension CMS—for those same member visits. But no regulation has ever required Anthem to use its retrospective chart reviews to confirm that previously-submitted diagnosis codes were supported in the members' medical records. In fact, CMS proposed a regulation to impose such a requirement in 2014 but withdrew it after receiving industry comments objecting to the proposal. Plaintiff has thus sued Anthem here for not implementing a business practice that CMS itself expressly declined to require.

In the Amended Complaint, Plaintiff alleges that when Anthem submitted annual attestations to CMS that its risk adjustment data was "accurate, truthful and complete," those attestations were knowingly false claims for payment under the FCA because Anthem did not use its chart review program to identify potentially unsupported diagnosis codes. The Amended Complaint relies on two separate theories of FCA liability—one based on allegedly false attestations and another based on individual diagnosis codes that were allegedly false. Plaintiff's attestation-based FCA theory, appearing in Claims One and Two of the Amended Complaint, and part of Claim Three, is that Anthem's chart review program rendered its attestations false because the program did not include a review of medical records to identify unsupported

diagnosis codes that healthcare providers had previously submitted to Anthem and that the Company in turn submitted to CMS. Amended Complaint ("AC") ¶¶5-7, 156. Plaintiff's diagnosis code-based theory, which is stated in Claim Three, is that Anthem submitted specific diagnosis codes to CMS that the Company later learned (or should have learned) were unsupported by medical records, that Anthem did not correct those unsupported codes, and that each of those unsupported diagnosis codes resulted in the Company retaining an overpayment from CMS. *Id.* ¶171; *see also id.* ¶¶42-43.

This memorandum of law is filed in support of three motions, one that addresses where this suit should be litigated and two addressing flaws in Plaintiff's pleading. The allegations in Plaintiff's Amended Complaint are virtually identical to its allegations against a separate MAO for its chart review operations in *United States ex rel. Poehling v. United Health Care*, 16-cv-08697-FMO (C.D. Cal.), where the court held that the appropriate venue for FCA claims related to the MAO's chart review program was the district where that program was located. Additionally, in *Poehling* and another case like it, the district courts concluded that Plaintiff's allegations regarding the MAO's attestations—virtually identical to those at issue here—failed to adequately allege materiality under the FCA, and dismissed Plaintiff's attestation-based claims. *See United States ex. rel. Swoben v. Scan Health Plan*, 2017 WL 4564722 (C.D. Cal. Oct. 5, 2017); *Poehling*, 2018 WL 1363487 (C.D. Cal. Feb. 12, 2018). Anthem similarly moves to transfer this case to the judicial district where its chart review operations were located, and to dismiss the attestation-based Claims asserted in the Amended Complaint for the reasons stated in *Poehling* and *Swoben*.

I. Motion To Transfer: The Southern District of New York is not the appropriate forum for this case. ***No*** material witnesses live in this judicial district and ***no*** business operations

relevant to this litigation have ever been based here. Indeed, during its three-year investigation, Plaintiff did not depose a single witness who lives here. New York is referenced in only four of the Amended Complaint's 178 paragraphs, and then only to allege that Anthem serves MA beneficiaries, maintains an office, and collects medical records from healthcare providers in this district; facts that make this judicial district indistinguishable from other districts across the country. Those facts may establish the bare jurisdictional connection to this district, but fall far short of establishing that it is the most appropriate and convenient forum under 28 U.S.C. § 1404(a).

The most appropriate forum for this case is the Southern District of Ohio. To resolve Plaintiff's Claims, the Court will need to understand Anthem's retrospective chart review program and related business processes. This program originated out of Anthem's office in Columbus, Ohio, was designed by Anthem personnel in that office, and has continuously been operated out of that location for essentially the entire time period at issue. The other business processes that Anthem designed to satisfy the regulatory obligations cited throughout the Amended Complaint—such as provider education, guidance on diagnosis coding standards, and audits of provider-submitted data—were likewise designed and directed predominantly by Anthem personnel in Columbus. The centrality of the business processes based in Ohio is evident from the Amended Complaint; approximately 40 paragraphs in the Amended Complaint describe these and other business processes that were primarily directed by Anthem personnel based in Columbus, and the Amended Complaint repeatedly quotes documents written by Anthem employees who live and work there.

Under § 1404(a), those facts far outweigh the irrelevant connections the Amended Complaint draws to this district, which do not distinguish this judicial district from others across

the country. Indeed, in *Poehling*, on nearly identical facts, ***Plaintiff*** convinced the court to transfer the action from New York to the venue where the defendant MAO's chart review program had been operated. The same logic compels that this case be transferred to the Southern District of Ohio under 28 U.S.C. § 1404(a).

If the Court transfers this action to the Southern District of Ohio, it need not address Anthem's remaining motions. At the same time, because Anthem moves to dismiss only some of Plaintiff's Claims, Anthem's motion to transfer will not be rendered moot if the Court grants Anthem's other motions.

II. Motion To Dismiss: Plaintiff has failed to allege that its FCA Claims based on Anthem's attestations were material, as required by the FCA. Accordingly, the Court should—consistent with the only two courts to have addressed this exact issue—dismiss Claim One, Claim Two, and a portion of Claim Three. Anthem does not move to dismiss the portion of Claim Three that alleges violations of the FCA based on the Company knowingly retaining overpayments tied to certain individual diagnosis codes submitted to CMS that Anthem allegedly learned were not supported by the members' medical records.

Under *Universal Health Services v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016), Plaintiff must allege facts demonstrating that the manner in which Anthem operated its chart review program was "material to the Government's payment decision," *id.* at 1996, meaning that CMS "would not have paid [the] claim[] had it known of [the] violation[]," *id.* at 2004. Thus, Plaintiff must allege facts showing that CMS would have refused to make risk adjustment payments to Anthem had it known that Anthem was not using its chart review program to identify potentially unsupported diagnosis codes that were previously submitted to the agency.

But Plaintiff fails to make the basic and necessary allegation that CMS would have refused to make payment, much less allege facts plausibly supporting that contention. That failure is particularly telling given that Plaintiff has twice brought nearly identical claims based on the retrospective chart review practices of another MAO, and in both cases, the courts dismissed Plaintiff's attestation-based claims for failing to adequately plead materiality under the FCA. *Swoben*, 2017 WL 4564722, at *6; *Poehling*, 2018 WL 1363487, at *10. As here, *Swoben* and *Poehling* involved FCA claims by the United States alleging that the MAO's annual attestations were false because it did not use its chart review program to identify potentially unsupported diagnosis codes. And as here, Plaintiff failed to allege that CMS would have refused to pay the MAO if it had known how the MAO was conducting its chart reviews. In both cases, the district courts held that this failure was fatal to Plaintiff's claims and dismissed those claims for failure to meet the FCA's "rigorous" and "demanding" materiality standard described in *Escobar*. As the *Swoben* court put it, under *Escobar* "the complaint must allege that the violations at issue 'are so central that the Government would not have paid these claims had it known of these violations.'" 2017 WL 4564722, at *6 (quoting *Escobar*, 136 S. Ct. at 2004 (alterations omitted)). The *Poehling* court reached the same conclusion, holding that "as in *Swoben*, the Government . . . failed to allege that CMS would have refused to make risk adjustment payments if it had known the Attestations were false." 2018 WL 1363487, at *10.

Knowing full well that it would need to address the pleading failures that doomed its attestation-based claims in *Swoben* and *Poehling*, Plaintiff nevertheless failed to allege that it "would have refused to make risk adjustment payments" to Anthem if it had known how the Company's chart review program operated. As in *Poehling* and *Swoben*, the only explanation

for Plaintiff's failure to assert this basic allegation is that it cannot do so in good faith under Rule 11.

Instead, Plaintiff alleges that CMS might have taken certain actions had it known that Anthem had specific knowledge of particular unsupported diagnosis codes that were submitted to CMS but never deleted. AC ¶¶162, 167. This materiality allegation fails to meet *Escobar*'s standard in three crucial ways, each of which independently requires dismissal of Plaintiff's attestation-based Claims.

First, the Amended Complaint does not plead that the alleged falsity of the attestations was material to CMS's decision to pay Anthem. Plaintiff never contends that if the agency had known how the Company operated its chart review program, it would have denied payment to Anthem because of the supposedly false attestations. Instead, Plaintiff alleges that something ***entirely different*** would have been material to CMS, namely that it would have been material to CMS if Anthem had actual knowledge of specific unsupported diagnosis codes. Thus, the alleged falsity of the attestations is not what Plaintiff alleges would have been material to CMS. The fact that is allegedly material to CMS in the Amended Complaint is not the manner in which Anthem conducts its retrospective chart reviews but instead the Company's supposed knowledge that specific diagnosis codes previously submitted to the agency are unsupported by the medical records. *Escobar* makes clear that, for false certification theories of liability, Plaintiff must plead that the government would have rejected the claim for payment because of the alleged falsity. *Escobar*, 136 S. Ct. at 2004; *see id.* at 2003 n.5. As *Swoben* and *Poehling* held, here that requires an allegation that CMS would have refused to make "risk adjustment payments" if it had known of the chart review practices that allegedly rendered the attestation false. *Poehling*, 2018 WL 1363487, at *10. Because the Amended Complaint does not allege that CMS would have

done ***anything*** if the agency had learned how Anthem was operating its chart review program (much less that it would have denied payment), the attestation-based FCA Claims must be dismissed.

Second, Plaintiff's materiality allegation fails for the independent reason that it provides a non-exhaustive list of actions that CMS ***might*** have taken, rather than making the clear and definite statement required by *Escobar* that CMS ***would*** have denied payment. Specifically, Plaintiff alleges that had CMS known that Anthem's attestations were false, it might have taken certain actions in response, including (but not limited to) recouping payments through administrative processes, adjusting reconciliation payments, or pursuing an enforcement action. AC ¶¶162, 167. But this allegation merely establishes that CMS would have had the ***option*** to deny payment, which *Escobar* squarely held is insufficient to plead that an allegedly false certification was material, *Escobar*, 136 S. Ct. at 1995. This contention falls well short of the concrete allegation required by *Escobar*, *Swoben*, and *Poehling*.

Finally, Plaintiff does not allege that CMS has denied payment "in the mine run of cases" based on the kind of conduct alleged here, even though such evidence is central to a showing of materiality under *Escobar*. *See id.* at 2003. Plaintiff, in fact, does not allege that CMS has ***ever*** withheld payment from any MAO upon learning that the MAO did not use its chart reviews to identify unsupported diagnosis codes. Nor does Plaintiff allege that, at any time after its three-year investigation of these issues, CMS ever denied payment to Anthem on this basis (because it cannot). The Amended Complaint also does not explain ***why*** operating a chart review program in this manner would have mattered at all to CMS's payment decision.

Indeed, Plaintiff has failed to allege ***any*** facts to support its conclusory assertion that the alleged falsities in Anthem's attestations might have impacted CMS's payment decision. FCA

plaintiffs must not only allege that CMS would have denied payment, but they also must plead specific facts to support the allegation. Here, Plaintiff has not alleged any facts bearing on materiality beyond the conclusory assertions held to be insufficient in *Poehing* and *Swoben*. These fatal pleading failures are understandable in light of the fact that CMS has never required perfect data accuracy from MAOs and expressly declined in 2014 to impose a regulation requiring that MAOs conduct chart reviews in the precise manner advanced by Plaintiff in this case.

Plaintiff is well aware after *Swoben* and *Poehling* that to adequately plead materiality of its attestation-based FCA Claims, it must allege that CMS would have denied payment to Anthem had it known how the Company operated its chart review program. The fact that it has not made this simple allegation (much less with the required supporting factual contentions), even after the dismissal of identical claims in *Swoben* and *Poehling*, is clearly because it cannot truthfully do so. The Court should dismiss Plaintiff's attestation-based Claims for failure to plead sufficient facts to meet the materiality standard required by *Escobar*.

III. Motion To Strike: The Amended Complaint improperly references Plaintiff's prior settlements—down to the dollar amounts—with other MAOs or healthcare providers in suits challenging conduct that is not at issue here. Under clear Second Circuit authority, those allegations have no place in a complaint, are unfairly prejudicial, and must be stricken pursuant to Rule 12(f). *See Lipsky v. Commonwealth United Corp.*, 551 F.2d 887, 894 (2d Cir. 1976).

For these reasons, the Court should grant Anthem's motions.

BACKGROUND

I. The Medicare Advantage Program's Risk-Adjusted Payments

Medicare is a federal health insurance program administered by CMS. AC ¶21. Beneficiaries may receive their hospital and medical benefits through either Medicare Parts A

and B, which is known as traditional Medicare, or through Part C, which is called Medicare Advantage. *Id.* ¶¶22-23. In MA, beneficiaries receive their benefits through private MA plans administered by insurance companies that CMS calls MAOs. *Id.* ¶23. CMS contracts with MAOs, such as Anthem, to offer MA plans to Medicare beneficiaries. *Id.* ¶26.

The payment systems for traditional Medicare and MA differ significantly. In traditional Medicare, CMS directly reimburses physicians and other healthcare providers on a fee-for-service basis. *Id.* ¶22. CMS thus compensates healthcare providers ***retrospectively*** for services they have already rendered to beneficiaries. In the MA program, CMS compensates MAOs ***prospectively*** based on the estimated cost of care for the MAO's members during the next year. *Id*. ¶39.

MAOs receive a monthly payment from CMS that takes into account the risk profile of theirs members based, in part, on the likelihood that those members will require increased cost for their care. 42 U.S.C. § 1395w-23. CMS thus pays MAOs more for MA members who are more likely to incur additional healthcare costs based in part on each of the members' prior year health profiles. CMS, Medicare Managed Care Manual, Chapter 7, § 70.1 and 70.5.1 (2014). The process of adjusting payments to MAOs to account for variations in the anticipated cost of insuring members is known as "risk adjustment." *Id.*

The risk adjustment system that CMS employs to determine payments to MAOs relies on "diagnosis codes," which are primarily assigned by healthcare providers during face-to-face encounters with beneficiaries, for two different purposes. First, CMS determines the expected costs of care for various health conditions by calculating "risk coefficients" that are designed to measure the marginal expected costs of providing medical care for beneficiaries diagnosed with certain conditions. For instance, if CMS has determined that having a particular condition—*e.g.*,

diabetes—increases a patient's expected healthcare costs by 20% based on traditional Medicare cost data, then the risk coefficient for that condition in the MA program would be 0.2. As a general matter, risk coefficients increase based on the relative expense historically associated with treating the various health conditions reported by providers. For that reason, the risk coefficient for diabetes with acute complications is higher than the coefficient for diabetes without complications, because CMS's analysis of traditional Medicare claims data indicates that CMS has historically incurred higher marginal costs for the treatment of beneficiaries diagnosed with the former condition. *See* CMS, Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, at 79-82 (Apr. 4, 2016), *available at* https://tinyurl.com/h8ny3x9. The CMS risk coefficients are derived from diagnosis codes submitted to CMS by healthcare providers who treat traditional Medicare beneficiaries, and the vast majority of that data are not audited by CMS to determine if they are supported by the relevant medical records.

Second, CMS relies on the diagnosis codes that MAOs submit for their members to determine which risk coefficients will be applied to "adjust" an MAO's base payment rate for a particular member. Like the diagnosis codes that CMS receives for traditional Medicare beneficiaries, the diagnosis codes submitted by MAOs are primarily assigned by healthcare providers who treat the MAOs' members. Those providers submit diagnosis codes to MAOs that, in turn, submit them to CMS. CMS then assigns the risk coefficients that correspond to each of the diagnosis codes that the MAOs submitted for their members. The agency aggregates the various risk coefficients for each MAO member as part of calculating that member's so-called "risk score," which determines the monthly premium payment to the MAO for each member. The CMS risk adjustment model is premised on the average MA member having a risk

score of 1.0. A simplified illustration shows how the CMS system works. Hypothetically, if an otherwise average member is diagnosed by her physician with both diabetes, with the hypothetical risk coefficient of 0.2, and rheumatoid arthritis, with a hypothetical risk coefficient of 0.4, then that member's risk score would be 1.6. The two coefficients (*i.e.*, 0.2 + 0.4) would be added to the base risk score of 1.0 to produce a total risk score of 1.6. CMS would then pay the MAO 160% of the applicable base rate for that member. So, if the applicable base rate were $1,000 in this hypothetical, CMS would pay a $1,600 monthly premium to the MAO for that member.

By statute, CMS not only must adjust MA premium payments "for such risk factors as . . . health status," but must do so in a manner that "***ensure[s] actuarial equivalence***." 42 U.S.C. § 1395w-23(a)(1)(C)(i) (emphasis added). As Plaintiff has put it, the Social Security Act's ("Act's") "actuarial equivalence" requirement mandates equivalence "between the average payments that CMS would expect to make on behalf of a given beneficiary under traditional . . . Medicare, and the payments made to [MAOs] for covering an individual with those same characteristics." Defs.' Cross-Mot. for Summ. J. 8, *United Healthcare Ins. Co. v. Azar II ("Azar II")*, No. 1:16-cv-00157-RMC (D.D.C. Dec. 4, 2017), ECF No. 57-1 at 16. In other words, the statute requires CMS to compensate MAOs for a given MA member in an amount that equals the costs that CMS would incur in traditional Medicare to provide benefits to that same beneficiary. *Azar II*, 330 F. Supp. 3d 173, 184 (D.D.C. 2018).

II. CMS Calculates Payments to MAOs Based in Part on Diagnosis Code Data from Traditional Medicare That CMS Knows Is Not Supported by the Medical Records

As CMS is well aware, a significant percentage of diagnosis codes submitted by healthcare providers in traditional Medicare lack sufficient support in the medical record under established CMS coding and documentation standards. Nevertheless, CMS uses these

unsupported diagnosis codes to calculate the risk coefficients for different medical conditions. *See id.* at 186 (noting that CMS acknowledged in litigation that traditional Medicare diagnosis data contains "known and unknown errors").

Those unsupported diagnosis codes are thus baked into the MA payment model. Specifically, because the vast majority of the traditional Medicare diagnosis data that CMS uses to calculate risk coefficients is ***not audited***, the coefficients calculated from that data understate the actual costs required to treat the medical conditions included in the risk adjustment model. Simplifying somewhat, CMS's risk coefficients reflect the agency's total expenditures on traditional Medicare beneficiaries assigned a particular diagnosis code, divided by the total number of beneficiaries assigned that diagnosis code. But because some of the beneficiaries in traditional Medicare do not actually have the underlying medical condition associated with the reported diagnosis code—at least as reflected in their medical records—the denominator is artificially high, and so the resulting risk coefficient (and corresponding payment to the MAO) is artificially depressed.

Another simplified example illustrates the point: If traditional Medicare data showed that the additional cost of providing healthcare to 10 beneficiaries diagnosed with diabetes was a total of $100,000, the expected increase in Medicare's per-capita cost for care related to diabetes would be $10,000 (*i.e.*, $100,000 of marginal costs for treating Medicare beneficiaries diagnosed with diabetes divided by 10 Medicare beneficiaries diagnosed with diabetes = $10,000 per capita marginal cost of care for diabetes). But if only 8 of the 10 beneficiaries in CMS's sample ***actually*** had diabetes, that $100,000 figure should be divided by 8, not 10, to calculate the true cost of providing care associated with a diabetes diagnosis. Thus, the per-capita cost estimate should actually be $12,500, rather than $10,000 (*i.e.*, $100,000 of marginal costs for treating

Medicare beneficiaries diagnosed with diabetes divided by 8 Medicare beneficiaries who actually have diabetes = $12,500 per capita marginal cost of care for diabetes). In CMS's own words, "[i]f we include diagnoses for beneficiaries who don't actually have the disease, or for whom the medical record documentation is not clear, this tends to reduce the estimated average cost of various conditions and therefore our risk adjustment factors." *Azar II*, 1:16-cv-00157-RMC (D.D.C. Oct. 2, 2017), ECF 44-4 at 3; *see also Azar II*, 330 F. Supp. 3d at 184 ("[T]he risk adjustment model is built on unaudited data about traditional, fee-for-service Medicare beneficiaries, which must contain errors." (quoting CMS brief)). CMS thus ***knows*** that some of the unaudited diagnosis codes that it receives for traditional Medicare beneficiaries reflect conditions those beneficiaries do not have, yet those codes are hard-wired into its MA payment system.

CMS's decision to build the risk adjustment payment system on unaudited diagnosis codes submitted for beneficiaries in traditional Medicare is important to this case for two reasons. First, the Act's requirement of "actuarial equivalence" prohibits the United States from using a different documentation standard to determine payment to MAOs than the documentation standard that it used to create the risk coefficients. Second, when CMS requires more stringent documentation for the MAO data than it does for the data in traditional Medicare that is used to calculate the risk coefficients, CMS systematically undercompensates MAOs for the likely costs of providing Medicare benefits to MA members.

CMS has recognized as much. In CMS's Risk Adjustment Data Validation ("RADV") audit program, CMS reviews the medical records for selected MAO members to determine if the conditions on file with CMS for the selected members are supported by the members' medical records. Declaration of Brian Matthew Cogdill ("Cogdill Decl.") ¶10(vi) n.3. In 2010, CMS

proposed that it would calculate "payment errors" to MAOs through the RADV program by identifying the difference between the amount that the agency paid an MAO for the sampled members and the amount that CMS would have paid the MAO based on just the diagnosis codes for those members that the RADV audit found were supported by the medical records. It proposed to then extrapolate that "payment error" contract-wide.[1] Responding to this proposal, MAOs explained that "[i]t is mathematically certain that payments calculated using [CMS's] Proposed Methodology would not accurately reflect the costs of providing benefits to Medicare Advantage members" and would "significantly underpay[] [MAOs] for the risks they assume." Humana, Comment Letter on RADV Sampling and Error Calculation Methodology 1 (Jan. 21, 2011), *Poehling*, 2:16-cv-8697-FMO-SS, ECF No. 182-1 at 42. In response, CMS acknowledged the MAOs' actuarial concerns and announced that payment recoveries based on RADV audits would be calculated only after applying a fee-for-service adjuster ("FFS Adjuster") to "account[] for the fact that the documentation standard used in RADV audits to determine a contract's payment error (medical records) is different from the documentation standard used to develop the Part C risk-adjustment model ([traditional Medicare] claims)."[2]

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[1] CMS, Medicare Advantage Risk Adjustment Data Validation (RADV) Notice of Payment Error Calculation Methodology for Part C Organizations Selected for Contract-Level RADV Audits – Request for Comment (Dec. 20, 2010). *See Poehling*, 2:16-cv-8697-FMO-SS, ECF No. 182-1 at 8 (filed Dec. 8, 2017).

[2] CMS, Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation for Contract-Level Audits, at 4-5 (Feb. 24, 2012), available at https://tinyurl.com/ybwc6lwt. CMS explained that it did so to "take[] into account how CMS payments would change" if the same documentation standard that is applied to MAO diagnosis code submissions during the RADV audits "was also used when calculating [the] risk [coefficients]." *Azar II,* 1:16-cv-00157-RMC (D.D.C. Oct. 2, 2017), ECF No. 44-3 at 11 (Document authored by CMS staff titled "Model Calibration Factor"); *id.* at 8 ("Why does FFS Diagnosis Error Matter? . . . Inclusion of undocumented diagnoses tends to reduce risk adjustment values.").

In 2014, however, CMS unexpectedly changed course. It finalized a regulation that equated each and every diagnosis code that lacked sufficient support in an underlying medical record to an "overpayment."[3] In 2018, a federal district court vacated that rule on the ground that it "inevitabl[y]" violates the Act's actuarial equivalence requirement to calculate MA payments using largely unaudited traditional Medicare data but then treat each inadequately supported MA diagnosis code as an overpayment. *Azar II*, 330 F. Supp. at 187. The court explained that "the rates at which CMS pays Medicare Advantage insurers are based on flawed data . . . [y]et the 2014 Overpayment Rule ignores those flaws when defining an 'overpayment.'" *Id.* at 184.[4]

III. CMS Requires MAOs to Take Reasonable Steps to Ensure the Accuracy of Risk Adjustment Data But Has Never Required MAOs to Audit or Guarantee the Accuracy of Every Diagnosis Code Submitted to CMS

CMS understands that payments to MAOs are based on diagnosis data from traditional Medicare, which contains significant errors and is not comprehensively audited, and that MAOs cannot possibly audit all of the millions of diagnosis codes that they receive from healthcare providers and then submit to CMS. As a result, CMS has not required that MAOs affirmatively audit the diagnosis codes that they submitted to the agency. Indeed, during the period at issue in this case, CMS did not require MAOs to undertake any specific compliance measures to verify the accuracy of their diagnosis code data.

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[3] *See* Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 29,844, 29,847 (May 23, 2014) ("2014 Overpayment Rule").

[4] The United States has appealed the *Azar II* decision to the D.C. Circuit. *See UnitedHealthcare Insurance Co., et al. v. Azar, et al.*, No. 18-5326 (D.C. Cir.).

During the time period relevant to Plaintiff's Claims—the 2013 through 2016 payment years, *see* AC ¶155—CMS regulations required MAOs to attest that the risk adjustment data they submitted, including diagnosis codes from healthcare providers who treated the MAOs' members, were accurate, truthful, and complete based on their "best knowledge, information, and belief." 42 C.F.R. § 422.504(l). But CMS deliberately implemented a ***qualified*** attestation standard that did not require MAOs to review all risk adjustment data submitted to CMS. Medicare Program; Medicare+Choice Program, 65 Fed. Reg. 40,170, 40,268 (June 29, 2000). CMS has made unmistakably clear that Anthem and other MAOs are not required to ensure that their diagnosis code data is entirely complete or accurate; instead, MAOs are only "held responsible for making ***good faith efforts*** to certify the accuracy, completeness, and truthfulness of encounter data submitted." *Id.* (emphasis added).

CMS did not specify the data accuracy or compliance processes that MAOs must implement to satisfy this "good faith" standard. The agency instead granted discretion to MAOs to determine what constituted a "good faith effort" and acknowledged, for example, that MAOs "cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that [CMS], the [Office of Inspector General for the U.S. Department of Health and Human Services], and [Department of Justice] believe is reasonable to enforce." *Id.* In fact, CMS's "good faith" standard recognized "that encounter data [can] come into [MAOs] in great volume from a number of sources, presenting significant verification challenges for the organizations." *Id.* Anthem, for its part, received tens of millions of diagnosis codes ***each year*** from healthcare providers during the period at issue in the Amended Complaint. Cogdill Decl. ¶5. For these reasons, the Office of Inspector General for the U.S. Department of Health and Human Services has explicitly noted that the annual risk adjustment data attestation from MAOs

"does not constitute an absolute guarantee of accuracy." Publication of the OIG's Compliance Program Guidance for Medicare+Choice Organizations Offering Coordinated Care Plans, 64 Fed. Reg. 61,893, 61,900 (Nov. 15, 1999).

CMS regulations also required MAOs to implement a general compliance program that included "measures that prevent, detect, and correct fraud, waste, and abuse." 42 C.F.R. § 422.503(b)(4)(vi). This requirement was general, however, and not specific to risk adjustment data. And similar to the attestation requirement, CMS conferred on MAOs broad discretion to determine the precise methods that they would use to comply with these general requirements. *See* 65 Fed. Reg. at 40,265.[5]

CMS, in sum, recognizes that many of the diagnosis codes that MAOs receive from healthcare providers and submit to CMS will be unsupported in the medical records, but understandably has never required or expected MAOs to review and verify every diagnosis code they submitted to the agency. Thus, contrary to Plaintiff's suggestions in the Amended Complaint, CMS has ***never*** required MAOs to conduct any particular type of audit of the diagnosis code data that they submit to CMS.

IV. Anthem Designed Its Retrospective Chart Review Program to Supplement the Diagnosis Code Data Reported to Anthem by Healthcare Providers

CMS regulations require that MAOs make good faith efforts to report to the agency all of the medical conditions for each member and certify that the data they submit to CMS is

[5] Anthem and other MAOs engage in a variety of good faith efforts beyond their chart review programs to improve the quality of the diagnosis code data that healthcare providers submit, including provider education and diagnosis coding guidance as well as audits of samples of provider-submitted diagnosis codes. Discovery will show the full extent of those efforts, but the Amended Complaint describes some of them. AC ¶66; *see* Cogdill Decl. ¶¶9-10.

complete. *See, e.g.*, 42 C.F.R. § 422.504(l).[6] To satisfy this requirement, it is common in the industry for MAOs to review their members' medical records to determine if they support additional diagnosis codes that healthcare providers neglected to report. CMS has not only sanctioned this practice, but has expressly authorized MAOs to submit additional diagnosis codes that they identify through these chart reviews.[7]

The Amended Complaint contends that, during the period at issue in this case, Anthem contracted with a vendor, MediConnect, to collect medical records from healthcare providers who rendered medical care to Anthem's members and to assign teams of certified MediConnect coders to review those records and identify properly-documented diagnosis codes for potential submission to CMS. AC ¶111. Anthem then allegedly directed certified coders from its own quality assurance team to conduct a rigorous quality assurance review of the diagnosis codes identified by the MediConnect coders. *Id.* ¶129. Plaintiff contends that, once Anthem's quality assurance team had completed its review, the Company submitted to CMS the diagnosis codes identified in these reviews that it had not previously reported to the agency. *Id*.

The Amended Complaint contends, however, that Anthem was also required to use its retrospective chart reviews to separately identify ***unsupported*** diagnosis codes from provider-submitted claims. *E.g.*, *id.* ¶¶8, 154. But no CMS regulation or guidance has ever required

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[6] *See also* CMS, Medicare Managed Care Manual, Chapter 7, § 40 (2014) (requiring MAOs to "[s]ubmit all required diagnosis codes for each [member]"), *available at* https://tinyurl.com/yc9b3hwc; CMS, Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations 2008 Participant Guide 6.1, *available at* https://tinyurl.com/y33s2sx8.

[7] *See* CMS, Final Encounter Data Diagnosis Filtering Logic at 5 (Dec. 22, 2015) ("In addition to submitting records for encounters, plan sponsors are also allowed to submit encounter data records that reflect their reviews of medical records (called 'chart review' records)."), *available at* https://tinyurl.com/ybppxz5c.

Anthem or other MAOs to do so.[8] And this makes sense because, as explained *supra* at 12-14, CMS does not itself comprehensively audit the vast majority of the provider-submitted diagnosis codes from traditional Medicare on which the MA risk adjustment system is based. *See* Brief of Appellants Alex Michael Azar, II et al., at 15, *UnitedHealthcare Insurance Co., et al. v. Azar, et al.*, D.C. Cir. No. 18-5326 (Apr. 23, 2020) (noting that CMS conducts only "limited error correction of traditional Medicare diagnosis data").

In fact, CMS has affirmatively declined to adopt ***exactly the requirement*** that Plaintiff seeks to impose through this FCA action. In January 2014, CMS proposed a rule that would have prohibited an MAO from conducting medical record reviews to identify previously unreported diagnosis codes unless those medical record reviews were also designed to confirm that all codes that the MAO had previously submitted to CMS had adequate support in the underlying medical records. *See* Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and The Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 1918, 2053 (Jan. 10, 2014) ("Proposed Chart Review Rule"). CMS candidly acknowledged that this rule was designed to substantively change the relevant regulatory landscape by "strengthen[ing] existing regulations" concerning MAOs' obligations with respect to diagnosis code data. *Id.* at 1922.

But CMS later ***withdrew that rule*** after receiving comments from MAOs that explained that the rule was unnecessarily burdensome, and that it contravened the statutory requirement

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[8] By their plain text, the annual Part C contracts between MAOs and CMS that Plaintiff cites in the Amended Complaint, AC ¶63, do not obligate MAOs to conduct chart reviews in any particular manner. In fact, they say nothing about chart reviews at all, and also do not reference any obligation to correct unsupported diagnosis code data that MAOs previously submitted to CMS.

that payment to MAOs ensure actuarial equivalence between the MA program and traditional Medicare.[9] In short, CMS squarely considered and abandoned the very requirement that Plaintiff seeks to impose here through FCA litigation.

V. Plaintiff's Amended Complaint

Plaintiff alleges that Anthem submitted two types of false claims to CMS.

First, the Amended Complaint contends that Anthem's annual risk adjustment data attestations were false claims under the FCA because Anthem operated a chart review program that could have been, but was not, designed to identify and withdraw unsupported diagnosis codes that the Company received from healthcare providers and previously submitted to CMS. AC ¶¶160, 165. The Amended Complaint focuses on this point from the outset, alleging in paragraph 5 that Anthem's retrospective chart review program was a practice operated "in direct contravention of its promises and attestations to CMS." *Id.* ¶5.

Plaintiff's attestation-based FCA theory is that Anthem's chart review program rendered its attestations false because, even though the Company represented that its risk adjustment data were "accurate, complete, and truthful" based on the Company's "best knowledge, information, and belief," the program did not review the medical records for the same member visits to identify diagnosis codes that healthcare providers previously submitted to Anthem in error and

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[9] 2014 Overpayment Rule, 79 Fed. Reg. at 29,925-26; *see* United Healthcare, Comment Letter on Proposed Chart Review Rule at 33-36 (Mar. 7, 2014), *available at* https://beta.regulations.gov/comment/CMS-2014-0007-1689 (explaining that proposed rule would violate actuarial equivalence and "make MAO members appear artificially healthier than otherwise identical FFS beneficiaries"); Humana Inc., Comment Letter on Proposed Chart Review Rule at 44 (March 7, 2014), *available at* https://beta.regulations.gov/comment/CMS-2014-0007-1652 (arguing that rule "would be fundamentally at odds with the MA payment model, which is based on diagnoses in Medicare FFS ***claims*** rather than ***medical records***" (emphasis added)).

that Anthem in turn submitted to CMS. *Id.* ¶¶5, 156; *see id.* ¶7 (alleging that Anthem could have used its chart review program to find and delete unsupported diagnosis codes, but did not do so); *id.* ¶8 (alleging that Anthem's chart review program failed to "identify[] and delet[e] inaccurate codes"). Plaintiff also describes the purpose of the attestations as confirming that Anthem made "good faith efforts" to ensure the accuracy, completeness, and truthfulness of its data, including by having adequate "systems" and "activities" in place. *Id.* ¶¶89, 90. The "system" that Plaintiff challenges in the remainder of the Amended Complaint is Anthem's chart review program, and Plaintiff spills much ink describing that program, its purposes, and how it failed to search for, identify, or correct unsupported diagnosis codes. *See, e.g., id.* ¶¶106-33. The Amended Complaint does not allege, however, that Anthem's attestations were false because Anthem actually knew of specific unsupported diagnosis codes that it previously submitted to CMS but failed to correct. *See id.* ¶¶5, 160, 165, 170.

These attestation-based theories of FCA liability are stated in Claim One, Claim Two, and part of Claim Three in the Amended Complaint. Anthem moves to dismiss only these attestation-based FCA Claims.

Plaintiff's second theory of FCA liability is stated in the other part of Claim Three in the Amended Complaint, which alleges that Anthem submitted specific unsupported diagnosis codes to CMS, and that each of these allegedly false diagnosis codes constitutes a false claim for payment under the FCA that Anthem had a duty to correct when it learned that the codes were false. *Id.* ¶171; *see also id.* ¶¶42-43 (alleging that Risk Adjustment Processing System data submissions and "each diagnostic cluster" is a separate "claim for payment"). This diagnosis code-based theory is premised on the so-called reverse false claims provision of the FCA. *See* 31 U.S.C. § 3729(a)(1)(G); *Poehling*, 2018 WL 1363487, at *6 (noting Plaintiff's claim based on

a "[v]iolation of the second part of 31 U.S.C. § 3729(a)(1)(G), . . . known as the 'reverse false claims' provision, by knowingly concealing or knowingly and improperly avoiding an obligation to pay or transmit money to the Government"). Plaintiff does not allege that Anthem knew the diagnosis codes were unsupported at the time the Company submitted the codes to CMS; instead, it asserts that Anthem had an obligation to correct the codes when Anthem allegedly learned sometime thereafter that they were not supported in the relevant medical records. AC ¶171. Anthem is not moving to dismiss the portion of Claim Three that relies on this diagnosis code-based theory of FCA liability.

MOTION TO TRANSFER

Pursuant to 28 U.S.C. § 1404(a), the Court should transfer this FCA action to the Southern District of Ohio.

I. This Case Is About Business Processes and Conduct that Predominantly Occurred in the Southern District of Ohio, and Most Material Witnesses Live in that District

A. The Chart Review Program and Risk Adjustment Compliance Processes at Issue in this Case Were Conducted from Anthem's Columbus, Ohio Office

Anthem's retrospective chart review program was developed and managed primarily by personnel in the Southern District of Ohio, and virtually every aspect of that program operated out of that district. Cogdill Decl. ¶¶7, 10. This includes the selection of medical records to collect from healthcare providers in Anthem's network, *id*. ¶10(iv); the configuration of the diagnosis coding process, AC ¶¶121-27; Cogdill Decl. ¶10(i); and the quality control measures that Anthem implemented to confirm medical record support for the diagnosis codes identified from reviewing medical records, AC ¶¶113-15, 128-29; Cogdill Decl. ¶10(ii)-(iv).

The risk adjustment compliance functions related to Plaintiff's allegations were similarly managed from that district. Those compliance activities include Anthem's implementation of CMS and industry diagnosis coding guidelines, AC ¶¶45-50; the development of Anthem's

diagnosis coding manual, *id*. ¶¶67-69, 132, 136; Medicare risk adjustment compliance education and training for healthcare providers and Anthem employees, *id.* ¶¶66, 90, 116; Anthem's sample audits of diagnosis codes submitted to the Company by healthcare providers, *id*. ¶¶110, 128-29; Anthem's development of risk adjustment policies and procedures, *id*. ¶¶76, 86; and Anthem's responses to CMS's RADV audits, *id*. ¶¶91-97, 138, 140. *See* Cogdill Decl. ¶10.

Likewise, the Anthem personnel with the most material involvement in directing the chart review and risk adjustment compliance processes at issue in the Amended Complaint live in the Southern District of Ohio. These personnel include the following:

- **Brian M. Cogdill** is the Manager of Risk Adjustment Quality Control and former Manager of Retrospective Risk Programs. He lives in the Columbus, Ohio area and works in the Columbus office. Cogdill participated in developing key Medicare risk adjustment programs at Anthem, including the chart review program. Cogdill was involved in the selection of Anthem's chart review vendor and creating its current chart review program. From 2010 through approximately 2016, Cogdill directed the operations of the chart review program and was the primary point of contact with that vendor. Since 2010, Cogdill has also been responsible for Anthem's quality assurance processes relating to the chart review program, and supervised Anthem's quality assurance review of the chart review results conducted by Anthem's chart review vendor. He developed and implemented the quality assurance audits that Anthem conducted of the vendor's chart review results. Additionally, he implemented a separate audit of a sample of diagnosis codes from the chart review results reported by the vendor. Finally, Cogdill developed a corporate manual regarding diagnosis coding standards for Anthem's vendors and employees, has managed Anthem's response to CMS's RADV audits since 2007, and is responsible for maintaining hard copy documents in Columbus relating to RADV audits. Cogdill Decl. ¶12(i)-(vii).

- **Patricia Cabrera** is Anthem's Director of Policy and Strategic Initiatives and was formerly the Medicare Risk Adjustment Regulatory Compliance Manager and Manager of Performance & Quality Audit. She lives and works in the Columbus, Ohio area. From 2010 to 2018, she was responsible for analyzing CMS guidance and regulations in connection with Anthem's Medicare risk adjustment programs and developing Anthem's Medicare risk adjustment policies and procedures. From 2010 through 2015, she also supervised Anthem's quality assurance audits of the chart review results reported to Anthem by its vendor in connection with the Anthem chart review program, and was responsible for conducting other audits of Anthem's Medicare risk adjustment programs and vendors. Also between 2010 and 2015, she supervised Anthem's education and training for healthcare providers regarding Medicare risk adjustment compliance. From 2010 through 2018, Cabrera was responsible for developing and supervising Anthem's

education and training for associates regarding Medicare risk adjustment compliance *Id.* ¶12(viii)-(xii).

- **Tonya Ries** is Manager Compliance (Medicare Risk Adjustment and Coding) and formerly a Medical Records Auditor and Training Consultant. She lives in the Columbus, Ohio area and works in Anthem's Columbus office. Ries was Team Lead, as a Medical Records Auditor and Training Consultant, from 2015 through 2017. Ries has also been responsible, along with Cogdill, for developing Anthem's diagnosis coding manual and implementing CMS and industry diagnosis coding guidelines. Ries supervises the Anthem team that conducts various coding audits that Anthem has performed since 2016. Ries also revised Anthem's diagnosis coding manual, and separately has supervised the training for healthcare providers, Anthem employees, and vendors on diagnosis coding and proper medical record documentation. Starting in 2012, Ries also performed audits of a sample of the diagnosis codes generated by the Anthem chart review program until the Quality Audit team's chart review audit process was consolidated with Cogdill's quality assurance audit team in 2015. *Id.* ¶12(xiii)-(xvii).

The conduct of these Anthem employees is referenced throughout the Amended Complaint. For example, paragraphs 112 through 116 describe a set of Frequently Asked Questions regarding Anthem's chart review program and the document with these questions is attached as an exhibit to the Amended Complaint. AC Ex. 10. This document directs individuals to contact Cogdill for questions concerning the program. *Id.* at 3. The Amended Complaint also refers extensively to Anthem's 2015 Coding Manual, and attaches that document as an exhibit. AC ¶¶67-69, 132, 136, Ex. 5. Cogdill and Ries created this document and regularly updated it each year. Cogdill Decl. ¶12(iv), (xv). And Cabrera authored an email that Plaintiff quotes in paragraph 75. *See* Declaration of James A. Bowman ("Bowman Decl.") ¶6.

Several other employees from Anthem's Columbus office were involved in developing and implementing the business and compliance operations that are central to the allegations in the Amended Complaint. Those employees include Lori Bishop (currently Program Manager, Sales Performance & Programs, and formerly a Medicare Risk and Recovery Compliance Training and Policy consultant), Chanda Caffey (currently Director of Performance Audit, Medicaid Risk Revenue, and formerly a Medical Record Audit and Training consultant), and

Paul Etterling (Medicare Risk and Recovery Specialist, who drafted and maintained MA policies and procedures). Cogdill Decl. ¶13. They all live in the Columbus area as well. *Id.*

B. Current and Former CMS Officials Who Are Material Witnesses in this Case Do Not Live or Work in the Southern District of New York

In addition to the Anthem witnesses located in the Columbus area, the most important witnesses in this case will be current and former CMS employees who promulgated the MA regulations and program guidance that Plaintiff now seeks to enforce through FCA litigation. Based on publicly available information, most of those current and former CMS officials live and work in the Baltimore and Washington D.C. area and, to Anthem's knowledge, none of those witnesses live in the Southern District of New York. Bowman Decl. ¶7.

Anthem expects to assert defenses in this case that are based, in part, on the conduct and communications of CMS and its representatives. Anthem intends to seek testimony and documents from current and former administrators of the MA program regarding their understanding of program requirements. Anthem expects that these witnesses will confirm that there was no requirement to perform chart reviews to audit the accuracy of previously-submitted diagnosis codes. For example, in *Poehling,* a CMS official who supervised the creation of the MA risk adjustment system testified in his deposition that he did not believe it was "improper" or "fraud" for an MAO to perform chart reviews that did not seek to validate prior diagnosis codes submitted by healthcare providers to MAOs that were then passed along to CMS. *Id.* ¶8, Ex. 1 at 309-10.

C. The Amended Complaint Does Not Identify Any Material Witnesses Who Live in this District or Significant Business Processes That Occurred Here

The Amended Complaint does not identify any key Anthem personnel who live in the Southern District of New York. To Anthem's knowledge, although there were a number of Anthem employees involved in these business processes around the country, ***none*** of the

employees who were involved in the design and operation of the chart review program, or who were involved in related quality assurance processes, live in the Southern District of New York. *Id.* ¶¶8, 11.

The Amended Complaint contains only minimal allegations relating to New York. Plaintiff notes that Anthem operated an MA plan in New York, maintains an office in New York, and communicated with New York providers regarding medical record collection in New York. AC ¶¶11, 13, 118-19. These facts have no meaningful connection to Plaintiff's FCA theories. And they hardly distinguish New York from any other judicial district in the country. Anthem has offices and enrolls MA members across the country and communicates with healthcare providers in two dozen states in connection with its MA plans. Cogdill Decl. ¶3. Plaintiff's allegations thus do not distinguish New York from the other jurisdictions—such as Ohio, which is a larger MA market for Anthem than New York—where Anthem offers MA plans or collects medical records for chart reviews. *Id*. ¶4.

II. This Case Should Be Transferred To the Southern District of Ohio, Which Would Be a More Convenient Venue and Serve the Interests of Justice

The Court should grant Anthem's motion to transfer because the relevant factors under 28 U.S.C. § 1404(a) weigh decisively in favor of transfer to the Southern District of Ohio.

The Court has discretion to transfer a civil action "[f]or the convenience of parties and witnesses, in the interest of justice" to "any other district or division where it might have been brought." 28 U.S.C. § 1404(a). The § 1404(a) analysis proceeds in two steps. First, the Court asks "whether the case could have been brought in the transferee district." *Izkhakov v. Educ. Comm'n for Foreign Med. Graduates*, 2012 WL 2861338, at *2 (S.D.N.Y. July 10, 2012) (Carter, J.). Plaintiff cannot dispute that the Southern District of Ohio is a proper venue for this suit. That court has personal jurisdiction over Anthem due to the Company's operations in

Columbus, *see* Cogdill Decl. ¶¶4, 7, 10, and subject matter jurisdiction based on 28 U.S.C. § 1331 and 31 U.S.C. § 3731. Venue is proper in the Southern District of Ohio because "a substantial part of the events or omissions" giving rise to Plaintiff's Claims occurred there, and because Anthem "transacts business" there. *See* 28 U.S.C. § 1391(b)(2); 31 U.S.C. § 3732(a).

Second, the Court considers a number of factors to decide whether a transfer is warranted. *Izkhakov*, 2012 WL 2861338, at *2. Those factors include:

> (1) the convenience of the witnesses; (2) the location of relevant documents and the relative ease of access to sources of proof; (3) the convenience of the parties; (4) the locus of operative facts; (5) the availability of process to compel attendance of unwilling witnesses; (6) the relative means of the parties; (7) the forum's familiarity with the governing law; (8) the weight accorded a plaintiff's choice of forum; and (9) trial efficiency and the interest of justice based on the totality of the circumstances.

Id. at *3; *see United States v. Nature's Farm Prods., Inc.*, 2004 WL 1077968, at *3 (S.D.N.Y. May 13, 2004) (same). Anthem must make a "clear and convincing showing that the balance of convenience favors [its] choice" of forum. *Izkhakov*, 2012 WL 2861338, at *3. "There is no rigid formula for balancing these factors and no single one of them is determinative." *Citigroup Inc. v. City Holding Co.*, 97 F. Supp. 2d 549, 561 (S.D.N.Y. 2000). "[W]eighing the balance is essentially an equitable task left to the Court's discretion." *Id.* (quotation marks omitted).

"The core determination under § 1404(a) is the center of gravity of the litigation." *Viacom Int'l, Inc. v. Melvin Simon Prods., Inc.*, 774 F. Supp. 858, 868 (S.D.N.Y. 1991). Convenience of witnesses is "typically the most important factor," and the "location of operative events" is another "primary factor." *Izkhakov*, 2012 WL 2861338, at *3-*4 (citing *Eres N.V. v. Citgo Asphalt Refining Co.*, 605 F. Supp. 2d 473, 480-81 (S.D.N.Y. 2009)). "Courts routinely transfer cases when the principal events occurred, and the principal witnesses are located, in another district." *Viacom*, 774 F. Supp. 3d at 868.

Although the plaintiff's choice of forum is ordinarily "entitled to substantial consideration," *Warrick v. General Elec. Co.*, 70 F.3d 736, 741 (2d Cir. 1995) (citation omitted), "[t]he emphasis that a court places on plaintiff's choice of forum diminishes where the facts giving rise to the litigation bear little material connection to the chosen forum," *Nature's Farm*, 2004 WL 1077968, at *3. This is such a case. As detailed *infra* at 29-36, the most important § 1404(a) factors weigh—clearly and convincingly—in favor of transfer, and the remaining factors are neutral. ***None*** of the factors favor this district as the venue for this litigation.

A. Convenience of the Witnesses

The convenience of witnesses "is typically the most important factor." *Izkhakov*, 2012 WL 2861338 at *3. "When weighing the convenience of the witnesses, courts must consider the materiality, nature, and quality of each witness, not merely the number of witnesses in each district." *Royal & Sunalliance v. Biritish Airways*, 167 F. Supp. 2d 573, 577 (S.D.N.Y. 2001) (movant "demonstrated that the witnesses needed in [the proposed forum] are more material to this case"). "The convenience of witnesses who reside in neither the current nor the transferee forum ***is irrelevant*** when considering a motion to transfer." *Herbert Ltd. P'ship v. Elec. Arts Inc.*, 325 F. Supp. 2d 282, 288 (S.D.N.Y. 2004) (emphasis added); *see Command Arms Accessories, LLC v. ME Tech. Inc.*, 2019 WL 5682670, at *6 (S.D.N.Y. Oct. 31, 2019) (similar).

None of the current or former Anthem employees who designed and operated the Anthem chart review program, or who designed and managed Anthem's risk adjustment compliance processes, live in New York. Cogdill Decl. ¶¶8, 11. In fact, to Anthem's knowledge, there is not a single material witness who resides in the Southern District of New York. If the case proceeds in this judicial district, ***every single witness***, for ***both*** parties, will need to travel from some other location.

Plaintiff knows this fact—during its three-year investigation, Plaintiff did not depose a single Anthem employee or former employee who lives in the Southern District of New York. Bowman Decl. ¶4. Similarly, of the more than two dozen email custodians identified by Plaintiff for its document requests, none of those Anthem custodians live or work in this district. *Id*. ¶5.

The Anthem chart review program collected medical records from healthcare providers across the country, and followed the same process regardless of the state where the member or healthcare provider lived. Cogdill Decl. ¶6. In fact, Anthem's MA market in Ohio is larger than its MA market in New York. *Id.* ¶4. *See Rindfleisch v. Gentiva Health Sys., Inc.*, 752 F. Supp. 2d 246, 255 (E.D.N.Y. 2010) (transferring case from New York to district where corporate policy at issue in case was developed because "Plaintiffs' case . . . is based upon the allegation that defendant . . . has a 'corporate policy'" that applied to its operations broadly).

In contrast, as detailed *supra* at 24-26, the Anthem personnel who designed, operated, and supervised the Anthem chart review program and relevant compliance processes live in the Southern District of Ohio. Plaintiff cannot dispute the materiality of these witnesses—the Amended Complaint devotes countless allegations to describing statements made by these personnel or documents authored by them.

Courts in this district have repeatedly granted motions to transfer to the district where a defendant's employees with knowledge of the operative facts live, even in cases where the plaintiff was able to identify material witnesses in this district. *See, e.g.*, *Cirrex Sys. LLC v. InfraReDx, Inc.*, 2010 WL 3431165, at *3 (S.D.N.Y. Aug. 31, 2010) (transferring case to district where the defendant's employees knowledgeable about facts at issue resided, even though the plaintiff identified four potential witnesses in this district); *In re Glob. Cash Access Holdings,*

Inc. Sec. Litig., 2008 WL 4344531, at *4 (S.D.N.Y. Sept. 18, 2008) (similar). The convenience of witnesses factor therefore weighs heavily in favor of transfer to the Southern District of Ohio.

B. The Location of Relevant Documents and Access to Sources of Proof

The location of documents and sources of proof factor also weighs in favor of transfer. Because Columbus is the center of gravity for Anthem's risk adjustment coding operations, that location is where Anthem maintains all hard copy RADV audit files and similar documents—materials that will be relevant to Plaintiff's allegations. Cogdill Decl. ¶12(vii). In contrast, no Anthem hard copy documents relevant to this case are maintained in this district. *Id*. "While technology has made shipping documents easier and less expensive, retaining this action in New York would still impose additional costs on [Anthem] that [it] would not incur if the case were transferred to" Ohio. *Cirrex*, 2010 WL 3431165, at *3. Where, as here, transfer would reduce the burden of producing documents, even if the resulting benefit is "incremental," this factor weighs in favor of transfer. *Fuji Photo Film Co. v. Lexar Media, Inc.*, 415 F. Supp. 2d 370, 374-75 (S.D.N.Y. 2006); *see also Herbert Ltd. P'ship*, 325 F. Supp. at 289.

C. The Locus of Operative Facts

For similar reasons, the locus of operative facts also strongly favors transfer. "To determine the locus of operative facts, a court must look to the site of the events from which the claim arises." *Dickerson v. Novartis Corp.*, 315 F.R.D. 18, 30 (S.D.N.Y. 2016) (internal quotations and citation omitted). The Amended Complaint focuses on Anthem's chart review program. AC ¶¶3-5, 160, 165. It devotes approximately 40 paragraphs to describing that program and related business operations and corporate actions that occurred primarily in Columbus. *Supra* at 23-24. To prove its Claims, Plaintiff thus must present evidence about Anthem's chart review program, how it operates, and how it interacts with Anthem's other efforts to submit accurate and complete diagnosis code data to CMS. *See, e.g.*, AC ¶¶3-5. The

Southern District of Ohio is the historical "hub" of Anthem's chart review program, and Columbus is where most of the team leaders for Anthem's chart review operations, diagnosis coding audits, and key risk adjustment compliance activities were located during the relevant time period. *Supra* at 23-26; Cogdill Decl. ¶¶4, 7, 10, 12. The Anthem business units that directed the quality assurance operations of the chart review program and Anthem's Medicare risk adjustment compliance operations likewise centered their activities in Columbus. Cogdill Decl. ¶10. The core facts of this case relate to the business processes that were developed, implemented and conducted from Columbus.

In contrast, as explained *supra* at 26-27, the Amended Complaint's only factual allegations relating to this judicial district are that Anthem operates an MA plan, maintains an office, and has communicated with healthcare providers in New York regarding the collection of medical records. Those allegations have little weight in the § 1404(a) analysis because they are not material to Plaintiff's Claims and do not distinguish New York from many other states where Anthem does business. And again, Ohio is a larger MA market for Anthem than New York is, so even if the existence of MA members or healthcare providers in a particular location were relevant to venue, those facts would still favor transfer. Cogdill Decl. ¶4.

While there are other Anthem employees across the country who have also been involved in these business processes, ***none*** of the Anthem chart review processes at issue in the Amended Complaint have ever been operated from the Southern District of New York. *Id*. ¶8, 11.

D. <u>The Fifth, Sixth, and Seventh Factors Are Neutral</u>

Anthem is not aware of any "unwilling witnesses" who would require compulsion to appear in either judicial district. *Nature's Farm*, 2004 WL 1077968, at *3. Nor do the "relative means of the parties" independently weigh for or against a transfer. *Id.* Both Anthem, a public corporation, and the United States have the capability to litigate in either Ohio or New York.

And the "forum's familiarity with the governing law factor" is also "neutral" because "the False Claims Act is a federal statute and 'any district court may handle [a federal case] with equal skill.'" *Id.* at *6 (quoting *Bristol-Myers Squibb Co. v. Andrx Pharm. LLC*, 2003 WL 22888804 at *4 (S.D.N.Y. Dec. 5, 2003)).

E. Plaintiff's Choice of Forum

A plaintiff is typically entitled to a presumption in favor of its choice of forum but that choice "is given less weight where the case's operative facts have little connection with the chosen forum," *800-Flowers, Inc. v. Intercontinental Florist, Inc.*, 860 F. Supp. 128, 134 (S.D.N.Y. 1994), or where the "plaintiff chooses a forum other than [its] place of residence," *Izkhakov*, 2012 WL 2861338, at *4 (internal quotations and citation omitted). Here, Plaintiff has alleged no facts at all meaningfully connecting this case to the Southern District of New York and the Amended Complaint cites no material witnesses who live in this district.

This matter was not initiated by a relator, much less one living or working in this district. The only fact that distinguishes this district from numerous others, including the Southern District of Ohio, is the location of Plaintiff's lawyers. But courts—including this Court—have repeatedly held that "[t]he convenience of counsel is not an appropriate factor to consider on a motion to transfer." *Garity v. Tetraphase Pharm. Inc.*, 2019 WL 2314691, at *5 (S.D.N.Y. May 30, 2019) (Carter, J.) (quoting *InVivo Research, Inc. v. Magnetic Resonance Equip. Corp.*, 119 F. Supp. 2d 433, 438 (S.D.N.Y. 2000)). That is especially true where the plaintiff is the United States: "[T]he United States government clearly also has attorneys resident in the [transferee district]." *Nature's Farm*, 2004 WL 1077968, at *4.

Even Plaintiff's choice of attorneys in this case has an attenuated connection to the Southern District of New York. Here, the pre-filing investigation did not originate in New York. Instead, for over a year the investigation was directed by the Civil Fraud Section of the

Department of Justice located in Washington, D.C. Bowman Decl. ¶2. In early 2018, the Department of Justice transferred the investigation to the U.S. Attorney's Office for the Southern District of New York. *Id.* ¶3. Plaintiff's recent preference for this district is entitled to no weight in the transfer analysis. *Garity*, 2019 WL 2314691, at *5.

F. The Interest of Justice Based on the Totality of the Circumstances

Finally, the interests of justice and the totality of the circumstances weigh heavily in favor of transfer to the Southern District of Ohio. This factor considers the overall impact of transfer, and the Court's interest in the efficient adjudication of the case. *See Nature's Farm*, 2004 WL 1077968, at *7. Anthem filed this motion to transfer promptly, before the parties or the Court invested considerable resources litigating this action. And this case has no material tie to this district except that Plaintiff's attorneys happen to work here. As the *Nature's Farm* court put it, "the 'interests of justice' are not served by imposing travel inconvenience and significant expense on individual litigants for the convenience of the United States government." *Id.* (citation omitted).

Courts have repeatedly transferred cases filed by the United States where the operative facts occurred and material witnesses live in the transferee district, and where there was little connection to the judicial district where the complaint was filed. *Nature's Farm* is a prime example. There, a court in this district transferred a government FCA action from this district to the Northern District of California. Though some operative facts in *Nature's Farm* occurred in this district—as well as in Buffalo, Detroit, and Canada—the "bulk of the operative facts occurred" in California, and the United States failed to identify material witnesses living in the Southern District of New York. *Id.* at *5. The court afforded especially little weight to the Plaintiff's choice of forum "[b]ecause the United States government can adequately litigate in multiple fora." *Id.* at *6. The court also emphasized that the litigation was "in the early stages,

which weighs in favor of a transfer." *Id.* at *7. Indeed, although the defendant filed the motion to transfer within months of the Justice Department's intervention, the *Nature's Farm* litigation was initiated by a relator and had been pending for ***three years***, allowing the court to develop familiarity with the case and even rule on some motions. *Id.* Here, ***no*** material facts or witnesses connect the case to this district, and this case has been pending for far less time. A transfer is even more warranted here than it was in *Nature's Farm*.

In fact, Plaintiff itself previously convinced a New York district court judge to transfer a similar FCA case to the judicial district where the defendant MAO's chart review operations were conducted. *Poehling* similarly concerned allegations by Plaintiff that the defendant MAO should have used its chart reviews to identify potentially unsupported diagnosis codes that had previously been submitted to CMS. A relator originally filed the *qui tam* complaint in the Western District of New York. Plaintiff intervened and moved to transfer the case to the Central District of California, in part because the MAO's chart review operations were based in Los Angeles. *See* Mem. of L. in Support of Unopposed Motion of the United States to Transfer Venue, *Poehling*, 16-cv-08697, Dkt. 49 (C.D. Cal. Nov. 8, 2016). Plaintiff emphasized, among other things, that the defendant MAO had "a large office . . . in the Central District of California that performed a substantial portion of the work related to [its] submission of risk adjustment claims and its medical record review programs" and that "there are numerous witnesses who work or worked at that office with relevant knowledge, and many of the relevant documents are located there." *Id.* at 6. Plaintiff asserted that "in contrast . . . the Government did not take testimony from any witnesses located in [the Western District of New York], or obtain documents from any person or entity located in [that] district." *Id.* at 7.

Plaintiff's arguments there strongly support transfer here. Just as in *Poehling*, a "substantial portion of the work related to [Anthem's] submission of risk adjustment claims" occurred in Columbus, and "there are numerous witnesses who work or worked at that [Columbus] office with relevant knowledge, and many of the relevant documents are located there." *Id.* at 6. Further, during its pre-filing investigation, the Department of Justice deposed no witnesses, and collected no documents from any Anthem custodians, who live in this district. Bowman Decl. ¶¶4-5.

* * *

This case should not be litigated in the Southern District of New York. It belongs in the Southern District of Ohio—the venue that is convenient for the most material witnesses in the case, was the locus of the operative facts at issue, and is where the documents that relate to those facts are stored. No material witnesses reside or work in New York and no material events occurred here. Because the most important factors all weigh in favor of transfer, and because the remaining factors are neutral, Anthem respectfully requests that the Court transfer this action to the Southern District of Ohio pursuant to 28 U.S.C. § 1404(a).

MOTION TO DISMISS

If the Court decides to consider Anthem's motion to dismiss, it should dismiss Plaintiff's attestation-based FCA Claims with prejudice. This motion is directed at Claims One and Two of the Amended Complaint, as well as the portion of Claim Three that alleges Anthem submitted knowingly false risk adjustment data attestations to CMS.

I. Plaintiff Must Plead Materiality To Establish That Anthem Violated the FCA

For an allegedly false claim or statement to be actionable under the FCA, it must be "material." 31 U.S.C. § 3729(a)(1)(B). After the Supreme Court's seminal decision in *Escobar*,

whether an FCA complaint adequately pleads materiality must be analyzed "rigorous[ly]" and is appropriate for resolution on a motion to dismiss. *Escobar*, 136 S. Ct. at 2004 n.6.

In cases alleging a false certification as the basis for FCA liability, the supposed falsity of the certification "must be material to the Government's payment decision." *Id.* at 1996. It is insufficient for a plaintiff merely to allege that the certification or attestation is a condition of payment or that the government "would have the option to decline to pay" if the defendant failed to comply with the certification requirement. *Id*. at 2003. Instead, "materiality looks to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation"—*i.e.,* the impact on the government's payment decision of the practice that supposedly rendered the attestation false. *Id.* at 2002 (quotation marks omitted); *see also id.* at 2003 n.5 (an allegedly false attestation is material only if the government "would not have taken the action alleged to have been induced by the misrepresentation") (quoting 26 R. Lord, Williston on Contracts § 69:212, 549-50 (4th ed. 2003)).

Following *Escobar*, courts have dismissed FCA claims where the plaintiff failed to plausibly allege that the government would have refused payment of a claim if it had known the true facts regarding an alleged misrepresentation. In *Coyne v. Amgen, Inc.*, 717 F. App'x 26 (2d Cir. 2017), for example, the Second Circuit affirmed dismissal of an FCA complaint under *Escobar* because the plaintiff failed to include "concrete allegations" that the alleged misrepresentations "caused the Government to make the reimbursement decision" at issue. *Id.* at 29.[10]

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[10] *See also United States ex rel. Scharff v. Camelot Counseling*, 2016 WL 5416494, at *8 (S.D.N.Y. Sept. 28, 2016) (dismissing FCA claims and explaining that "[*Escobar*] stated that the relators must sufficiently allege that the defendant 'misrepresented its compliance with . . . requirements that are so central . . . that the Medicaid program would not have paid these claims

Specifically in the context of FCA claims against an MAO based on its alleged failure to use its chart review process to identify unsupported diagnosis codes, the courts in *Swoben* and *Poehling* applied *Escobar* to dismiss Plaintiff's attestation-based claims against another MAO. *Swoben*, 2017 WL 4564722, at *6; *Poehling*, 2018 WL 163487, at *3. Just as here, Plaintiff alleged in both cases that another MAO's annual attestations regarding the accuracy of its risk adjustment data were false because the MAO conducted chart reviews that were designed only to identify new diagnosis codes but not to audit or validate the accuracy of previously submitted codes. *See Swoben*, 2017 WL 4564722, at *6 ("[The complaint] asserts that the [defendant MAOs] were involved in and aware of the . . . chart review activities and, thus, the [defendant MAOs] were obligated to undertake additional validation efforts to confirm that the . . . diagnosis codes were supported by the underlying medical charts."); *Poehling*, 2018 WL 1363487, at *6 ("The Government alleges that in 2009 through 2016, Attestations were submitted to the Medicare Program on behalf of [defendant MAOs] by [defendant MAO] officers who ignored or

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had it known of these violations'" (quoting *Escobar*, 136 S. Ct. at 2004)); *United States v. N. Adult Daily Health Care Ctr.*, 205 F. Supp. 3d 276, 296 (E.D.N.Y. 2016) (dismissing complaint where relators "do not allege, as they are now required to do under [*Escobar*], . . . that the government would have refused reimbursement had it known of [defendant's] noncompliance with" the regulations at issue); *United States ex rel. Patel v. Catholic Health Initiatives*, 792 F. App'x 296, 301 (5th Cir. 2019) (affirming dismissal of relators' complaint because "the Supreme Court understands materiality to turn on whether the government would pay the claim or not if it knew of the claimant's violation"); *United States v. Pfizer Inc.*, 2019 WL 1200753, at *8 (N.D. Ill. Mar. 14, 2019) (dismissing complaint because it did not "allege that the Government's decision to pay would have been different had it known of the alleged regulatory violations"); *United States ex rel. Jersey Strong Pediatrics, LLC v. Wanaque Convalescent Ctr.*, 2017 WL 4122598, at *3 (D.N.J. Sept. 18, 2017) (materiality cannot be established unless "the government would 'not have paid the[] claims had it known of the[] violations" (quoting *Escobar*, 136 S. Ct. at 2004)).

disregarded that Defendants had failed to comply with requirements regarding submission of diagnoses.").

In *Swoben*, the district court held that Plaintiff was required to plead "that [CMS] would not have paid these claims had it known of these violations." 2017 WL 4564722, at *6 (reasoning that Plaintiff's complaint "fail[ed] to allege that CMS would have refused to make risk adjustment payments to the [defendants] if it had known about [their] alleged involvement with the . . . chart review process"). The court granted Plaintiff leave to amend its complaint to make the necessary allegation that CMS would not have paid based on the alleged false attestations, *id.* at *10, but Plaintiff instead voluntarily dismissed all of its claims against the MAO, *see* Notice of Dismissal Without Prejudice Pursuant to Fed. R. Civ. Proc. 41(a) or (c), *Swoben*, 2:09-cv-5013-JFW-JEM, Dkt. 341 (C.D. Cal. Oct. 12, 2017).

Following the dismissal in *Swoben*, Plaintiff knew in *Poehling* that it again faced dismissal of its attestation-based claims unless it alleged that CMS would not have paid the defendant MAO had it known that its attestations were false because of the manner in which the defendant MAO conducted chart reviews. But Plaintiff again did not make this basic allegation. The result was the same: the *Poehling* court held that Plaintiff must plead that "CMS would have refused to make risk adjustment payments if it had known the Attestations were false." 2018 WL 1363487, at *10. Because Plaintiff had not made this allegation, the court dismissed Plaintiff's claims based on the defendant MAO's attestations for failing to allege materiality under *Escobar*. *Id*. As in *Swoben*, the court gave Plaintiff leave to amend to make the necessary allegation, and again Plaintiff declined, electing instead to prosecute its other claims against the defendant MAO. In dismissing these attestation-based claims, the *Poehling* court remarked that the only explanation for Plaintiff's failure to make this allegation was that Plaintiff likely ***cannot***

assert it in good faith. *Id.* (Plaintiff's refusal to make that allegation suggests *Escobar*'s requirement is "more than just 'magic words'").

II. Plaintiff's Attestation-Based Claims Must Be Dismissed Because Plaintiff Fails to Allege That CMS Would Have Denied Payment to Anthem if the Agency Had Known of Anthem's Chart Review Practices

Plaintiff devotes dozens of pages in the Amended Complaint to describing Anthem's chart review program and how it allegedly rendered the Company's risk adjustment attestations false. Plaintiff fails entirely, however, to make the straightforward allegation required under *Escobar* that CMS would have refused to pay Anthem had it known how the program operated. As in *Swoben* and *Poehling*, this pleading failure is fatal to Plaintiff's attestation-based Claims.

After reviewing Plaintiff's original Complaint, Anthem submitted a letter to the Court seeking a pre-motion conference that highlighted Plaintiff's failure to plead materiality and sought permission to file this motion to dismiss based on the reasoning of *Swoben* and *Poehling*. Dkt. 20. Plaintiff then notified the Court that it would be amending its Complaint. Dkt. 23. In a vain attempt to avoid the same result in *Swoben* and *Poehling*, the Amended Complaint added a single conclusory allegation to its First and Second Claims for Relief:

> If CMS had known that Anthem's attestation was false because, at the time of the attestation, *Anthem knew that specific diagnosis codes it had submitted for payment and never deleted were inaccurate*, CMS would have taken appropriate actions to ensure that Anthem did not receive or retain risk adjustment payments to which it was not entitled, including by recouping payments through administrative processes, adjusting the reconciliation payments, or obtaining repayments in enforcement actions.

AC ¶¶162, 167 (emphasis added).[11]

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[11] Notably, Plaintiff makes no allegation at all regarding the materiality of the portion of its Third Claim that is based on Anthem's risk adjustment data attestations. The only materiality allegation in that Third Claim is the conclusory assertion that Anthem "knowingly made or used a false record or statement material to an obligation to repay the Government," AC ¶169, which simply paraphrases the relevant statutory language, *see* 31 U.S.C. § 3729(a)(1)(G) (providing for

For at least three independent reasons, this lone allegation, unaccompanied by any additional factual allegations regarding CMS's "likely or actual" behavior, cannot save Plaintiff's attestation-based Claims.

A. The Amended Complaint Does Not Allege That CMS Would Have Refused to Make Risk Adjustment Payments to Anthem Had It Known How Anthem Was Conducting Its Chart Review Program

Every plaintiff bringing a false certification claim must show that the alleged facts which render the certification false are the same facts that are material to the government's payment decision. *See, e.g.*, *United States ex rel. Gohil v. Sanofi U.S. Servs., Inc.*, 2020 WL 1888966, at *2 (E.D. Pa. April 16, 2020) ("The materiality inquiry focuses on whether a false claim's 'falsity' was of the type that could normally influence the government's decision to pay the claim."). Plaintiff fails that basic requirement. Specifically, Plaintiff fails to adequately plead materiality for its attestation-based Claims because the fact that was supposedly material to CMS's payment decision (*i.e.*, Anthem's failure to delete specific diagnosis codes that the Company subsequently learned were not supported by medical records) was not the fact that allegedly rendered Anthem's risk adjustment data attestations false (*i.e.*, how Anthem operated its chart review program).

Throughout the Amended Complaint, Plaintiff alleges that Anthem's annual attestations to CMS were false specifically because Anthem ***could have used*** its chart review program to identify potentially unsupported diagnosis codes, but chose not to do so. *See* AC ¶156 ("As

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liability for one who "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government"). Based on this failure alone, the attestation-based portion of Plaintiff's Third Claim must be dismissed. *See Poehling*, 2018 WL 1363487, at *10 (dismissing Plaintiff's similarly unsupported attestation-based reverse false claim theory, the "Fourth Claim" in that case).

Anthem knew, each of those Part C attestations was false. Specifically, Anthem had information in its possession—the chart review results it received from Medi-Connect—that Anthem ***could have used*** to uncover numerous inaccuracies like the seven examples enumerated in paragraph 154 above." (emphasis added)); *see also id.* ¶160 ("***[O]n account of its choice to operate its chart review program in deliberate ignorance or reckless disregard of its regulatory and contractual obligation to delete inaccurate diagnosis codes***, Anthem knowingly submitted false Part C annual attestations to CMS" (emphasis added)); *id.* ¶165 (same). These allegations are expressly premised on Anthem's failure to use its chart review program to identify specific diagnosis codes that were not supported by medical records, not the Company's failure to correct specific diagnosis codes that it had already determined were unsupported.

Nowhere in its Amended Complaint does Plaintiff allege that CMS would not have paid Anthem had the agency known that the Company's attestations were supposedly false because it chose to operate its chart review program in a manner that did not identify potentially unsupported diagnosis codes. Instead, in an effort to evade *Swoben* and *Poehling*, Plaintiff contends that CMS would have taken certain actions had it known that Anthem's attestations were purportedly false because of ***something entirely different***, namely, that "Anthem knew that specific diagnosis codes it had submitted for payment and never deleted were inaccurate." *Id.* ¶¶162, 167. But under *Escobar*, the FCA's materiality requirement "looks to the effect on the likely or actual behavior of the recipient ***of the alleged misrepresentation***," not of some other purported misrepresentation or alleged misconduct. 136 S. Ct. at 2002 (emphasis added). Because (1) the ***purported misrepresentation*** for Plaintiff's attestation-based Claims (*i.e.*, Anthem's attestations are false because it could have used its chart review program to identify unsupported codes and failed to do so) does not match (2) the ***purported material falsity***

affecting CMS's payment decision (*i.e.*, actual knowledge by Anthem that specific diagnosis codes it had submitted for payment and never deleted were unsupported), Plaintiff has failed to plead that the alleged misrepresentations were material.

The court in *Poehling* rejected a similar attempt to conflate the alleged falsity of the attestations with the materiality of specific, known unsupported diagnosis codes. There, Plaintiff attempted to save its attestation-based claims by asserting that the attestations were somehow "intertwined" with the accuracy of diagnosis codes, that the allegedly false attestations were how the defendant MAO concealed its fraudulent chart review operations from CMS, and that it would be illogical to conclude that diagnosis codes themselves are material but that "lying" in the attestations about diagnosis codes is not. *Poehling*, 2018 WL 1363487, at *10. In other words, as here, Plaintiff sought to establish the materiality of the allegedly false attestations by relying on the actions CMS would have supposedly taken had it known about allegedly false diagnosis codes submitted by the defendant MAO. *Id.*

The *Poehling* court rejected this argument, concluding that "the Government must do more than allege that the Attestations and the diagnosis codes are intertwined." *Id.* Instead, "[t]o the extent the FCA claims are based on violations related to the Attestations, the Government must plead that the Attestations are 'material to [the Government's course of action,' specifically, to the 'Government's payment decision.'" *Id.* (quoting *Escobar*, 136 S. Ct. at 2001). Thus, the court held, although the "allegations regarding the diagnostic data . . . appear[ed] to be material," the allegations regarding the attestations did not suggest that the

falsities in the attestations themselves "[were] likely to influence the payment of money." *Id*. (internal citations omitted).

Here, as in *Poehling*, the potential falsity of specific diagnosis codes cannot establish the materiality of the risk adjustment attestation in a case where the attestation is allegedly false because of how the MAO conducts its chart review program; therefore, Plaintiff's Claims based on the attestations must be dismissed. *See id*. at *9 ("[T]o be material the government must have made the payment as a result" of the challenged practice) (quoting *Coyne*, 717 F. App'x at 29) (internal quotation marks omitted).

B. The Amended Complaint Alleges Only That CMS Had the Right to Deny Payment to Anthem and Might Have Done So, Which Is Legally Insufficient Under *Escobar*

Plaintiff's attestation-based Claims must also be dismissed because the Amended Complaint only lists a series of ***potential*** actions that CMS might have taken had it known that Anthem's attestations were allegedly false, rather than making the concrete assertion—supported by factual allegations—that the agency would have refused payment, as *Escobar* requires. *See* AC ¶¶162, 167 (alleging that CMS would have taken steps "***including*** . . . recouping payments through administrative processes, adjusting the reconciliation payments, ***or*** obtaining repayments in enforcement actions" (emphasis added)). *Escobar* held that the fact the government "would have the option to decline to pay" or "would be entitled" to withhold payment "if it knew of the defendant's noncompliance" is not "sufficient for a finding of materiality." *Escobar*, 136 S. Ct. at 2003-04. Indeed, *Escobar* specifically rejected the government's argument that the appropriate test is whether "the government ***could*** lawfully withhold payment." *Id.* at 2004 (internal quotations and citation omitted, emphasis added); *see also Poehling*, 2018 WL 1363487, at *8 ("Nor is it enough that the Government 'would have the option to decline to pay if it knew of the defendant's noncompliance.'" (quoting *Escobar*, 136 S. Ct. at 2003)).

Plaintiff's non-exclusive list of possible options is also insufficient because it leaves open the possibility that all CMS "would have done" is authorized an enforcement action like this lawsuit. It is not sufficient under *Escobar* to allege that CMS would have authorized an FCA lawsuit or that it had brought FCA cases under other similar circumstances—otherwise the materiality standard would be a nullity whenever the government filed FCA claims or intervened in a relator's suit. Such a standard is contrary to *Swoben*, *Poehling*, and every other case that has assessed materiality in a government-filed FCA suit. *See Swoben,* 2017 WL 4564722 at *6; *Poehling*, 2018 WL 1363487 at *1 (same); *see also United States ex rel. Mei Ling v. City of Los Angeles*, 2018 WL 3814498, at *20 (C.D. Cal. July 25, 2018) ("[I]f the Government's decision to intervene in an action were given substantial weight, then materiality would be a fait accompli in any case where intervention has occurred, thus working an end-run around *Escobar*."). As these cases make clear, vague assertions regarding actions the government ***might*** have taken do not meet the *Escobar* standard; instead, *Escobar* demands that a plaintiff allege facts demonstrating that the government ***would not have paid*** the defendant had it known of the alleged misrepresentations. *Escobar*, 136 S. Ct. at 2002, 2004.

Plaintiff has not done that here. It instead lists an explicitly non-exclusive series of actions that CMS might have taken (or not) had it known of the allegedly false attestations, including a step (pursuing an FCA action) that is plainly insufficient to establish materiality. AC ¶¶162, 167. The optional nature of these allegations renders the entire allegation meaningless, as it is possible (consistent with Plaintiff's pleading) that CMS would have taken a step that would be plainly insufficient for materiality, or even that it would have done something else entirely. This empty allegation falls far short of the concrete statement required by *Escobar* regarding the

impact of the alleged misrepresentation on the government's payment decision and itself requires dismissal of Plaintiff's attestation-based Claims. *Escobar*, 136 S. Ct. at 2002.

C. Plaintiff Does Not Allege Facts Plausibly Demonstrating that CMS Would Have Refused to Pay Anthem Had It Known How Anthem Was Conducting Its Chart Review Program

Plaintiff has not only failed to make even the basic boilerplate allegation required under *Escobar* to plead materiality, it has also failed to support its allegation of materiality with any factual allegations. *Escobar* made clear that a primary form of evidence that would support a materiality showing is evidence "that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular" requirement at issue. *Id.* at 2003. Given that similar chart review practices are common in the MA industry—CMS even considered imposing a regulation addressing those practices in 2014, after all—and that Plaintiff amended its Complaint specifically to address this issue, one would have expected Plaintiff to support the materiality of its claims by alleging that CMS had denied payment to other MAOs "in the mine run of cases" based on their chart review practices. *Id.* But the Amended Complaint contains ***no allegation*** that CMS has ***ever*** denied payment to an MAO based on such practices.

Plaintiff also conspicuously fails to allege that CMS has refused, or likely will refuse, payment to Anthem because of how it operated its chart review program, despite the Justice Department's three-year investigation of these claims and the fact that CMS necessarily learned of Anthem's chart review practices long before Plaintiff filed this suit. *See, e.g.*, *U.S. ex rel. McBride v. Halliburton Co.*, 848 F.3d 1027, 1034 (D.C. Cir. 2017) ("[W]e have the benefit of hindsight and should not ignore what actually occurred: the DCAA investigated McBride's allegations and did not disallow any charged costs."). As the defendant MAO asserted in *Poehling*, the simple fact is that Plaintiff likely ***cannot*** plead that CMS would refuse to pay

claims as a result of an MAO's chart review practices "because it knows full well that CMS ***is*** paying them." *Poehling*, 16-cv-08697, Dkt. 182 at 14 (C.D. Cal. Dec. 8, 2017).

Plaintiff has also failed to plead any other facts suggesting that the alleged falsity in Anthem's attestations would have actually affected CMS's payment decision. "False Claims Act plaintiffs must . . . plead their claims with plausibility and particularity under Federal Rules of Civil Procedure 8 and 9(b) by, for instance, pleading facts to support allegations of materiality." 136 S. Ct. at 2004 n.6. Following *Escobar*, courts have consistently dismissed FCA claims where plaintiffs made only conclusory assertions that the government would not have paid the defendant if it had known of the alleged falsity. For example, in *United States v. CalPortland Construction*, 2018 WL 6262877 (C.D. Cal. Mar. 9, 2018), the court held that the relator's "conclusory allegations that . . . the government would not have purchased from Defendants had it been aware of Defendants' knowing violations" was "insufficient to allege materiality" under *Escobar* because "[a]n FCA complaint must allege facts to ***'explain why'*** the government would not have paid." *Id.* at *5 (emphasis added); *see also, e.g., United States ex rel. Kietzman v. Bethany Circle of King's Daughters of Madison, Indiana, Inc.*, 305 F. Supp. 3d 964, 977 (S.D. Ind. 2018) (finding that relator's "bald" allegations that the government "would not have paid" the defendant had it known of defendant's alleged noncompliance were insufficient to satisfy *Escobar*'s "demanding" materiality requirement); *United States ex rel. Dresser v. Qualium Corp.*, 2016 WL 3880763, at *6 (N.D. Cal. July 18, 2016) ("The Amended Complaint alleges in several places that the government would not have paid Defendants' claims had they known of Defendants' fraudulent conduct, but does not explain why. This does not meet [*Escobar*'s] heightened materiality standard."); *United States ex rel. Maetski v. Raytheon Co.*, 2017 WL 3326452, at *7 (C.D. Cal. Aug. 3, 2017) (allegation that United States would not have paid

Raytheon's requests for payment if it knew that Raytheon had not complied with contractual specifications was "insufficient" because "it does not show ***how*** Raytheon's misrepresentations were material" (emphasis in original)).[12]

Following the dismissals in *Swoben* and *Poehling*, and after amending its Complaint here, Plaintiff had every opportunity and incentive to plead specific facts regarding "the ***likely*** or ***actual behavior***" of CMS based on Anthem's alleged misrepresentation. *Escobar*, 136 S. Ct. at 2002 (emphasis added). But Plaintiff pleads no facts at all regarding CMS's likely or actual behavior in response to Anthem's alleged misrepresentations. Plaintiff's inability to allege such facts is not surprising given the regulatory backdrop to this suit. *See supra*, Background Sections II-IV. After all, in 2014, CMS expressly declined to impose a regulation that would have required MAOs to conduct chart reviews in the precise manner that Plaintiff advocates in this case. Plaintiff's pleading failure is, in short, no technicality. If it were, Plaintiff would have corrected it. The only reasonable inference is that Plaintiff ***cannot*** make the contention that *Escobar*, *Swoben*, and *Poehling* require; the required factual allegation is evidently "more than just 'magic words.'" *Poehling*, 2018 WL 1363487, at *10.

Accordingly, Anthem respectfully requests that the Court dismiss with prejudice the Plaintiff's First and Second Claims, as well as the portion of its Third Claim based on Anthem's allegedly false risk adjustment attestation.[13]

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[12] *See also United States ex rel. Potter v. CASA de Maryland*, 2018 WL 1183659, at *6 (D. Md. Mar. 6, 2018), *reconsideration denied,* 2018 WL 4733733 (D. Md. Oct. 2, 2018) ("Because the Complaint does not show ***how*** CASA's failure to disclose its I-9 noncompliance would have influenced the government's funding decisions, Potter has not adequately demonstrated materiality." (emphasis in original)).

[13] Plaintiff does not make any allegation regarding materiality in its Third Claim, and the

MOTION TO STRIKE

Anthem also moves under Rule 12(f) to strike from the Amended Complaint irrelevant and prejudicial allegations regarding prior settlements that Plaintiff entered with healthcare providers or other MAOs that are largely based on unrelated conduct. Specifically, the Amended Complaint describes the following settlements:

- A $3.82 million August 2012 settlement with a managed care company in a suit challenging the company's chart review program (that was part of a global settlement resolving a host of other unrelated allegations), AC ¶99;
- A $32.5 million May 2017 settlement with an MAO that allegedly submitted diagnosis codes to CMS that it knew were unsupported, *id.* ¶100;
- A $270 million October 2018 settlement with a provider "based in part" on a challenge to the provider's coding guidance and chart review program, *id.* ¶101; and
- An August 2019 settlement against a physician group for allegedly submitting diagnosis codes to CMS that it knew were unsupported, *id.* ¶102.

None of the alleged settlements involved Anthem, much less its chart review program.

A "court may strike from a pleading . . . any redundant, immaterial, impertinent, or scandalous matter." Fed. R. Civ. P. 12(f). "An allegation is 'impertinent' or 'immaterial' when it is neither responsive nor relevant to the issues involved in the action." *Anderson v. Davis Polk & Wardwell LLP*, 850 F. Supp. 2d 392, 416 (S.D.N.Y. 2012) (quoting 2 James Wm. Moore et al., Moore's Federal Practice ¶12.37[3] (3d ed. 2010)). Although motions to strike are "generally disfavored," they should be granted when "the matter asserted clearly has no bearing on the issue in dispute," particularly where the allegations would prejudice the defendant. *Correction Officers Benevolent Ass'n v. Kralik*, 226 F.R.D. 175, 177 (S.D.N.Y. 2005); *see also*

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attestation portion of that Claim must therefore be dismissed. *See supra* note 11.

OTG Brands, LLC v. Walgreen Co., 2015 WL 1499559, at *10-11 (S.D.N.Y. Mar. 31, 2015).

Here, Plaintiff's allegations regarding these unrelated settlements should be stricken for two reasons. First, courts in the Second Circuit have repeatedly held that allegations regarding prior settlements, including settlements with non-defendants, are inherently improper and should be stricken. *See, e.g.*, *Lipsky*, 551 F.2d at 893; *Low v. Robb*, 2012 WL 173472, at *9 (S.D.N.Y. Jan. 20, 2012); *Kralik*, 226 F.R.D. at 177; *In re Trilegiant Corp., Inc.*, 11 F. Supp. 3d 82, 131 (D. Conn. 2014), *aff'd sub nom. Williams v. Affinion Grp., LLC*, 889 F.3d 116 (2d Cir. 2018); *Shahzad v. Meyers*, 1997 WL 47817, at *13-14 (S.D.N.Y. Feb. 6, 1997). Second, the allegations regarding these unrelated settlements should be stricken because they are irrelevant, are highly prejudicial to Anthem, and will result in burdensome and unnecessary litigation if not stricken.

I. The Amended Complaint's Allegations Relating to Settlements by Non-Defendants Should Be Stricken Because Such Allegations Are Inadmissible and Immaterial for any Proper Purpose

Allegations regarding a prior settlement "between a federal agency and a private corporation" cannot "be used as evidence in subsequent litigation between that corporation and another party" to imply that the defendant is liable, and therefore are not "appropriately within the pleadings." *Lipsky*, 551 F.2d at 893, 894. In *Lipsky*, the Second Circuit affirmed a district court's order striking allegations regarding a prior U.S. Securities & Exchange Commission ("SEC") complaint against the defendant. Because a subsequent consent judgment between the defendant and the SEC was "not the result of an actual adjudication of any of the issues," it could "not be used as evidence in subsequent litigation between that corporation and another party." *Id.* at 893.

Following *Lipsky*, district courts in this circuit have considered it "well settled under Second Circuit law that allegations in a complaint that are either based on, or rely on, complaints in other actions that have been dismissed, settled, or otherwise not resolved, are, as a matter of

law, immaterial within the meaning of Fed. R. Civ. P. 12(f)." *Robb*, 2012 WL 173472, at *9 (striking "references to unrelated disputes and lawsuits").[14] As these cases have explained, allegations regarding prior settlements, like the allegations here, "could have no possible bearing on the dispute before the court" because they are "the result of a private bargain between the parties and was not a 'hearing or ruling[] or any form of decision on the merits by the . . . court.'" *Fridman*, 643 F. Supp. 2d at 403 (quoting *Lipsky*); *see also Silverman v. Wachovia Bank, N.A.*, 2011 WL 13305358, at *3 (E.D.N.Y. May 4, 2011) (granting motion to strike allegations about prior proceedings "because they are 'not the result of an actual adjudication of any of the issues' and thus are not 'appropriately within the pleadings'") (quoting *Lipsky*).

The logic of those decisions applies with equal (if not greater) force to allegations regarding prior settlements or proceedings involving non-defendants. As one court put it, such allegations are "clearly irrelevant" because they say nothing about the current "case or the facts giving rise thereto." *Kralik*, 226 F.R.D. at 177; *see also In re Trilegiant*, 11 F. Supp. 3d at 131 (striking allegations regarding prior settlement to which several defendants were not a party); *Shahzad*, 1997 WL 47817, at *13-14 (striking allegations regarding several consent orders the defendant entered into with regulators, as well as an affidavit written by an SEC investigator in a suit involving different defendants).

Under *Lipsky* and well-established authority in this circuit, Plaintiff's allegations relating to its settlements with nonparties must be stricken from the Amended Complaint.

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[14] *See also Footbridge Ltd. v. Countrywide Home Loans, Inc.*, 2010 WL 3790810, at *5 (S.D.N.Y. Sept. 28, 2010); *RSM Production Corp. v. Fridman,* 643 F.Supp.2d 382, 403 (S.D.N.Y. 2009); *Gotlin v. Lederman*, 367 F. Supp. 2d 349 (E.D.N.Y. 2005), *aff'd sub nom. Gotlin ex rel. Cty. of Richmond v. Lederman*, 483 F. App'x 583 (2d Cir. 2012); *In re Merrill Lynch & Co., Inc. Research Reports Secs. Litig.,* 218 F.R.D. 76, 78 (S.D.N.Y.2003).

II. The Settlement Allegations Should Also Be Stricken Because They Are Not Relevant and Are Highly Prejudicial

The settlements alleged in the Amended Complaint, which do not involve Anthem and relate primarily to practices not at issue in this case, are irrelevant to Plaintiff's assertions that Anthem's retrospective chart review program rendered its risk adjustment data attestations false. Further, any possible relevance of these allegations is plainly outweighed by the unfair prejudice to Anthem and the wasteful expenditure of resources that will necessarily result if they are not removed from the Amended Complaint.[15] *See, e.g.*, *OTG Brands*, 2015 WL 1499559, at *10-11.

A. The Amended Complaint's Allegations Regarding Settlements Are Not Relevant

None of the allegations involving prior government settlements involve Anthem, and by the Amended Complaint's own description, two of the settlements do not involve chart review practices at all. *See* AC ¶¶99, 101. For the two settlements that marginally involved chart review practices, government press releases suggest that those cases predominantly involved other business practices that appear to have driven the settlements in those cases.[16]

One reason why allegations regarding such prior settlements rarely, if ever, have

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[15] Courts have recognized that in appropriate cases the Rule 12(f) analysis is very similar to the evidentiary analysis required by Federal Rules of Evidence 402 and 403. *See Ledford v. Rapid-Am. Corp.*, 1988 WL 3428, at *1-2 (S.D.N.Y. Jan. 8, 1988) (striking allegations per *Lipsky* and noting that Rules 402 and 403 were "the governing evidentiary Rules"); *Kent v. AVCO Corp.*, 815 F. Supp. 67, 71 (D. Conn. 1992) (allegations about separate litigation had "no relevance . . . and their only effect [was] to prejudice the defendant," such that "[t]he value of allowing these references in this case [was] outweighed by the prejudicial effect they would have").

[16] *See* U.S. Dep't of Justice, *DaVita to Pay $350 Million to Resolve Allegations of Illegal Kickbacks* (Oct. 22, 2014), https://www.justice.gov/opa/pr/davita-pay-350-million-resolve-allegations-illegal-kickbacks; U.S. Dep't of Justice, *Long Beach-Based Health Plan Pays Nearly $320 Million to Settle Allegations that it Received Overpayments for Medi-Cal Patients* (Aug. 23, 2012), https://www.justice.gov/archive/usao/cac/Pressroom/2012/112.html.

probative value in later cases is that it is impossible to know the basis for the prior settlements without a mini-trial into the circumstances or motivations of the settling parties. Perhaps the United States settled its chart-review allegations in those cases for pennies on the dollar because it doubted the viability of its claims. For instance, Plaintiff's $3.2 million settlement with SCAN Health Plan, alleged in paragraph 99 of the Amended Complaint, was a minuscule portion of a much larger settlement totaling nearly $324 million—***one hundred times*** the amount of the chart review-related settlement. *See supra* n.16. Such allegations are not "appropriately within the pleadings" because they are the result of a "private bargain," not a finding by any court. *Lipsky*, 551 F.2d at 893-94. Those concerns are heightened here because Anthem was not even a party to those settlements, and is not able to address the settlements without extensive discovery from Plaintiff and the non-parties that negotiated the settlements. *See, e.g.*, *Kralik*, 226 F.R.D. at 177.

The ostensible basis offered in the Amended Complaint for these irrelevant allegations is that they somehow support the materiality of Plaintiff's FCA Claims. *See* AC ¶98; Dkt. 23. But as detailed above, *supra* at 36-39, 44-45, whether or not a false claim is material is based on the impact of an alleged misrepresentation on "the Government's ***payment decision***," *Escobar*, 136 S. Ct. at 2002 (emphasis added), rather than whether the government chose to file a lawsuit against that defendant or, for unknown reasons, it settled prior lawsuits involving similar conduct. In short, prior lawsuits filed by the United States, and then settled, say nothing about CMS's decision to continue payments to MAOs that conduct so-called "one-way" chart reviews, and thus are not relevant to the materiality of Plaintiff's FCA Claims under *Escobar*. *See Poehling*, 2018 WL 1363487, at *10.

The Amended Complaint also alleges that Anthem was aware of "the Government's active efforts to pursue legal remedies in order to enforce Medicare Part C's risk adjustment data

accuracy requirement" and that Anthem executives were aware of one of the alleged settlements. AC ¶¶103-05. But it is not clear how these allegations are relevant to any element of Plaintiff's Claims, such as knowledge of falsity. The allegation that Anthem was aware that Plaintiff had filed and settled an FCA suit connected in some unknown way to another MAO's chart review practices does nothing to establish that Anthem (or even the settling MAO) should have concluded that its own practices were unlawful. Plaintiff acknowledges the limited relevance of this allegation, asserting in the Amended Complaint only that Anthem was aware of the potential for "scrutiny in connection with how retrospective reviews are performed and . . . how risk adjustment payments are calculated." *Id.* ¶104. But a general awareness of government oversight—in a highly regulated government program—falls far short of specific knowledge by Anthem that its own chart review program violated a particular CMS requirement.

B. The Settlement Allegations Are Unfairly Prejudicial to Anthem and Will Waste the Resources of the Parties and the Court

The settlement allegations should also be stricken because any potential relevance of those settlements is substantially outweighed by the unfair prejudice and waste of time and resources that would result if they remain.

The effect of these allegations is to "bootstrap" Plaintiff's Claims by suggesting that Anthem is liable because other defendants have settled purportedly similar suits before. Thus, even if the allegations were somehow relevant to Plaintiff's Claims, they should be stricken under the Rule 403 standard because any potential relevance is substantially outweighed by the obvious prejudice to Anthem and the confusion to the litigation that would result from submitting evidence regarding non-party settlements. *See Ledford*, 1988 WL 3428, at *2 (striking "bootstrapping" allegations regarding a prior administrative finding against the defendant, because the evidence pertaining to the allegation would violate Rule 403); *Gotlin*, 367

F. Supp. 2d at 364 (striking similar allegation because the "probative value [of the allegation was] likely to be outweighed by prejudice to defendants" were the case to proceed to trial).[17]

The settlement allegations, if not struck, will also waste time and resources because the allegations will necessitate costly litigation of issues entirely unrelated to Plaintiff's Claims against Anthem. "The function of the motion [to strike] is to avoid the expenditure of time and money that must arise from litigating spurious issues, by dispensing with those issues prior to trial." 2 James Wm. Moore et al., Moore's Federal Practice § 12.37(3) (2020); *cf.* Fed. R. Evid. 403; *see also Lokai Holdings LLC v. Twin Tiger USA LLC*, 306 F. Supp. 3d 629, 647 (S.D.N.Y. 2018) (Carter, J.). Unless these allegations are stricken, Anthem will have no choice but to seek discovery regarding the nature of the business practices challenged in the prior actions and the circumstances of the settlements to distinguish their facts, as well as to test Plaintiff's professed reasons for entering into these settlements. Despite putting the settlements directly at issue, Plaintiff to date has refused to waive any assertion of privilege over documents related to the settlements. *See* Dkts. 19, 23. As a consequence, Anthem will be forced to challenge that untenable position if the allegations remain part of the Amended Complaint, ensuring that these irrelevant and prejudicial allegations will result in unnecessary and expensive discovery litigation.

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[17] *See also Reiter's Beer Distribs., Inc. v. Christian Schmidt Brewing Co.*, 657 F. Supp. 136, 144 (E.D.N.Y. 1987) (allegations in a private antitrust suit that the state Attorney General had pursued actions against beer wholesalers, generally, for antitrust violations, "impl[ied], without so stating directly, that the Attorney General has begun an investigation into [the defendant's] practices in this case," and the "only effect" of those allegations was to prejudice the defendant); *MC1 Healthcare, Inc. v. United Health Grp., Inc.*, 2019 WL 2015949, at *11 (D. Conn. May 7, 2019), *on reconsideration in part*, 2019 WL 3202965 (D. Conn. July 16, 2019) ("The Court agrees with United that the Ingenix litigation is irrelevant to this proceeding. As such, its only intended effect can be to prejudice United and therefore it is stricken.").

CONCLUSION

For the foregoing reasons, this Court should transfer this suit to the Southern District of Ohio. If the Court addresses Anthem's motion to dismiss and motion to strike, it should dismiss Plaintiff's First and Second Claims, and the portion of Claim Three based on Anthem's attestations, and strike paragraphs 99 through 105 from the Amended Complaint.

Dated: September 17, 2020

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, v. ANTHEM, INC., Defendant.	Case No. 1:20-cv-02593-ALC **DECLARATION OF BRIAN MATTHEW COGDILL IN SUPPORT OF DEFENDANT ANTHEM, INC.'S MOTION TO TRANSFER VENUE**

I, Brian Matthew Cogdill, declare and state as follows:

1. I am the Manager of Risk Adjustment Quality Control in the Medicare Risk & Recovery department at Anthem, Inc. ("Anthem"), which is the position I have held since 2016. I previously served as the Manager of Risk Adjustment programs at Anthem from 2007 to 2010 and the Manager of Retrospective Programs at Anthem from 2010 through 2016. I live in the Columbus, Ohio area and I work at Anthem's office in Columbus, Ohio.

2. I submit this declaration in support of Defendant Anthem, Inc.'s Motion to Transfer Venue. I have personal knowledge of the matters set forth in this declaration, and if called to testify to the facts below, I could and would do so competently.

Anthem's Medicare Risk Adjustment Program

3. Anthem is a health insurance company incorporated in the State of Indiana and headquartered in Indianapolis. Anthem offers health insurance plans to Medicare beneficiaries under the Medicare Advantage ("MA") program, which is also called Medicare Part C. Health insurers like Anthem that participate in the MA program are called Medicare Advantage Organizations ("MAOs"). Anthem has offices and enrolls members across the country. Anthem

also communicates with healthcare providers in approximately two dozen states in connection with its MA plans.

4. Most of Anthem's MA risk adjustment business operations originated in Columbus, Ohio. From 2013 to 2018, Ohio has consistently had the largest or among the largest number of Anthem MA members, and consistently has had a larger number of members than New York. These business operations include programs that supplement the provider-generated diagnosis data that Anthem submits to the Centers for Medicare and Medicaid Services ("CMS") for risk adjustment purposes, such as the Anthem corporate chart review program described below, as well as Medicare risk adjustment compliance and auditing activities.

The Anthem Corporate Chart Review Program

A. Background

5. For the relevant time period alleged in Plaintiff's Amended Complaint, which I understand to be the 2013, 2014, 2015 and 2016 payment years, (*see* AC[1] ¶155), Anthem's Medicare Risk & Recovery department operated a retrospective chart review program designed to supplement the diagnostic data reported to Anthem by healthcare providers. For the vast majority of the diagnosis code data on file with CMS for Anthem's MA members, physicians and other healthcare providers who treat Anthem's members first identify the applicable diagnosis codes on claims and/or other encounter records that they submit to Anthem. Anthem then reports the applicable diagnosis codes to CMS. Anthem receives tens of millions of diagnosis codes each year from healthcare providers. Healthcare providers frequently do not report to Anthem all of the diagnosis codes that are supported by the medical records for their Anthem MA members, and occasionally errors in the transmission of that data to Anthem results

[1] "AC" refers to the Amended Complaint in the above-captioned action (Dkt. 26).

in diagnosis codes from members' encounters with their healthcare providers not being reported to CMS.

6. The Anthem corporate chart review program collected medical records from healthcare providers relating to Anthem members across the country, and followed the same process to collect charts regardless of the state where the member or healthcare provider lived. For the Anthem corporate chart review program, Anthem contracted with a non-party vendor, MediConnect Global, Inc. ("MediConnect"),[2] to collect medical records from healthcare providers who rendered medical care to Anthem's MA members. Certified coders from MediConnect, working primarily from Utah and overseas, then reviewed those records to identify diagnosis codes that were documented in those records for potential submission to CMS. Certified coders from Anthem's quality assurance teams then conducted two separate quality assurance reviews of the diagnosis codes identified by the MediConnect coders. I supervised and managed one of those teams, the Coding Auditor team, from Anthem's Columbus office, and one of my Anthem colleagues, Patricia Cabrera, supervised the other team, the Quality Audit team, which was also based in our Columbus office; in 2015, Ms. Cabrera was promoted to Medicare Risk Adjustment Regulatory Compliance Manager, where she continued to supervise risk adjustment compliance programs and audits. Once those quality assurance reviews were completed, Anthem then submitted to CMS the diagnosis codes identified from these reviews of the medical records that had not previously been reported to the agency.

[2] MediConnect later changed its name to Verisk Analytics, Inc., and then to Verscend Technologies, Inc., and it currently operates as Cotiviti Holdings, Inc.

B. Location of Anthem Corporate Chart Review Program

7. The Anthem corporate chart review program, as operated through MediConnect, was initiated and designed from Anthem's Columbus office in 2010, and has been largely managed out of that office from that time through the present. Anthem personnel based in Columbus directed the work of Anthem's chart review vendor (MediConnect), configured the chart review coding process, and developed quality assurance measures to confirm medical record support of some of the diagnosis codes identified from the vendor's review of the medical records. These quality assurance measures included: (i) audits that my team (the Coding Auditor team) performed from 2010 through 2018 of the diagnosis codes identified by MediConnect's coders, and (ii) a secondary audit that Anthem's Quality Audit team conducted from 2010 to approximately 2014 to review a sample of the diagnosis codes that MediConnect reported to Anthem.

8. To the best of my knowledge, none of the employees who were most involved in operating the Anthem corporate chart review program or related quality assurance processes during the 2013, 2014, 2015, and 2016 payment years live in the Southern District of New York, and none of those business operations occurred there during these payment years. None of those Anthem business operations occur there now.

Medicare Risk Adjustment Compliance Activities

9. The Anthem corporate chart review program was designed, among other things, to help ensure that diagnosis code data submitted to CMS for Anthem's MA members was complete. Anthem also instituted business and compliance processes regarding the diagnosis code data that Anthem received from healthcare providers. These processes included provider

education sessions and diagnosis coding guidance, as well as audits of samples of provider-submitted diagnosis codes.

10. From the 2013 through the 2016 payment years, Anthem's Medicare risk adjustment compliance activities were largely performed from Columbus, Ohio. These activities included:

i. Anthem's implementation of CMS and industry diagnosis coding guidelines,

ii. The development of Anthem's diagnosis coding manual and training on the manual,

iii. Medicare risk adjustment compliance education and training for healthcare providers and Anthem employees,

iv. Selection of which medical records to collect for review from healthcare providers in Anthem's network around the country as well as audits initiated in 2016 of samples of diagnosis codes submitted to Anthem by healthcare providers to determine if the codes were supported by MA members' medical records,

v. Development of Medicare risk adjustment policies and procedures, and

vi. Anthem's responses to CMS's Risk Adjustment Data Validation ("RADV") audits.[3]

11. To the best of my knowledge, none of the employees most responsible for performing these Medicare risk adjustment compliance functions from the 2013 through 2016 payment years live in the Southern District of New York.

[3] RADV audits are conducted by CMS. In a RADV audit, CMS reviews the medical records for selected MAO members to determine if the conditions on file with CMS for the selected members are supported by the members' medical records.

Key Anthem Medicare Risk Adjustment Personnel in Ohio

12. Most of the Anthem personnel involved in supervising and directing the Anthem corporate chart review program, performing related quality assurance processes, and implementing day-to-day Medicare risk adjustment data compliance activities work in Columbus, Ohio and live in the Columbus area:

- **Manager of Risk Adjustment Quality Control and Former Manager of Retrospective Risk Programs**

  i. I participated in developing Anthem's Medicare risk adjustment programs, including the Anthem corporate chart review program. In that role, I was involved in the selection of MediConnect as Anthem's chart review vendor.

  ii. From 2010 through approximately 2016, I directed the operations of the Anthem corporate chart review program and was the primary point of contact with Anthem's chart review vendor. Even after management of the chart review vendor relationship was transitioned to other Anthem personnel, I remained responsible for supervising the diagnosis coding process in the Anthem corporate chart review program.

  iii. Since 2010, I have also been responsible for Anthem's quality assurance processes relating to the Anthem corporate chart review program. In this role, I supervised Anthem's quality assurance review of the chart review results conducted by Anthem's chart review vendor. I developed and implemented the quality assurance audits that Anthem conducted of MediConnect's chart review results. I also implemented a separate audit of a sample of diagnosis codes from the chart review results reported by

MediConnect. This audit process was later transitioned to Ms. Cabrera, who was the Manager of Performance & Quality Audit. All of these audits were supervised from Anthem's Columbus office.

iv. In 2010, I developed a corporate manual regarding diagnosis coding standards for use by Anthem's vendors and Anthem employees, and in subsequent years I assisted Medicare Risk Adjustment and Coding Compliance Manager, Tonya Ries, in preparing a new manual using the original manual as a guide, and in revising that new manual. This work on the Anthem diagnosis coding manual occurred in Anthem's Columbus office.

v. Since 2007, I have also managed Anthem's response to CMS's RADV audits, including collection and review of medical records to be submitted to CMS and analysis and internal reporting of audit results.

vi. I live in the Columbus area and performed all of these business functions from Anthem's office in Columbus.

vii. I am also responsible for maintaining hard copy documents relating to RADV audits. I maintain those records in the Columbus office. To the best of my knowledge, no hard copy documents relating to the Anthem corporate chart review program are stored or maintained in the Southern District of New York.

- **Director of Policy and Strategic Initiatives and Former Medicare Risk Adjustment Regulatory Compliance Manager and Former Manager of Performance & Quality Audit, Patricia Cabrera**

viii. Ms. Cabrera has performed Medicare risk adjustment compliance functions since she joined Anthem in 2010. During the period at issue in the Amended Complaint, Ms. Cabrera worked in Anthem's office in Columbus.

ix. From 2010 through 2018, Ms. Cabrera was responsible for analyzing CMS guidance and regulations in connection with Anthem's Medicare risk adjustment programs and developing Anthem's Medicare risk adjustment policies and procedures.

x. Between 2010 and 2015, she also supervised Anthem's education and training for healthcare providers regarding Medicare risk adjustment compliance. From 2010 through 2018, Ms. Cabrera was responsible for developing and supervising Anthem's education and training for associates regarding Medicare risk adjustment compliance.

xi. Between 2010 and 2015, Ms. Cabrera also supervised Anthem's quality assurance audits of the chart review results reported to Anthem by its vendor in connection with the Anthem corporate chart review program, and was responsible for conducting other audits of Anthem's Medicare risk adjustment programs and vendors.

xii. Ms. Cabrera lives in the Columbus area and performed all of these business functions from Anthem's office in Columbus.

- **Manager Compliance (Medicare Risk Adjustment and Coding) and Former Medical Records Auditor and Training Consultant Tonya Ries**

xiii. Since she joined Anthem in 2012, Tonya Ries has worked in Anthem's office in Columbus. Ms. Ries was Team Lead, as a Medical Records

Auditor and Training Consultant, from 2015 through 2017. She has been responsible for Medicare risk adjustment coding compliance functions, including analysis and implementation of CMS and industry diagnosis coding guidelines.

xiv. Ms. Ries supervises the Anthem team that conducts various coding audits that Anthem has performed since 2016.

xv. Ms. Ries also revised Anthem's diagnosis coding manual, and separately has supervised the training for healthcare providers, Anthem employees, and vendors on diagnosis coding and proper medical record documentation.

xvi. Starting in 2012, Ms. Ries also performed audits of a sample of the diagnosis codes generated by the Anthem corporate chart review program until the Quality Audit team's chart review audit process was consolidated with my team's quality assurance audits in 2015.

xvii. Ms. Ries lives in the Columbus area and performed all of these business functions from Anthem's office in Columbus.

13. At least three other Anthem employees who were involved in Anthem's Medicare Risk Adjustment compliance functions live and work in the Columbus area: Lori Bishop (currently Program Manager, Sales Performance & Programs, and formerly a Medicare Risk and Recovery Compliance Training and Policy consultant), Chanda Caffey (currently Director of Performance Audit, Medicaid Risk Revenue, and formerly a Medical Record Audit and Training consultant), and Paul Etterling (Medicare Risk and Recovery Specialist, who drafted and maintained MA policies and procedures). As relevant to the allegations in the Amended

Complaint, Ms. Bishop performed Medicare risk adjustment training and education for healthcare providers who submitted diagnosis code data to Anthem for MA members. Ms. Caffey conducted quality assurance audits for the Anthem corporate chart review program. Ms. Bishop and Ms. Caffey conducted these business processes from Anthem's office in Columbus.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on 9/17/20 in Dublin, Ohio.

By: Brian M. Cogdill
Brian Matthew Cogdill

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, v. ANTHEM, INC., Defendant.	Case No. 1:20-cv-02593-ALC **DECLARATION OF JAMES A. BOWMAN IN SUPPORT OF DEFENDANT ANTHEM, INC.'S MOTION TO TRANSFER VENUE**

I, James A. Bowman, declare and state as follows:

1. I am a partner of O'Melveny & Myers LLP and I represent Defendant, Anthem, Inc. ("Anthem" or "Company"), in the above-captioned matter. I submit this declaration in support of Defendant Anthem, Inc.'s Motion to Transfer Venue. I have personal knowledge of the matters set forth in this declaration, and if called to testify to the facts below, I could and would do so competently.

2. This case stems from an investigation that began in December 2016 when the Civil Fraud Section at the U.S. Department of Justice in Washington, D.C. notified Anthem that it was investigating the Company's chart review and risk adjustment compliance programs and activities related to the Medicare Advantage ("MA") program.

3. In 2018, after the investigation had proceeded for well over a year, the Justice Department transferred the investigation to the U.S. Attorney's Office for the Southern District of New York. On March 26, 2020, after the U.S. Attorney's Office for the Southern District of New York had investigated this matter for two years and after more than three total years of investigation, the United States ("Plaintiff") filed the Complaint in this case. I have represented

Anthem during the entirety of the investigation that preceded Plaintiff's filing of the Complaint and the subsequently filed Amended Complaint.

4. To the best of my knowledge, based on personal knowledge and/or publicly available information, none of the current or former Anthem employees who were deposed or requested for deposition during Plaintiff's three-year investigation live in the Southern District of New York or even the State of New York.

5. To the best of my knowledge, based on personal knowledge and/or publicly-available information, none of the document custodians whose documents Plaintiff requested in its three-year investigation lives in the Southern District of New York or the State of New York.

6. Based on my review of the Anthem documents produced to the Plaintiff in the underlying investigation, Patricia Cabrera, Director of Policy and Strategic Initiatives, authored an email message that Plaintiff quotes in paragraph 75 of the Amended Complaint.

7. To the best of my knowledge, based on personal knowledge and/or publicly-available information, the current or former employees of the Centers for Medicare and Medicaid Services ("CMS") who Anthem anticipates will be witnesses in this case do not reside in the Southern District of New York:

Likely Witness	Location
Sean Cavanaugh (Former Deputy Administrator and Director of CMS)	Washington, D.C.
Dan Farmer (Former Special Assistant at CMS)	Washington, D.C.
Julia Gorner (Director, Division of Capitated Plan Audits at CMS)	Maryland
Jeffrey Grant (Former Division Director, Capitated Payment)	Maryland
Jennifer Harlow (Acting Director and Deputy Director of Medicare Plan Payment Group, Division of Payment Systems at CMS)	Maryland

Cynthia Howe (Acting Director of CMS' Division of Payment Error Rate Measurement)	Maryland
Tom Hutchinson (Former Director of the Medicare Plan Payment Group at CMS)	Maryland
Cheri Rice (Acting Deputy Director of the Center for Medicare at CMS)	Maryland
Jennifer Shapiro (Acting Director of Medicare Plan Payment Group)	Maryland
Marilyn Tavenner (Former Administrator of CMS)	Washington, D.C.
Cynthia Tudor (Deputy Center Director, Parts C and D at CMS)	Maryland
Seema Verma (Administrator of CMS)	Washington, D.C., Maryland, or Indiana

8. Attached hereto as Exhibit 1 is a copy of excerpts from the transcript of the deposition of Jeffrey Grant, a former CMS official, in *United States ex rel. Poehling v. UnitedHealth Group, Inc.*, Case No. 16-cv-08697-FMO (C.D. Cal. July 23, 2018) (ECF 254-1). I obtained this transcript from the publicly-filed exhibits filed by UnitedHealth Group, Inc. (and the other defendants) in support of their Opposition to Plaintiff's Motion for Partial Summary Judgment.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED on September 17, 2020 in Goleta, California.

By: _____
James A. Bowman

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
Case No. CV 16 08697 MFW (SSx)

UNITED STATES OF AMERICA,)
ex rel. BENJAMIN POEHLING,)
Plaintiffs,)
v.)
UNITEDHEALTH GROUP, INC., et al.,)
Defendants.)

(Volume 2)

DEPOSITION OF JEFFREY GRANT

Washington, D.C.

May 16, 2018

Reported by: Mary Ann Payonk
Job No. 140253

May 16, 2018

10:00 a.m.

Deposition of JEFFREY GRANT, Volume 2, held at the law offices of Latham & Watkins LLP, 555 Eleventh Street, N.W., Suite 1000, Washington, D.C., pursuant to Notice before Mary Ann Payonk, Shorthand Reporter and Notary Public of the District of Columbia, Commonwealth of Virginia, and State of New York.

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APPEARANCES (Cont'd.):

ON BEHALF OF RELATORS:

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ALSO PRESENT:

Glen Fortner, Legal Video Specialist
Johanna Kriesel, HHS
Matthew Shors, Senior Deputy
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THE VIDEOGRAPHER: This is the start of tape labeled number 1 of the videotaped deposition of Jeffrey Grant in the matter of United States of America v. UnitedHealth Group, Inc. et al., in the United States District Court, District of -- Central District of California, Case Number CV-16-08697(MFW). This deposition is being held at 555 11th Street Northwest, Washington, D.C. on May 16, 2018, at approximately 10:03. 10:02 10:02 10:02 10:02 10:02 10:02 10:02 10:02 10:03 10:03 10:03

My name is Glen Fortner from TSG Reporting, Inc., and I am the legal video specialist. The court reporter is Mary Ann Payonk, in association with TSG Reporting. 10:03 10:03 10:03 10:03 10:03

Will counsel please introduce yourselves? 10:03 10:03

(Whereupon, counsel placed their appearances on the video record.) 10:03 10:03

THE VIDEOGRAPHER: The court reporter may swear the witness and we will begin. 10:03 10:03

JEFFREY GRANT,
called as a witness, having been duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. QURESHI:

Q. Good morning, Mr. Grant.

A. Good morning.

Q. You understand that we are today continuing the deposition that was commenced on March 20?

A. Yes.

Q. Do you recall generally the instructions that we reviewed at the beginning of that deposition?

A. I do.

Q. I'm not going to repeat all of them, but I will ask you to, or remind you to listen carefully to my questions. If you do not understand a question, please ask me to clarify it. And I may ask you what you don't understand so I can learn how to clarify my question. Is that fair?

A. Yes.

Q. If you answer my question, I'll

assume that you've understood it. Okay? 10:04

If you need to take a break at any 10:04

time to get some coffee, water, use the 10:04

restroom, just let me know and we will go off 10:04

the record. I would ask, however, that we not 10:04

take a break while a question is pending unless 10:05

you need to confer with your counsel about 10:05

questions of privilege. 10:05

A. I understand. 10:05

Q. Are you aware of any reason your 10:05

deposition should not go forward today? 10:05

A. No. 10:05

Q. Okay. Are you on any medication or 10:05

substance that might impact your ability to 10:05

recall information truthfully? 10:05

A. No. 10:05

MR. HASEGAWA: Can we have the same 10:05

agreement that we had last time, that 10:05

relator joins in any objection to form? 10:05

MR. QURESHI: Yes. 10:05

MR. HASEGAWA: Thank you. 10:05

BY MR. QURESHI: 10:05

Q. Mr. Grant, are you familiar with the 10:05

phrase "coding intensity adjuster? 10:05

A. Yes. 10:05

Q. Okay. What is it? 10:05

A. I have a general understanding of it. I have never worked on the coding intensity adjuster. It's something that Medicare does, and they did it after I stopped working on Medicare. 10:05

Q. And what is your general understanding of a coding intensity adjuster? 10:05

MS. KRIEG: Object to the question. 10:05

A. My general understanding is that it's an adjuster for differences in the intensity of coding that occur, regardless of reason, between like one -- a base group like, for instance, in risk adjustment, a base group that is used to calibrate the model, fee-for-service base group, and a Medicare Advantage group that is actually being paid based on the codes submitted. 10:06

Q. Do you have an understanding that Medicare Advantage groups or plans engage in activities to gather more complete diagnostic codes than does CMS? 10:06

MS. KRIEG: Object to the question. 10:06

A. Definitionally, when you say CMS, you mean CMS fee-for-service Medicare? 10:07

Q. Correct. 10:07

A. That was -- yeah, that has been my understanding is that by paying for something, it causes folks to wish to code more completely than those who are not paid for. 10:07

Q. And are you able to identify any of those activities that MA plans might engage in to code more completely, using your words? 10:07

A. Yes. 10:07

Q. Okay. Can you please provide examples? 10:07

A. It would start with provider outreach to try to educate providers, physicians who do not get paid for diagnosis codes, of the portion of diagnosis codes in an MA setting. It would then also go to pulling charts, medical records for review, and then in kind of the 2008-2009 period, it extended to doing home visits to folks that had not been to the doctor to do medical assessments and using those health assessments to then develop diagnosis codes off the health assessments and submit those. 10:07 10:08

Q. Sir, do you have a view as to whether any of the three activities you mentioned are 10:08

improper? 10:08
MS. KRIEG: Object. 10:08
A. Yes. 10:08
Q. Okay. I'd like to go through each one of them and then ask whether you believe it's appropriate or not. 10:08
Provider outreach. 10:08
MS. KRIEG: Object to the question. 10:08
Q. Do you believe that that's an appropriate activity for MA plans to engage in? 10:08
A. Yes. 10:08
MS. KRIEG: Object to form. 10:08
A. Yes. 10:08
Q. Okay. The same question with respect to pulling charts for review. Is that an appropriate activity for MA plans to engage in? 10:08
MS. KRIEG: Object to the question. 10:09
A. Yes. 10:09
Q. And the last one was home visits. Do you believe that home visits are an appropriate activity for MA plans to engage in? 10:09
MS. KRIEG: Object to the question. 10:09
A. I think they can be. 10:09
Q. Okay. In what instances might they not be appropriate? 10:09

MS. KRIEG: Object to the question.

A. I think a home visit that is not part of kind of what I would characterize as a continuity of care, so home visit that is done strictly for the purpose of generating diagnosis codes with no intent of actually caring for the individual would not be consistent with the goals of the Medicare Advantage program.

Q. Other than home visits that are done strictly to generate diagnoses codes with no intent of actually caring for the individual, are there other instances in which you believe home visits are inappropriate?

MS. KRIEG: Object to the question.

A. I think -- I think the homes visits subject is very complicated is what I would say, so I think it all depends -- you would have to be very specific about how a home visit was conducted, the terms under which it was done. There are many ways to do it appropriately and inappropriate. I think you would have to be very specific about how a home visit was done to judge it appropriate or inappropriate.

Q. Sir, do you have an understanding as to why a coding intensity adjuster is used by the Medicare program? 10:11

MS. KRIEG: Object to the question. And to the extent it calls for deliberative process, I instruct you not to answer. 10:11

A. Well, the simplest thing is I was not involved in the deliberative process so any understanding I would have would be just my opinion as to why they did it. 10:11

Q. And that's all I'm interested in, sir. 10:11

A. Okay. My understanding is -- well, first of all, it goes to a statute that required it. I think Medicare probably could have done it within the statute but instead, they were required to do it. So it was something that would have been optional, something that became required by statute, so that is the simplest answer. 10:11

I think the reason that Medicare would look at doing such a thing would be that they would see a different pattern of coding going on in Medicare Advantage than they 10:12

observe in fee-for-service. 10:12

Q. And how would the coding intensity adjuster relate to this different pattern of coding? 10:12

MS. KRIEG: Object to the question. 10:12

A. That would entirely depend on how it is calculated, so it's hard to say. 10:12

Q. You referenced a statute, sir. Do you know which statute? 10:12

A. It would fall within the Social Security Act, but I have no idea what section. 10:12

Q. Mr. Grant, you mentioned that the coding intensity adjuster would address a different pattern of coding going on in Medicare Advantage than what was observed in fee-for-service? 10:13

A. That's correct. 10:13

Q. Why would that difference need addressing? 10:13

MS. KRIEG: Object to the question. 10:13

A. You've calibrated an actuarial model to predict a pattern of expenditures based on people's characteristics. When you define a similar group of people but give them different characteristics that indicate that they are 10:13

sicker than or more expensive, they have more expensive conditions than what would be predicted under the calibration of the model, then you're going to pay more than the model calibration would anticipate that you would pay.

Q. And it is to address that issue that the coding intensity adjuster is focused?

MS. KRIEG: Object to the question.

A. Again, not having been in that, that would be my understanding. Again, I did not work on the coding intensity adjuster, but that theoretically would be what it would be for.

MR. QURESHI: I'm going to begin by marking a document that I'd ask you to review.

(Exhibit No. 1014 was marked for identification.)

BY MR. QURESHI:

Q. Mr. Grant, you've been handed a document that's marked Exhibit 1014, and you're welcome to review the entirety of it. I'm going to be focusing on portions on page 12. Please take as much time as you need to flip through it.

On page 12, the section that I would be interested in is the one that begins with the italicized "More complete coding." It's near the bottom of the page. 10:16

A. On page 12? 10:16

Q. I'm sorry, it's page 20. 10:16

MR. HASEGAWA: What page? 10:16

MR. QURESHI: 20. 10:16

MR. HASEGAWA: Just to make sure, you're looking at the April 7, 2008 announcement of 2009 rates? 10:16

MR. QURESHI: I believe we're looking at the April 7, 2008. 10:17

MR. HASEGAWA: And on page 20, we're looking at something that begins with an Italicized -- 10:17

MR. QURESHI: No, we're just looking at the top of the page. 10:17

MR. HASEGAWA: Okay. 10:17

MR. QURESHI: It begins with "Given the fact that." 10:17

MR. HASEGAWA: Okay. 10:17

THE WITNESS: So I've read the section in question. 10:19

BY MR. QURESHI: 10:19

Q. Okay. Sir, I'm going to go through the first sentence on page 20, different components, and then ask you whether or not you agree with them or not. 10:19

Do you agree that the MA payment methodology is based on fee-for-service payments? 10:19

MS. KRIEG: Object to that question. 10:19

A. I would agree that aspects of the MA payment methodology are related to the MA payments. The risk adjustment model calibration, I mean, is based on fee-for-service payments, specifically the risk adjustment model calibration. 10:19

Q. Okay. So the risk adjustment model calibration is based on fee-for-service payments? 10:19

A. Yes. 10:19

Q. And would you agree further that the risk adjustment methodology is designed to compare the risk scores of MA plan enrollees to other plan enrollees and beneficiaries not enrolled in MA plans? 10:19

MS. KRIEG: Object to the question. 10:20

A. I think that's an odd way of wording it is what I would say, but I think -- I'm not sure that design to compare beneficiaries not enrolled in MA plans is true. I mean, I think you can do it. I think the design is to pay MA plans. The method by which that is done is to calibrate expected cost patterns using fee-for-service data.

So I think I would restate that there -- you would want there to be a comparability between the data that was being used to pay the plans and the data on which it was calibrated, which is a little bit different than saying it was designed to be that way.

Q. Okay. And why would you want that comparability?

A. Because you're calibrating a model using a certain data set you would like the data set that you pay on to be comparable to the data set that you used to calibrate the expected costs; otherwise, you have a misalignment between risk adjustment in practice and risk adjustment as you develop the model.

Q. In your view, what are the

consequences of misalignment? 10:21

MS. KRIEG: Object to the question. 10:21

A. The specific consequences that were being addressed here were that the coding intensity was greater in Medicare Advantage. I mean, if you have -- in any case, you could have somebody that undercoded, theoretically. If they were bad at submitting risk adjustment data, they would be underpaid. If they good at submitting risk adjustment data and got more data in, they would be overpaid according to the design of the methodology, which would anticipate that they would submit data exactly the same as fee for service. 10:21 10:21 10:21 10:21 10:21 10:22 10:22 10:22 10:22 10:22

Q. And in connection with that last point, would you agree with this clause that states for the comparison, comparability, to use your words, to be valid, MA plans must code the way Medicare Part A and B does? 10:22 10:22 10:22 10:22 10:22 10:22

MS. KRIEG: Object to the question. 10:22

A. As a theoretical construct, I think yes. But as a practical matter, it's kind of impossible once you've started all of these other things oriented around focusing on diagnosis codes, I think it is practical -- it 10:22 10:22 10:22 10:22 10:22

is not a practical construct. It is a theoretical statement. But I think it is impossible once people start focusing on diagnosis codes to say that Medicare plans would code exactly the way fee for service does. 10:22 10:23 10:23 10:23 10:23 10:23

Q. But in your view, they should? 10:23

MS. KRIEG: Object to the question. 10:23

A. I think the whole point of the adjuster is that they don't and won't so I don't know that they should. I think -- I would never expect that they would, so -- and we were running -- I mean, from the time we ran the payment system, we realized, as with every payment system Medicare has ever implemented, that once you start paying for A, A becomes focused on and A is no longer equivalent to A. It becomes A prime. It becomes something different by virtue of paying for it. 10:23 10:23 10:23 10:23 10:23 10:23 10:23 10:23 10:23 10:23 10:23 10:23 10:23

So as an ideal, like, way the world would be nice if it existed, yes, but that's not really economically how a world works. When you focus on something, it changes it. 10:23 10:24 10:24 10:24

Q. And in order to address that issue that you've just described, the coding 10:24 10:24

intensity adjuster was introduced? 10:24
MS. KRIEG: Object to the question. 10:24
A. Again, if you read this, that would be what this would indicate, and that would be my understanding of it. But again, I didn't introduce the coding intensity adjuster, so -- 10:24
Q. I understand, Mr. Grant. 10:24
A. But reading -- you know, that's what this record would indicate, and it makes sense. 10:24
Q. Okay. I'm just interested in your understanding. 10:24
A. That is my understanding of it, yes. 10:24
Q. The paragraph goes on to state: "This would result in the MA plan's coding accurately reflecting the fee-for-service coding used on the beneficiaries to whom MA plan enrollees are being compared." 10:24
Did I read that correctly? 10:25
A. Yes. 10:25
Q. And do you agree with that statement? 10:25
MS. KRIEG: Object to the question. 10:25
A. I agree if you had an ideal world where you could just magically have MA data come in the same way fee-for-service data, not influenced by the fact that you paid on it, 10:25

then you would end up with data that was accurate from the standpoint of being kind of comparable data, which is what that is saying. It's predicated on the idea that plans would code exactly the same way, which I've already said I don't believe is true. But if you could create a magical world where that would happen, that would be true. 10:25

Q. And in your response, you indicated accurate with -- the word "accurate" relates to comparability to fee-for-service data? 10:25

A. Right. 10:25

MS. KRIEG: Object to the question. 10:25

THE WITNESS: Oh, sorry. 10:25

A. Yes, and that's what the next sentence is referring -- I mean, the -- if you look at this in the context of the overall paragraph here, and the statements below by the Senators and by -- by Senator Grassley, I mean, you have to look at this in the whole context of this. And they are using accuracy not to talk about whether any specific diagnosis code in fee-for-service or managed care is accurate. It is to compare -- to have comparable diagnoses. So it is accuracy of risk 10:25 10:26 10:26 10:26 10:26 10:26 10:26 10:26

adjustment, really, not accuracy of coding. That's what they're talking about here. 10:26

So they are -- when they say "inaccurate," they are not referring to the accuracy or inaccuracy of any specific code on any specific claim or any specific RAP submission. They're talking about comparable types of data. 10:26

Q. Mr. Grant, if you focus in on the excerpt attributed to Senator Grassley on page 20, there's a reference to paying plans accurately. 10:27

Do you see that in the last sentence of the excerpt? 10:28

A. Yes. 10:28

Q. Okay. What is your understanding of the relationship between paying plans accurately and ensuring this comparability between the fee-for-service data and Medicare Advantage plan data? 10:28

MS. KRIEG: Object to the question. 10:28

A. So again, what this is saying in its entirety is that there is not comparability. So given that there is not comparability, some external adjustment must be made to make 10:28

payment comparable or risk adjustment comparable to what risk adjustment would be if plans coded just like fee for service. 10:28

Q. So in your response, I take it that the accuracy of payment depends on the comparability between fee-for-service data and Medicare Advantage plan data. 10:28

A. No, because it's not comparable. So what you do is you take data, fee-for-service data, managed care data. You run it through a model. You will get different results. 10:29

So if we put all of us in the room in fee for service and then magically put us in managed care and had all the same visits coded by managed care, we'd all end up with higher risk scores, the theory here. Or like overall, the overall average risk score of this room would rise. 10:29

We're not changing the data. That data is what it is. But because of those data differences, we are imposing an external adjustment to bring the risk score down. So it is not an adjustment to the data, it is an adjustment to the risk score that results from noncomparable data. So you don't achieve 10:29

comparable data; you achieve comparable risk scores. 10:29

Q. Understood. Thank you. And what's the impact of the comparability of risk scores on payment? 10:29

MS. KRIEG: Object to the question. 10:30

A. The goal of establishing comparable risk scores, if you could perfectly establish comparable risk scores, is have the payment that's going out to the plans or the risk adjustment component of the payment that goes out to the plans be reflective of how the model was calibrated. 10:30

Q. The goal that you mentioned of establishing comparable risk scores, in your view, that is the goal of the risk advantage -- the risk adjustment system? 10:30

MS. KRIEG: Object to the question. 10:30

A. I think the principal goal of the risk adjustment system is to pay plans relative to each other and relative to fee for service an amount that reflects the actuarial risk they've assumed. 10:31

So that is -- the overall goal is -- this is like within that goal then you have 10:31

kind of necessary things that must occur to achieve that goal. So I would characterize this as something that helps you achieve that goal. It's not the goal itself. 10:31 10:31 10:31 10:31

Q. And the "this" that you referred to in your response, what is that? 10:31 10:31

A. Oh, having comparability in the risk scores between the two systems. That is a building block toward achieving the goal. So you -- I can't remember the phraseology you used, if you want to restate your question. 10:31 10:31 10:31 10:31 10:31

Q. And when you say that it's a building block towards achieving the goal, do you believe that it's a necessary component in order to get to the goal? 10:31 10:32 10:32 10:32

MS. KRIEG: Object to the question. 10:32

A. I think that varies through time. So early on, we had a budget neutrality component built into risk adjustment that intentionally kept payments where they had been traditionally without risk adjustment. So there was no goal of paying comparably. So I think goals change through time. 10:32 10:32 10:32 10:32 10:32 10:32 10:32 10:32

Q. And in the 2008-2009 time frame, do you know what the goal was? 10:32 10:32

MS. KRIEG: Object to the question.

A. I don't know what the specific goal was in 2008-2009.

Q. Okay. You mentioned the goal at the outset. Did it change at some time?

MS. KRIEG: Object to the question.

A. I honestly don't know. Processes definitely changed, as evidenced by the record here. Whether that is a change of goal, I don't know.

Q. Okay. Mr. Grant, had you seen -- other than in meetings with your lawyers, had you seen the exhibit that's been marked 1014 previously?

A. I am sure I must have seen aspects of this. I'm sure it went through my "In" box when I was, you know, part of the overall clearance process. But I'd have to look through it and see if there was anything that related to what I worked on. I'd have to flip through this and refresh my memory on what would have been in here.

But again, this was outside of the period when I was doing Medicare Advantage payment. I was strictly focused on Part D at

this point in time. And at this point in time, in April of 2008, we were very focused on our first reopening of the Part D payment reconciliation. So the very first year payment reconciliation, we were doing our very first reopening, which was very complex, so I was not paying a whole a lot of attention to anything that was not directly related to Part D. 10:34

Q. Okay. In this time, were you still part of the approval process for something akin to Exhibit 1014? 10:34

A. I would say review, not necessarily approval. It would not have had -- like, they would not have required a sign-off from me for this to go out the door. They would have sent it to me and asked me if I had any comments. If I didn't say anything, there were people far senior to me that would be approving it. 10:34

MR. QURESHI: We're going to mark another document and perform a similar exercise. 10:35

(Exhibit No. 1015 was marked for identification.) 10:35

BY MR. QURESHI: 10:35

Q. Mr. Grant, you've been handed a 10:35

document that's marked Exhibit 1015. Please take a moment to review it. My questions are going to be focused on a specific page, actually, two pages, 20 and 21, but please do flip through it as much as you like. 10:35 10:35 10:35 10:35 10:36

And on page 20 I will be focused on the section at the bottom of the page that starts with the word "Response" that's underlined. 10:36 10:36 10:36 10:36

A. All right. 10:39

Q. Have you had a chance to review that section? 10:39 10:39

A. I did. 10:39

Q. Okay. In that section, there's a sentence that states on page 20, the last paragraph: "This means that MA organizations are coding accurately when they're coding in a manner similar to fee-for-service coding used on the beneficiaries to whom MA plan enrollees are being compared." 10:39 10:39 10:39 10:39 10:39 10:39

Did I read that correctly, sir? 10:39

A. You did. 10:39

Q. Do you agree with this assertion? 10:39

MS. KRIEG: Object to the question. 10:39

A. I think similar to in the previous 10:39

document, I agree that if theoretically that were possible to occur, which I do not believe it is possible for that to occur, if it were theoretically possible for that to occur, MA plans would precisely represent fee-for-service coding. They would be paid consistently with how the model is calibrated, which is the definition of accuracy here. 10:39 10:39 10:39 10:39 10:39 10:39 10:40 10:40

Q. And because it's not, according to your view, theoretically possible, what occurs in practice to ensure that MA plans are paid consistent with how the model is calibrated? 10:40 10:40 10:40 10:40 10:40

MS. KRIEG: Object to the question. 10:40

A. Well, I think that question has a buried assumption that something is done in practice to make sure that has occurred. 10:40 10:40 10:40

Q. Is it? 10:40

MS. KRIEG: Object to the question. 10:40

A. I don't know now. I would say a plain language reading of this entire section would indicate absolutely not. 10:40 10:40 10:40

Q. What about the coding intensity adjuster? What role does that play? 10:40 10:40

A. If you go back -- 10:40

MR. HASEGAWA: Object to form. 10:40

MS. KRIEG: Yeah, object to the question. 10:40

THE WITNESS: Sorry. 10:40

A. There's a whole discussion of coding intensity adjustment here and what the value is and very -- making the point that the degree to which coding intensity varies is changing through time and accelerating. And as we discussed before, the home visit thing is starting right in this time period, which will continue to accelerate coding intensity. 10:41

So what you have is coding intensity exceeding the rate at which CMS could keep up with it through any study. They're doing a three-year longitudinal study and averaging the results, knowing that the third year is likely to underpredict the year for which they're paying and they're not using the third year, they're using a three-year average. 10:41

So they are in writing here saying that they are underpredicting the effect of coding intensity. To what degree, we don't know, because again, this is a payment notice for a future year in which the coding intensity is not even known. It is an expectation that 10:42

this is underpredicting coding intensity. 10:42

Now, where they've gone after this, 10:42

we'd have to see other payment notices to see 10:42

if they have ever tried to do an anticipatory 10:42

adjustment to actually make it equal. But they 10:42

are saying here they are take a very 10:42

conservative approach, which is another way of 10:42

saying not trying to make it exactly equal. 10:42

Q. And what impact would this have on 10:42

payments to MA plans if they're 10:42

underpredicting? 10:42

MS. KRIEG: Object to form. 10:42

A. MA plans' risk adjustment scores 10:42

would be higher than they would -- than those 10:42

same people coded and fee for service and run 10:42

through the risk adjustment model so even -- 10:42

and then -- and not adjusted. So you have a 10:42

zero adjustment to fee for service, you have 10:42

some adjustment to the MA risk scores. And 10:42

again, if you could theoretically put these two 10:42

people -- these same group of people through 10:43

two different claim submission methods, the 10:43

scores would always come out higher in MA. By 10:43

what degree, it's impossible to say. 10:43

Q. And is that consistent with your 10:43

understanding of the goal of the risk adjustment program?

MS. KRIEG: Object to the form.

A. Again, I think the goal of the risk adjustment form -- program is to pay on relative risk. How much you want to pay is determined every year through regulatory policymaking.

So if you again look in other places here, they talk about the budget neutrality factor, which we've talked about earlier. They talk about rate book issues and indicate that the rate books are already -- and I think maybe the combination of the rate books and the budget neutrality are 14 percent higher, just the base that you're paying on. So already you're paying more than a fee-for-service basis by 14 percent.

Now you have some other thing added in here, and the degree to which that varies depends on what rate book you're in. So it's not even evenly distributed variance from fee for service. So I would not say that there's -- you know, again, it's not a goal of paying exactly the same as fee for service.

The goal is to appropriately pay plans under whatever policy they've set, which I -- is somewhat different, because they've never really in any of these payment notices here said they're trying to pay exactly as fee for service.

Q. Is it an objective of the plan to have comparability between the risk scores on the fee-for-service side and the MA side?

MS. KRIEG: Object to form.

A. Is it a goal of an MA plan to do that?

Q. No, is it a goal of the program.

A. To have comparability?

Q. Yes, sir.

MS. KRIEG: Object to form.

A. To have exact comparability might be a theoretical goal. I don't know. But clearly here, it is not an objective that they are striving toward in this payment notice. They are very specifically not achieving exact comparability on the risk adjustment side.

Q. What makes you say that it is a theoretical goal?

MS. KRIEG: Object to form.

Q. What's your basis for saying that? 10:45
MS. KRIEG: Object. 10:45
A. I said it might be. It could be an underlying goal for this, but it is clearly not the objective that they are trying to achieve with this payment notice. Whether somebody has that overall goal, I don't know. 10:45
Q. Okay. And during the period of time in which you were involved in the Medicare Advantage program, did you understand what the objective of the program was? 10:45
A. The objective of Medicare Advantage? 10:45
Q. Yes, sir. 10:45
MS. KRIEG: Object to the form. 10:45
A. Just Medicare Advantage, or the Medicare Advantage payment? 10:45
Q. The -- let's start with the program. 10:46
MS. KRIEG: Object to form. 10:46
A. It is to provide alternate ways for members to receive care, so you could go into fee for service, but it's a model that, lacking any, you know, any, like, coordinated physician practice or, you know, being in a health -- you know, happening to fall into a health system on the fee-for-service side that has independent 10:46

coordination of care activity, the goal of this is to provide opportunities for folks that would like different options for care, including possibly care management programs and stuff that allows the flexibility that private sector entities can provide. 10:46

So they have to provide a minimum benefit, but the way in which they provide it can vary from the way that minimum benefit is provided is just a claims payment model, which is fee for service. And so it's providing options to members. 10:46

Q. As part of the program, I believe you talked about the model calibration. 10:47

Do you recall that? 10:47

A. Yes. 10:47

Q. Okay. What is the purpose of calibrating the model? 10:47

MS. KRIEG: Object to form. 10:47

A. It's a necessary condition of -- you have to create a risk adjustment factor, so you have to create risk adjustment factors so that you can pay under health status risk adjustment. 10:47

Q. And what data is used to calibrate 10:47

that model? 10:47

A. Fee-for-service claims data. 10:47

Q. Okay. If you look at the last 10:47

sentence on page 20 -- 10:47

A. Yes. 10:48

Q. -- it states: "In this sense, 10:48

differences in coding patterns, regardless of 10:48

the source, would make the MA plan coding 10:48

inaccurate for purposes of implementing risk 10:48

adjustment." 10:48

Did I read that correctly? 10:48

A. Yes. 10:48

Q. Okay. Do you agree with that? 10:48

MS. KRIEG: Object form. 10:48

A. Again, if you think that the purpose 10:48

of implementing risk adjustment is to have some 10:48

comparability between the cost structures in 10:48

the calibration and the theoretical cost 10:48

structures of the plan is the risk that a plan 10:48

is taking on by picking up these members, yes. 10:48

Q. And is that, in your view, a 10:48

reasonable reading? 10:48

MS. KRIEG: Object to form. 10:48

A. Again, as not the writer of it, if 10:48

you're asking my opinion, yes, it's a 10:48

reasonable reading.

MR. QURESHI: Can we take a short break?

MS. KRIEG: Sure.

THE VIDEOGRAPHER: Going off the record. The time is 10:50.

(Recess taken.)

THE VIDEOGRAPHER: We are going back on the record. The time is 11:06.

BY MR. QURESHI:

Q. Mr. Grant, are you familiar with the phrase "RADV audit"?

A. Yes.

Q. What is a RADV audit?

MS. KRIEG: Object to the form.

A. RADV stand for risk adjustment data validation.

Q. And do you have expertise in RADV audits?

MS. KRIEG: Object to the form.

A. I have overseen them. I have expertise in overseeing RADV audits. There are many different components to a RADV audit, some of which I know well and some of which I do not.

Q. You were at the healthcare consulting firm Health Risk Partners for a period of time, 2008 to 2010, sir? 11:07

A. Yes. 11:07

Q. Okay. And when you were at Health Risk Partners, did you offer consulting guidance on RADV audits? 11:07

MS. KRIEG: Object to the form. 11:07

A. We supported clients that were undergoing RADV audits. 11:07

Q. And you used the word "we." Were you personally involved in those efforts? 11:07

A. I was the client services manager, so on certain engagements, I was in charge of kind of coordinating the engagement along with others. 11:07 11:08 11:08

Q. And in August 2009, you were with -- the spring-summer of 2009, you were with Health Risk Partners? 11:08 11:08

A. Yes. 11:08

(Exhibit No. 1016 was marked for identification.) 11:08

BY MR. QURESHI: 11:08

Q. Mr. Grant, I'm going to hand you a document that's marked Exhibit 1016. I'll ask 11:08

you to please take a moment to review it. Sir, have you had an opportunity to review Exhibit 1016? 11:08 11:10 11:10

A. I have. 11:10

Q. What is it? 11:11

MS. KRIEG: Object to form. 11:11

A. It is an email forwarded among CMS employees of an email that I sent to Tom Hutchinson. 11:11 11:11 11:11

Q. And the email that you sent to Mr. Tom Hutchinson is dated on or about Friday, May 29, 2009? 11:11 11:11 11:11

A. Yes. 11:11

Q. And at this period of time, you were with Health Risk Partners; correct? 11:11 11:11

A. I was. 11:11

Q. And Mr. Tom Hutchinson was with CMS? 11:11

A. He was. 11:11

Q. Do you recall his position with CMS at this point in time? 11:11 11:11

A. Yes. 11:11

Q. And what was that position? 11:11

A. The director of the Medicare plan payment group. 11:11 11:11

Q. And why were you writing to 11:11

Mr. Hutchinson in May of 2009?

MS. KRIEG: Object to form.

A. It was part of an ongoing discussion related to RADV that was precipitated by the RADV pilot of extrapolated RADV methodology.

Q. Do you recall when this discussion commenced?

A. It would have been in the fall of 2008, sometime after I found out that one of our clients was part of this, and I was working through how it worked.

Q. So the purpose of your correspondence with Mr. Hutchinson was to understand how the RADV methodology worked?

MS. KRIEG: Object to form.

A. Not this particular correspondence. This was later in the conversation.

Q. Okay. What was the purpose of this conversation, exhibit -- that's reflected in Exhibit 1016?

MS. KRIEG: Object to form.

A. It was to point out potential problems that I was observing with the proposed method of extrapolating RADV findings to Medicare Advantage plans.

Q. And in this correspondence that's reflected in Exhibit 1016, were you being truthful with Mr. Hutchinson?

MS. KRIEG: Object to form.

A. Yes.

Q. Did you correspond with any other government person about this issue during this time?

MS. KRIEG: Object to form.

A. I -- you know, I don't remember specific conversations. I would say that during the entire period of time, I mean, if you -- are you -- if you're focusing on May, I have no idea who I was talking to in May. If you want to talk about the entire span of my engagement, that's a different question. So I guess I want to just be clear about what time frame you're talking about.

Q. Sure. Let's talk about the wider span. And it would be helpful before you answered the question to define for us what the wider span is.

A. These would still be approximate dates, but sometime after I first discovered, you know, what was going on with RADV and one

of our clients in mid-late October, 2008. And then for a period of time, I don't know if it extended throughout my time at Health Risk Partners, but it was certainly for an extended period of time. I would say upwards of a year, at least.

Q. And were these discussions during this wider span all on behalf of a particular client --

MS. KRIEG: Object to form.

Q. -- or a group of clients?

MS. KRIEG: Object to form.

A. I would characterize it as not on -- specifically on behalf of a client. I was not there to represent. I was not a representative of -- official representative of a client. It was spurred by concerns my clients had and then I had.

Q. So the concerns that are expressed during this wider span, are they your personal concerns or are they the concerns of your clients, or both?

MS. KRIEG: Object to form.

A. Certainly, any concern that I would express in writing -- again, you asked about

truth. These are true expressions of my personal opinions. So I did not go take something somebody else said that I did not believe and then push that in front of CMS. Whether or not my client -- client came up with some of this or I did, at this point, it would be hard to say. I had many discussions with clients and, you know, I would say that was just a starting point. Others in the industry. It's hard to say where a specific idea may have originated. 11:16

Q. Is it fair to say that you wouldn't have pushed it forward to CMS unless you believed it to be true? 11:16

MS. KRIEG: Object to form. 11:16

A. That is fair to say. 11:16

Q. Let's focus on your email to Mr. Hutchinson on May 29 there. It appears that you are sending him, quote, "select pieces of my RA For Dummies presentation." Is that correct? 11:17

A. Yes. 11:17

Q. RA in your email refers to risk adjustment? 11:17

A. That's correct. 11:17

Q. And do you recall when you created a presentation entitled RA For Dummies? 11:17

MS. KRIEG: Object to form. 11:17

A. First of all, I'm not sure that I had a presentation that was titled RA For Dummies. I think that is how I am characterizing a presentation that I produced of simplified RA concepts so that you didn't have to be -- have a -- you know, advanced actuarial science skills to be able to understand the principles of how risk adjustment worked. 11:17

So it was a simplification of risk adjustment. It was used for many different purposes, so it was used to educate clients, it was used to educate Health Risk Partners staff, and I -- I don't remember when I would have created that. 11:18

Q. And the particular principles that you are highlighting for Mr. Hutchinson in this email are based, according to your email, on a simple world with one demographic factor and one disease factor; is that correct? 11:18

MS. KRIEG: Object to form. 11:18

A. That is correct. 11:18

Q. But then you go on to say "Same 11:18

principles apply to more complex models, obviously." Is that correct?

MS. KRIEG: Object to form.

A. That is correct.

Q. You go on to write: "I walk through the calibration and then how it pays wrong when the calibration has flaws." Did I read that correctly?

A. You did.

Q. What does that mean?

A. It's probably very loose terminology. I would probably restate that, if that's okay.

Q. Please.

A. So I think it's basically saying that if you wanted the calibration to perfectly reflect expected costs of a disease condition that an individual had, the model has flaws in that it will have people in there that don't have the condition included in with people that do have the condition. It will have people that have a condition not labeled as having the condition. And so you end up with some levels of inaccuracy in the model that are due strictly to the codes not accurately reflecting what somebody's health status is.

So if you really want to know what diabetes costs, you're getting somewhat of an inaccuracy on the expected costs of diabetes relative to being healthy or relative to CHF or something else. 11:19 11:20 11:20 11:20 11:20

Q. And when you write "how it pays wrong," what payment are you referring to? 11:20 11:20

MS. KRIEG: Object to form. 11:20

A. Again, I think focusing on the term "pays wrong" is probably not appropriate. It's leading to an inaccurate prediction is a better way to state it. 11:20 11:20 11:20

Q. Okay. And did you have a conversation with Mr. Hutchinson in which you explained to him that the use of the phrase "pays wrong" really reflects inaccurate prediction? 11:20 11:20 11:20 11:20 11:20

A. I don't know if I used those terms precisely. I mean, I think we understood that we were dealing with a predictive model. I don't know precisely what words I would have used in the conversation. This is now, what, nine years ago? 11:20 11:20 11:20 11:20 11:20 11:20

Q. Okay. And the email is one that you wrote, or did someone write it for you? 11:20 11:20

A. I wrote it. 11:20

Q. Okay. So you chose to use those words? 11:21

MS. KRIEG: Object to form. 11:21

A. I did. 11:21

Q. If you read the -- that entire paragraph, the last sentence states: "Again, that requires the study of FFS coding and documentation that we have previously discussed and will not be able to inform your immediate issue." 11:21

Did I read that correctly? 11:21

A. You did. 11:21

Q. What do you recall about the immediate issue referenced in that sentence? 11:21

MS. KRIEG: Object to form. 11:21

A. The immediate issue that we were concerned about was a straight extrapolation of risk adjustment data validation findings on a small sample to the entire population of a plan. 11:21

Q. And what's the issue related to that topic? 11:21

MS. KRIEG: Object to form. 11:21

A. It -- there are a series of issues 11:21

that are laid out in the email.

Q. Okay. Let's go over --

A. Okay.

Q. -- those particular issues, starting with the one numbered 2.

A. Number 2?

Q. Yes, sir.

A. Okay.

Q. What issue were you referring to there?

MS. KRIEG: Object to form.

A. So this goes back to statements that we made early on in risk adjustment about the data submission policies and how they related to diagnosis codings. And plans were worried about how diagnosis codings were reflecting and -- and, you know, accuracy of diagnosis codings might impact them.

And kind of the consistent CMS statement at the time was if you just submit claims like fee for service and don't do all those other things, they were -- this is a whole alternate data sources discussion where they wanted to use things other than claims. We were saying you don't need to use things

other than claims. Use claims. The model's calibrated on claims. Use claims.

Q. You referred to a consistent CMS statement at the time. Where could I find this consistent CMS statement?

A. I'm not sure if it's in writing or if it was verbal. I think there are discussions in the original risk adjustment documents about alternate data sources and how they would be used or how they could or could not be used.

Q. That first sentence in section 2 states in part that CMS consistently responded that FFS coding represented then you have quotes, perfect payment, i.e., replication of the model calibration, end quote. Did I read that correctly?

A. Yes.

Q. Okay. And was that information communicated to plans?

MS. KRIEG: Object to form.

A. Again, now you're going back to, you know, 2001, 2002, 2003. Whether it was phrased that way, I don't know. This -- again, an email conversation I'm having with Tom, but the -- this is a statement that is basically

consistent with the statements made in the other documents, that it -- it is -- that this theoretical perfection is that data looks exactly like it looks in calibration and when it varies from that, it doesn't look like that.

Q. And when it varies, it requires some adjustment?

MS. KRIEG: Object to form.

A. It depends on what the policy is.

Q. And when you were writing to Mr. Hutchinson, what policy were you referring to?

A. My note was not about how payment was calculated, it was dealing with RADV extrapolation.

Q. Okay. But, sir, in the first paragraph of your email you write: "I walked through calibration and then how it pays wrong when the calibration has flaws." Is that right?

A. Right.

Q. Did that refer to payment to MA plans?

MS. KRIEG: Object to form.

A. So if you go back to how I answered

that, that is sloppy terminology that is actually referring to that the -- the calibration is inaccurately predicting -- within the fee-for-service population inaccurately predicting the attribution of specific costs to any disease condition or any demographic category that results from inaccurate coding. 11:26

So not having an accurate description of who has what disease leads to some level of inaccuracy in the calibration. I used the word "payment," but I would say now that that is kind of an inaccurate way of stating it and it would be better to say, you know, that the predictions of the model are affected by it. 11:26 11:27

Q. Sir, when we were talking about number 2 on your itemized email, I want to go back to your testimony that there were some oral statements in which CMS may have represented that fee-for-service coding represented perfect payment. And the question is, did you ever have any conversations with anyone while you were at CMS before writing this email in which you informed plans that fee-for-service coding represented perfect 11:27

payment?
MS. KRIEG: Object to form.
A. Again, I --
MS. KRIEG: Can I also object?
You're asking conversations with people outside of CMS?
MR. QURESHI: Yes.
MS. KRIEG: Okay.
A. Again, we are going back to 2001, 2002, 2003. We would have user group calls with like a bunch of us sitting around the table. So I don't know who would have said what in what precise terminology.
I'm now summarizing my understanding of what we communicated to plans in an email to Tom Hutchinson. So whether we used this precise word, because I believe that's not like a quote like we said, and that's a, quote, perfect payment. It's like air quotes, perfect payment. And it is explained what I mean much clearer by not saying perfect payment but replication of the model calibration, which we always did talk about with -- this with plans who were concerned about needing to get all this extra data in.

I mean, the main point of contention between us and the industry implementing risk adjustment is they said you're not going to get all the diagnosis codes. That was the whole alternate data sources, and this is what this is -- this goes back to alternate data sources and the pressure for alternate data sources to supplement what comes in on the claim because they say you're not going to get all the diabetics but we can get them by, like, if we have an insulin claim, for instance. We're like, that's how the model's calibrated. You cannot submit insulin and get credit for diabetes. And then we came out with alternate data source instructions. But then we would always say we don't believe this is necessary. We believe that if you just rely on the claims data, you don't need to supplement the claims data. And those were the kind of statements we were making.

Q. And I certainly understand that you don't remember who in particular may have made misstatements, but when you're writing to Mr. Hutchinson in 2009, you're not making stuff up; right? This is based on your recollection

and facts that you understood at the time. 11:30
MS. KRIEG: Object to the form. 11:30
A. So I am not making stuff up, but I 11:30
may not be perfectly quoting it either. I am 11:30
saying a general understanding, which I think 11:30
this paragraph gives a general understanding, 11:30
and it is getting back to the same discussions 11:30
we have had over differences between MA data 11:30
and fee-for-service data and trying to convince 11:30
plans that if they could end up in this 11:30
theoretically perfect world where they looked 11:30
like fee-for-service data, they would be 11:30
matching the model calibration, and that's the 11:30
point of this paragraph. 11:30
Q. And they would be paid correctly? 11:30
MS. KRIEG: Object to form. 11:30
A. They would be paid commensurate with 11:30
the model calibration. I think "correctly" is 11:30
eye of the beholder. 11:30
Q. Sir, let's go back to your email. In 11:30
the same section, you write: "Plans were told 11:31
that if they stuck to how the data comes into 11:31
FFS, they would be paid correctly." Did I read 11:31
that correctly? 11:31
A. Yes. 11:31

Q. And was that a true statement when you wrote it? 11:31

MS. KRIEG: Object to form. 11:31

A. The concept that it is conveying, again, I do not want to say that -- like, I'm summarizing conversations with plans here, not giving direct quotes. That's all I want to say. 11:31

So as the general concept reflected by the entire paragraph in an email, I am trying to -- not a policy document or something else. I am in a brief email trying to summarize issues that I believe exist with an extrapolation. And one of them is the assurances that if they submitted data like fee for service, they would be paid equivalent to the calibration and they didn't need to worry about finding other data to supplement fee-for-service data. 11:31

Q. I understand that you were summarizing. But were you endeavoring to summarize accurately? 11:32

MS. KRIEG: Objection, form. 11:32

A. Oh, absolutely. 11:32

Q. Then you go on to state: "Now that 11:32

is doubly not true." What did you mean by that? 11:32

A. I'm not sure why I said "doubly not true." I'm trying to remember what that would refer to. 11:32

I can see the singular of why it would not be true with the point I was making about the RADV extrapolation, that if you -- like, in a theoretical world, if you could get somebody to submit data, just claims, not do any provider education, not in any way alter how data came in, if you had that perfect plan that did that and then you did RADV, you would find some degree of error in those diagnosis codes. And then extrapolating that error would then create a difference between what was started out as logically the same as the fee-for-service data that went into the model to then something that is less than the fee-for-service data that went into the model. That was the point I was making here. 11:33

Q. Okay. And why would this discrepancy exist after a RADV audit? 11:33

MS. KRIEG: Object to form. 11:33

A. It only exists not in the RADV audit 11:33

itself, which is a small sample, 200 people, you find things wrong, you correct those things. It doesn't exist in the audit sample; it exists when you extrapolate the findings of an audit sample to then say we're going to reduce your payment. 11:33 11:33 11:33 11:33 11:33 11:33

This was the argument I'm making, that it causes a problem if you are going to extrapolate the finding of a RADV against a plan that coded exactly like fee for service, as you had -- you know, you encourage everybody to do that, they did that, then you extrapolate on that, you're going to end up paying them less than you would pay them if you just took fee-for-service data and paid them. 11:34 11:34 11:34 11:34 11:34 11:34 11:34 11:34 11:34 11:34

Q. In that same paragraph there's a sentence in which you write: "Trying to look for additional diagnoses results in increased coding intensity (for which CMS is now making an adjustment)." Did I read that correctly? 11:34 11:34 11:34 11:34 11:34 11:34

A. Yes. 11:34

Q. And the adjustment you're referring to in that sentence is the coding intensity adjuster? 11:34 11:34

MS. KRIEG: Object to form. 11:34

A. I believe so. 11:35

Q. Now, you conclude that section 2 by saying in the last sentence, a statement in parentheticals, and the statement reads: "I have looked through QAs and searched the website for certain key phrases and find no formal documentation of this answer, unfortunately." Did I read that question -- that statement correctly? 11:35

A. You did. 11:35

Q. And what exactly were you looking for on the website and on the QAs? 11:35

A. The statements that I say I recall now, somebody having made and I even recall then people having made, that there was no need to go after alternative data because mere submission of claims data would look the same as the risk adjustment model and to worry about, you know, the missing diabetes code was not a relevant concern. And evidently, we didn't actually write that answer down in a Q and A; we wrote down different responses to how alternative data sources could be done, but we didn't go into that. 11:36

Q. And in your answer, you referenced 11:36

"people" and "we." In both instances, the persons making the statements are people affiliated with CMS? 11:36

A. That is correct. 11:36

Q. Are they government officials? 11:36

MS. KRIEG: Object to form. 11:36

Q. We're talking about government people; correct? 11:36

A. Yes. 11:36

Q. Okay. In statement number 3, you reference a PFFS. What is that? 11:36

A. Private fee for service. 11:36

Q. Okay. That's the traditional Medicare FFS we have been referring to? 11:36

A. No. 11:37

Q. What is it? 11:37

A. The private fee-for-service was ... 11:37

Q. Please. 11:37

A. It was an option that was put in that allowed a Medicare Advantage product to be started that was called private fee for service where I don't -- you know, I am not familiar with all of the rules on that, but the essential outlines of it were that they did not have a network. They operated like 11:37

fee-for-service Medicare in that they would reimburse any qualified provider for providing services as opposed to having a narrow network. 11:37

Q. You go on to say: "They ideally should have the best payment because it is most like the original model calibration." Did I read that correctly? 11:37

A. You did. 11:38

Q. Okay. And did you believe that to be a true statement? 11:38

MS. KRIEG: Object to form. 11:38

A. I did. 11:38

Q. When you say "they should have the best payment," are you making a relative statement? Best payment compared to who? 11:38

MS. KRIEG: Object to form. 11:38

A. It's relative to anybody else that's submitting risk adjustment data. Again, I think "payment" is a probably a sloppy term. It is accuracy, you know, risk adjustment factors that most accurately represent the model calibration because again, you don't have this narrow network where you are influencing the network in how the coding goes on. 11:38

Q. You go on to say, sir: "Again, 11:38

extrapolation for RADV does not provide an equitable treatment for these plans and is not consistent with how the payment methodology was developed." Did I read that correctly? 11:38 11:38 11:38 11:39 11:39

A. You did.

Q. Was that a true statement when you wrote it? 11:39 11:39

MS. KRIEG: Object to form. 11:39

A. It is a reflection of my opinion when I wrote it. 11:39 11:39

Q. And did you hold that opinion when you wrote it? 11:39 11:39

MS. KRIEG: Object to form. 11:39

A. I did. 11:39

Q. Do you hold it today? 11:39

MS. KRIEG: Object to form. 11:39

A. As long as they were -- as long as my understanding that they were submitting like fee for service, with the extrapolation that was proposed at the time, I still hold that opinion, yes. 11:39 11:39 11:39 11:39 11:39

Q. Okay. And what about your opinion regarding how the payment methodology was developed? Has your opinion regarding that changed? 11:39 11:39 11:39 11:39 11:39

MS. KRIEG: Object to form. 11:39

A. Well, my understanding of how the payment methodology was developed has not changed. 11:39

Q. Do you recall having a oral conversation with Mr. Hutchinson in connection with your email? 11:40

A. The specific oral conversation? 11:40

Q. Let's start with the specific and then we will go to the general. 11:40

A. No. 11:40

Q. Okay. Do you recall a general discussion with Mr. Hutchinson regarding the topics of your email? 11:40

A. I -- you mean do I recall in general that I had oral discussions? Is that what you're asking? 11:40

Q. Yes, sir. 11:40

A. Yes, in general, I recall having oral discussions. A specific oral discussion versus another one, I don't recall timing of any specific oral discussion. 11:40

Q. And do you recall the substance of any oral conversation with Mr. Hutchinson? 11:40

A. Of -- I would -- the substance of a 11:41

specific oral discussion or a series of oral discussions? 11:41

Q. Mr. Grant, I'm just trying to understand if you recollect talking to Mr. Hutchinson about the subject of this email. 11:41

Do you have any such recollection? 11:41

A. The overall subject of the email related to extrapolation. Let me -- this is an email that is being written in response to a proposed -- or not even a proposed. I mean, at the time, they thought they were going forward and marching forward when it wasn't even considered a proposal at the time. It was their policy for five pilot issuers how they were going to deal with their RADV extrapolation. So this was a series of discussions critiquing that approach. 11:41

Whether any specific discussion had all of these components in it, whether some of these I raised later in an email without having an oral discussion with them, I honestly could not tell you. 11:42

Q. That's fair. 11:42

And do you remember the substance of any of those discussions? 11:42

Do you remember Mr. Hutchinson's position on any of the issues we've talked about? 11:42

Do you remember the back-and-forth? 11:42

Any other details you can provide me about discussions with Mr. Hutchinson about these topics? 11:42

MS. KRIEG: Object to form. 11:42

A. So I would say again this was a long series of discussions. The first ones I think he was not -- he needed to understand where I was coming from, so -- but I would say he was open to having discussions, first and foremost, so he was open to the discussion. 11:43

He listened to me. He would go back and talk to folks and come back and say, my folks say this isn't true. And I'd say, well, I believe it is. And we would go further and further. 11:43

And what you are seeing is after probably -- if this is May, this is at least six months of discussions about this topic with him, I'm sending him an email and summarizing some of the key things that he appears to have sent to his folks and is at least wanting to 11:44

discuss it with them. 11:44

I can't vouch for what his opinion 11:44
was. I mean, he was in a position of 11:44
representing a program that had a policy, so he 11:44
can't reverse policy in any discussion with me, 11:44
and I wouldn't expect him to. 11:44

I mean, my expectation, as with 11:44
anybody that approaches a government official, 11:44
is, like, they cannot on the spot make a just 11:44
fiat policy change. They're going to have to 11:44
go through a process. 11:44

But my job is to represent what I 11:44
think is the issues with the policy as it 11:44
currently stands. Their job is to go back and 11:44
take it back and decide what they want to do 11:44
with what I presented to them, so -- and 11:44
frankly, because I'm out of that field now, I'm 11:44
not even sure what has happened even with the 11:44
original pilot plans. So, you know, I don't 11:44
stay in touch with Medicare Advantage risk 11:44
adjustment so I honestly have no idea where the 11:44
first five plans ended up. 11:45

Q. Okay. But at the time you wrote this 11:45
and you're informing Mr. Hutchinson that CMS 11:45
has told plans that fee-for-service coding 11:45

represents perfect payment, you are informing Mr. Hutchinson of your honest opinions; right?

MS. KRIEG: Object to form.

A. Yes.

Q. Okay. And when CMS is informing plans that use of fee-for-service coding is perfect payment or represents perfect payment, CMS knew that plans are doing chart review; correct?

MS. KRIEG: Object to form.

A. I am not saying that's correct.

Q. You write, sir, in your email: "Trying to look for additional diagnoses result in increased coding intensity." Correct?

A. Yes.

Q. And doesn't looking for additional diagnoses, isn't that a result that could occur after performing chart review?

MS. KRIEG: Object to form.

A. So you are positing a bunch of things in CMS people's heads that may or may not have been true at the time that I am talking about. So again, we are turning the clock back. We have not yet risk-adjusted for physician data. We are in the process of risk adjusting on a

hospital inpatient model. We are rolling out an inpatient -- or a physician and outpatient data collection, and the health plans are objecting to our rollout because we're going to miss diagnosis codes. 11:46

They're constantly saying we need to be able to get other data in. We know who our diabetics are, and they're not all diabetics on claims. 11:46

So there was a long, protracted discussion with plans about, okay, you say you know who these people are. How could you possibly account for it? And during that discussion, we're saying you don't really -- we do not believe this is a valid concern. You think it's a valid concern. We're taking it back with us. We understand your valid concern. 11:47

So again, similar to the type of conversation we just talked about me having with Tom Hutchinson, this is now I'm in the government back in 2003. Plans are saying we object to your policy. We are saying we don't think there's a basis for your objection. 11:47

But they are insisting that there is, 11:47

and they would like to know what we're going to do about it. And we come up with an alternative data sources methodology. Whether anybody was using it, how they would use it in 2001, 2002, 2003, I have no idea whether anything was -- anybody was doing anything like that. We knew people were looking for options and so we gave them, this is how you could do it and then said we're not -- we're not saying you should do this. 11:47 11:47 11:47 11:47 11:47 11:47 11:48 11:48 11:48 11:48

Q. Okay. I'm focused on 2009, the time you write this email, sir. 11:48 11:48

A. But the conversations that this email refers to, which you are taking a paragraph in an email that is referring to conversations that took place way back in the past. So you're in 2009. I'm not talking about 2009 statements by CMS. 11:48 11:48 11:48 11:48 11:48 11:48

Q. In your email, you write "for which CMS is now making an adjustment." 11:48 11:48

A. Correct. 11:48

Q. What period of time are you referring to? 11:48 11:48

A. In that, I'm referring to in 2009. 11:48

Q. Okay. What adjustment is being made? 11:48

A. The coding intensity adjustment. 11:48
Q. Why is it being made? 11:48
MS. KRIEG: Object to form. 11:48
A. That goes back to what CMS's reasons were. I was not part of the policy development. We can all look at the record of what CMS said. 11:48
Q. And when you wrote to Mr. Hutchinson, did you go back and review the record? 11:48
A. Did I go back and review the record of what CMS said? 11:49
Q. Yes, sir. 11:49
A. I reviewed the 2009 payment notice, as I was external to CMS at the time the payment notice went out. But on behalf of my client, I absolutely reviewed the 2009 payment notice extensively. 11:49
Q. So when you wrote plans were told that if they stuck to how the data comes in to fee for service, they would be paid correctly, that statement was based on a review of the record? 11:49
A. No. 11:49
Q. What was it based on? 11:49
A. That goes back to 2001, 2002, 2003. 11:49

This is where I'm saying that you are blending different points in time. I'm talking about -- alternative data sources is a discussion that happened when I was in CMS. So you're taking kind of a parenthetical statement in the middle of a discussion about things that were said in the past and me updating, like, in the current world, this is what is happening. But the discussions I'm talking about are discussions that happened when I was in CMS. I was not in CMS when the coding intensity adjustment came out. So I think it's a blend of things, and that's what's confusing here. It's an email.

Q. Mr. Grant, if you look at the first page of the email, you do send another email to Mr. Hutchinson a few months later in August of 2009.

Do you see that?

A. Yes.

Q. Why did you do that?

MS. KRIEG: Object to the form.

A. Yeah, I mean, it's hard to say. It doesn't say much. It says "Note from before with presentation." I honestly don't know what the genesis of me sending this was.

Q. Did he ask it for it or was it unsolicited? 11:52

MS. KRIEG: Object to the form. 11:52

A. I would be speculating at this point. I don't remember how our conversations evolved. 11:52

MR. QURESHI: I'm going to mark as the next Exhibit 1017. 11:53

(Exhibit No. 1017 was marked for identification.) 11:53

BY MR. QURESHI: 11:53

Q. I've handed you Exhibit 1017, and I'll tell you this is the PowerPoint presentation for slides that were attached to Exhibit 1016. Have you had a chance to review it, sir? 11:53

A. Yes. 11:54

Q. Okay. Do you recall preparing Exhibit 1017? 11:54

A. I recall that I prepared it. 11:54

Q. Okay. And I believe you mentioned earlier that you didn't give it the title "RA For Dummies," but that's how you characterized it in the email we just looked at; is that correct? 11:54

A. Correct. 11:55

Q. And I believe you also testified that in addition to sending it to Mr. Hutchinson, you would sometimes use it with clients to talk about the risk adjustment program; is that right? 11:55

A. That is correct. 11:55

Q. Do you recall when you prepared it? 11:55

A. Approximate time period would be late 2008, early 2009. And it may have been changed. I don't know that it was like -- it's probably -- it was probably updated through time as well. 11:55

Q. Do you recall preparing it while you were at Health Risk Partners? 11:55

A. Oh, yes. It was definitely while I was at Health Risk Partners. 11:55

Q. Okay. And in preparing it, were you endeavoring to be accurate? 11:55

MS. KRIEG: Object to the form. 11:55

A. I was endeavoring -- I mean, this is a very simplified model. I was endeavoring to show a principle with a very simplified model which is not accurate to like the world, but it presents an effect. I was trying to demonstrate an effect. 11:55 11:56 11:56

Q. But you weren't trying to manufacture information. You believed that the principle that is being illustrated in these slides is a genuine reflection of something you believed occurred. 11:56

MS. KRIEG: Object to the form. 11:56

A. So what I would say is, yeah, I mean, I used totally manufactured data because I just made up amounts for the -- and created a very, very simplified world, which is much simpler than what a real risk adjustment model looks like with multiple demographic factors, multiple disease factors, to illustrate a principle that I believed was true. 11:56

Q. And I believe in your email to Mr. Hutchinson you said that this principle would also hold true for more complex models. If you want to go back to Exhibit 1016, you certainly can. 11:56

A. Where was this at again? 11:57

Q. It's in the sentence that states: "Same principles apply to more complex models, obviously." 11:57

MS. KRIEG: Object to the form. 11:57

A. Yes, I see that, yeah. 11:57

Q. And you believed that? 11:57
MS. KRIEG: Object to the form. 11:57
A. I did. 11:57
Q. Okay. Sir, I'd like you to walk us through the principle you're attempting to illustrate. 11:57
MS. KRIEG: Object to the form. 11:57
A. There are a couple. So we -- I would say there's principle 1 and principle 2 for simplicity's sake so we can follow. Principle 1 is related to model calibration; principle 2 is related to RADV execution. 11:57
So principle 1 is that whenever you calibrate a model, there are some degree of diagnoses that are reported, but they are incorrectly reported. So somebody is reported as having condition; they do not have that condition. 11:58
And there's a general kind of principle that underlies risk adjustment. So the underlying principle of risk adjustment is we assume -- this is the basis on which we build every risk adjustment model. We assume that, on average, 65-year-olds have a certain cost. They're all going to vary. No 11:58

65-year-old is going to cost the same, but 65-year-olds that are healthy cost a certain amount, on average. 80-year-olds that are healthy cost a certain amount on average. People with diabetes on average cost a certain amount. People with congestive heart failure on average cost a certain amount. People with diabetes and congestive heart failure cost a certain amount, on average.

So this is then taking that knowledge, playing God, and saying I magically know what these values are. That's the way this is set up. So I magically know that all healthy people cost 500 bucks apiece and all sick people cost $1,500 because I've God-like powers and I can figure that out already.

And it is operating under the assumption that a person who is coded as sick but is actually not sick is actually the same as all the healthy people, they're just incorrectly coded.

And you can choose to accept or not accept that assumption. That is the assumption that I was operating under is that there is no difference between healthy coded as healthy and

healthy incorrectly coded as sick. 12:00

Q. Okay, so if I could pause you there, 12:00

Mr. Grant, is that sort of what the purpose is 12:00

of slide 2? You're referencing a healthy 12:00

personal mistakenly coded as sick and then 12:00

assigning the relative cost to that individual? 12:00

MS. KRIEG: Object to the form. 12:00

A. Yes. So this is again, with the 12:00

God-like power to know everybody's cost, I know 12:00

that these healthy people coded as sick cost 12:00

the same as all the other healthy people and I 12:00

magically already know they all cost $500, an 12:00

unknowable fact when running a risk adjustment 12:00

calibration, but in this world I've created I 12:00

know this. And so I have two people thrown 12:00

into the sick category from a coding 12:00

perspective, but from a cost perspective 12:00

appropriately residing in the healthy category. 12:00

Q. Okay. 12:00

A. And as you see from this -- and this 12:01

is only -- by the way, it's a one-directional 12:01

look at this, I will point out too, just 12:01

looking at the incorrect coding, not going the 12:01

other direction. The incorrectly -- 12:01

incorrectly coded as sick, not healthy, 12:01

incorrectly coded as healthy. It's not a robust presentation that has both sides. It's a one sided --

Q. I understood.

A. And then we just walk through it and say we haven't thrown any sick people into the healthy category erroneously, so healthy people still cost 500 bucks apiece. But by virtue adding two healthy people into the sick population, you lower the perceived average cost of the sick population and that results in the healthy still predicting at $500 and the sick person at $1,033. You've reduced kind of the relative cost of sick to healthy.

Q. When you refer to the 1333 as a result of healthy, two healthy persons being coded as sick, this amount decreases from 1500 to 1333; is that correct?

A. Correct.

MS. KRIEG: Object to form.

A. Correct.

Q. Okay.

A. That's what I'm saying.

Q. Okay.

A. Again, very simple. It's not running

a real linear regression model. It's taking a very simple view of the world: Healthy people, sick people. 12:02

Q. And so -- 12:02

A. And unified costs too, unitary costs, where every sick person costs the same amount, every healthy person costs the same amount. 12:02

Q. So what is the principle that you're illustrating with this example? 12:02

MS. KRIEG: Object to form. 12:02

A. That if there is a pattern of overreporting of diagnosis codes in fee for service, then that pattern would result in a underprediction of the disease-related factors in the model, and then the relative cost differences between sick and healthy are reduced. 12:02 12:03 12:03

Q. And, sir, is there, in fact, a pattern of overreporting of diagnoses codes in fee-for-service data? 12:03

MS. KRIEG: Object to form. 12:03

A. That's what nobody knows, at least nobody that I know of knows. 12:03

Q. Are you aware of any errors in the diagnosis codes and fee-for-service data? 12:03

MS. KRIEG: Object to form.

A. I would state it differently. I'm unaware of any systematic study of that. There may be, but I'm unaware of a systematic study.

Q. Putting aside a systematic study, what is your personal belief? Are there errors in diagnosis codes in fee-for-service data?

MS. KRIEG: Object to form.

A. It would be my belief that in any data set, there would be some degree of error. The question is always what the degree of error is, not whether there is something wrong in some -- you have -- you know, now we're 50 million people or whatever in fee for service. You get all their claims. You get over a billion claims a year. Every claim is not perfect. The real question is not is there an error, it's the degree of the error and it's the relative undercoding and overcoding, because both kind of error could exist. You could fail to code a diagnosis code, which is what the plans yelled at us about and wanted alternative data sources, or you could pick up a diagnosis code that should not have been there. Either type of error could exist in

fee-for-service data and you would need to do a systematic study to know the degree to which that error exists and what the bias is.

Q. So you are aware that there are errors, but you don't know the amount or extent because you believe there's no systematic study evaluating this issue?

MS. KRIEG: Object to form.

A. Again, "aware" is a strong term. I would say it is my firm belief, having processed data for years, that any data set has errors in it. My experience with data would say that every data set you ever deal with that is a very large data set has some degree of error and the only question is what that degree of error is. And unless you study it, it is not knowable what that degree of error is.

Q. And, sir, in slide 3, what are you illustrating?

MS. KRIEG: Object to form.

A. So again, this is living in a -- we're now moving from a slightly fictitious world to an exceptionally fictitious world where plan costs are the same as fee-for-service costs, which is not even an

assumption that necessarily CMS would share, let alone that every plan has the same underlying cost.

But assuming that a goal was to pay similar to how the model was calibrated, and that plan costs generally trend the same way fee-for-service costs do, that if you have an underlying error in fee-for-service data that overreports diagnosis codes and therefore undercalculates a risk adjustment factor that the plan would not be being paid the same as fee for service. And if you assume their costs were similar to fee for service, this would result in an underpayment to the plan. 12:06

Q. The last bullet point of slide 3, what are you illustrating in that? 12:07

MS. KRIEG: Object to form. 12:07

A. Again, I'm creating a fictitious world where sick people in fee for service costs 1500, sick people for the plan cost 1500, you know how many sick people you have, you know how many healthy people you have, and you submit them entirely accurately. This is the difference between what their actual cost is and what you get paid. 12:07

Q. Slide 2 suggests that there's 12 people coded as sick; correct? 12:07

A. Yes. 12:07

Q. Two of those 12 are, in fact, healthy; correct? 12:07

A. Yes. 12:08

Q. But in slide 3, there's only 10 sick members who are coded as sick; is that right? 12:08

A. That is what this slide is showing, yes. 12:08

Q. Okay. And are you attempting to highlight in your hypothetical world the differences between the fee-for-service data where you have healthy coded as sick and then in the plan data where there's only sick people coded as sick? 12:08

A. No. 12:08

MS. KRIEG: Object to form. 12:08

A. No, I'm not purporting to do that. I'm not suggesting that plans only code sick people as sick. I'm creating a hypothetical world where if a plan were to code only sick people as sick and then vary from fee for service as a result of doing that, because in fee for service we had two people who were sick 12:08

that were not. So in this world now we've changed it and said create a fake world where plans submit perfect data and every code a plan submits is perfect. This is the mathematical result of that --

Q. Okay.

A. -- in a world where we have the other assumptions already present.

Q. Okay. What is meant by the first bullet point --

MS. KRIEG: Object to form.

Q. -- on page 3?

MS. KRIEG: Object to form.

A. This is kind of going back to the email discussion of if you submit exactly like fee for service, so if you -- if this undercoding -- and it would equally apply to overcoding, by the way. This is a presentation, just assuming -- I mean, this is assuming overcoding. It would also apply to undercoding, I should say. That if you submitted -- if your data looked exactly like the data that went into the calibration, you would be paid exactly as the model anticipates you would be paid. If you vary from that in

either direction you're going to be paid differently than the model anticipates you being paid because you're going to get a risk adjustment factor that's either higher or lower than the model calibration would anticipate for a person with those characteristics. 12:10

MR. QURESHI: May we take a break? 12:10

THE VIDEOGRAPHER: We are going off the record. The time is 12:10. 12:10

(Recess taken.) 12:10

THE VIDEOGRAPHER: We are going back on the record. The time is 12:55. 12:56

BY MR. QURESHI: 12:56

Q. Mr. Grant, are you familiar with an organization called AHIP? 12:56

A. I am. 12:56

Q. What is AHIP? 12:56

MS. KRIEG: Object to the form. 12:56

A. It is the Association of Health Insurance Plans, I think. They're the industry organization that represents health plans. 12:56

Q. And during your tenure at Health Risk Partners, did you participate in AHIP meetings? 12:56

A. Attend AHIP meetings, you mean? 12:56

Q. Attend, participate. 12:56

A. I certainly went to the AHIP conferences, and then I had -- I met with AHIP.

Q. Was Health Risk Partners a member of AHIP?

A. No. Health Risk Partners is not a health plan.

Q. Okay. In your interaction with AHIP, did you ever prepare any written materials for them?

MS. KRIEG: Object to the form.

A. I was part of the preparation. I can't remember if I actually personally prepared written materials or was just part of the preparation, but I had a consulting contract with AHIP.

Q. Okay. So this consulting arrangement, was it with you personally or with you through Health Risk Partners?

MS. KRIEG: Object to the form.

A. It was me through Health Risk Partners.

Q. Okay. Approximately when were you engaged in connection with this matter?

MS. KRIEG: Object to the form.

A. At some point in time I was at Health

Risk Partners. I honestly don't know the dates.

Q. Okay. Sometime between 2008 and 2010?

A. Yes.

Q. And what was the purpose of the engagement as you understand it?

MS. KRIEG: Object to the form.

A. It was to work on the RADV extrapolation and to assist AHIP in responding to the RADV extrapolation methodology.

Q. Responding to whom?

A. To CMS.

Q. And what types of activities did you do to fulfill that objective?

MS. KRIEG: Object to the form.

A. I don't remember the exact activities. The general types of things that I did was I was in meetings with a working group of plan representatives, a mix of people that work on risk adjustment, actuaries from a select group of AHIP's member plans. You know, we discussed the official response that AHIP would provide to CMS regarding their concerns about the RADV extrapolation methodology.

Q. And the PowerPoint we looked at prior to the break, Exhibit 1017, did that contain any concerns about RADV? 12:59

MS. KRIEG: Object to the form. 12:59

A. Yes. 12:59

Q. And we will certainly get back to that in a moment. I want to focus on AHIP for the moment. 12:59

Who else from Health Risk Partners was helping on this particular engagement with AHIP? 12:59

MS. KRIEG: Object to the form. 12:59

A. I did this myself. I mean, we obviously had a contract so there were -- the people that did the contract and the president approved my doing the consulting arrangement, but the consulting arrangement was me with them. 12:59 01:00

Q. As part of your engagement with AHIP regarding this RADV issue you've referenced, did you endeavor to ensure that AHIP's presentations to the government were accurate? 01:00

MS. KRIEG: Object to the form. 01:00

A. I would say I was one of many people who had input into their presentation. It was 01:00

their presentation, so I exerted my influence on it, but it was their work product and their member plans's work product in the end. I was there in an advisory role. It was up to them what they presented to the government and I had no veto authority or anything like that over it. 01:00 01:00 01:00 01:00 01:00 01:00 01:01

Q. Do you recall any instance in which you had discomfort about positions or arguments that AHIP was expressing to the government regarding RADV? 01:01 01:01 01:01 01:01

MS. KRIEG: Object to the form. 01:01

A. So I recall that they had a decently lengthy discussion of it that was prepared, and I was involved in preparing that. I don't even remember if I was the original writer or a commenter on it. I honestly don't remember how the actual development process worked, and I'd have to look at a specific argument that was made in it to say whether I agreed with every single thing they said. 01:01 01:01 01:01 01:01 01:01 01:01 01:01

Q. Okay. 01:01

A. I don't recall what the specifics of that document were. 01:01 01:01

Q. Understood. And my question was 01:01

really testing your recollection.

Do you recall today any instance in which you disagreed with something they said or argued or presented to the government?

Do you recall any such instance?

MS. KRIEG: Object to the form.

A. I don't recall this. I'm not going to -- if I'm not recalling it, I'm not going to say that there was not an instance, but I don't recall, like, a specific disagreement that we had about it.

Q. Okay.

(Exhibit No. 1018 was marked for identification.)

BY MR. QURESHI:

Q. Mr. Grant, I'm going to hand you a document that's marked Exhibit 1018. Please take some time to review it. Mr. Grant, please take as much time as you need to flip through it. I'm going to focus on the cover email in the document that is entitled "AHIP Issue Paper."

A. Right. That's what I'm looking at right now is the issue paper.

MS. KRIEG: Are there Bates numbers

to go with this? 01:05

MR. QURESHI: No. It was not a 01:05

document that was produced. 01:05

MS. KRIEG: Okay. 01:05

BY MR. QURESHI: 01:05

Q. Mr. Grant, I think the document you 01:06

are looking at is actually not the issue paper. 01:06

You're welcome to continue reviewing it, but I 01:06

think the issue paper has a formal cover page 01:06

that says "AHIP Issue Paper." 01:06

A. Oh. This says "Issues for 01:06

Discussion." I'm sorry. 01:06

Q. The formal title is "AHIP Issue 01:06

Paper." 01:06

A. I'm sorry. 01:06

Q. Please look at whatever you'd like to 01:06

look at. My questions are going to be on the 01:06

cover email and then actually page 1 of the 01:06

issue paper. 01:06

A. So you're sticking with the first 01:07

page right now? 01:07

Q. Yes, sir. 01:07

A. Okay. 01:07

Q. Sir, do you recall reviewing the 01:08

portion of Exhibit 1018 that is entitled "AHIP 01:08

Issue Paper Risk Adjustment Data Validation: Policy and Payment Implications," January 4, 2010? 01:08

A. Yes. 01:08

Q. Did you draft it? 01:08

A. As I said before, I honestly don't remember if I drafted this or just reviewed it and contributed to it. 01:08

Q. And was your review and any contributions in connection with your engagement by AHIP to assist with RADV issues? 01:08

A. It was exclusively part of that contract. That was kind of the nature of the contract was to work with them in the development of these papers. 01:08

Q. Okay. And who other than yourself played a role in contributing and drafting the white -- the issue paper? 01:08

MS. KRIEG: Object to the form. 01:09

A. I would -- you know, I was looking at the names here. It's going to go back to there was a whole work group and I do not remember everybody that contributed to the issue paper. 01:09

Q. Was the issue paper presented to CMS? 01:09

A. That is my understanding. 01:09

Q. And how did you come about that understanding?

A. Through the participation in the work group. They would discuss that they were going to go meet with CMS. I was not invited to attend the CMS meeting.

Q. And what was the purpose of the issue paper?

What was the work group trying to accomplish?

MS. KRIEG: Objection to form.

A. They wanted to see the risk adjustment data validation methodology altered.

Q. Why?

MS. KRIEG: Object to the form.

A. They were concerned about the impact of extrapolating RADV sample findings to the entire plan population and adjusting payments.

Q. What was the concern?

MS. KRIEG: Object to the form.

A. There were multiple concerns raised in the issue paper and in the discussions we had. One was around advance notice of the intent to do this, so they were questioning whether or not CMS had the authority to, after

having announced the payment methodology for the year, come out with an adjustment to that payment methodology after plan bids had been submitted in response to the original payment notice for that year. 01:10 01:10 01:11 01:11 01:11

Q. What else? 01:11

A. That's the first issue that is number 2 within the paper. And then the first issue was the lack of knowledge of error rate within fee for service that went into the data that were used to calibrate the risk adjustment model. 01:11 01:11 01:11 01:11 01:11 01:11 01:11

Q. And when you say issue 1, is that the one on page 1 of the issue paper -- 01:11 01:11

A. Yes. 01:11

Q. -- as part of Exhibit 1018? 01:11

A. Yeah. 01:12

MS. KRIEG: Object to form. 01:12

Q. Sir, I'm going to read that title. It states: "Payment accuracy and coding accuracy/medical record documentation completeness are not synonymous." Did I read that correctly? 01:12 01:12 01:12 01:12 01:12 01:12

A. You did. 01:12

Q. What do you understand that to mean? 01:12

MS. KRIEG: Object to form. 01:12

A. What it means is -- I mean, I think it gets to why -- I can tell you why the statement is there. Is that helpful? 01:12

Q. I think it will be helpful, but I first want to understand in your words what you understand it to mean. 01:12

MS. KRIEG: Object to form. 01:12

A. I think without the background it's hard to just like -- it's saying these two things are not equivalent, but I think that's based on understanding why that statement is being made. 01:12

Q. Okay. Please. 01:13

A. So CMS is using -- CMS is using, as a proxy for determining payment accuracy, they are reviewing medical records to see if an individual is said to have a diagnosis code that that diagnosis code is documented in the medical record because we're paying on the basis of diagnosis codes at that point in time. 01:13

And then using that through an extrapolation basically to adjust payments on a broad scale suggests that finding the lack of a diagnosis code in a medical record properly 01:13

documented suggests that the entire payment to an organization is inaccurate. And this is saying that is not a true statement, that you can't on the basis of, like, medical record documentation establish whether or not the overall payment to an organization was accurate. 01:13 01:13 01:13 01:13 01:13 01:13 01:14

Q. If you go down further on page 1, the first sentence of the last paragraph states in part: "Under the new CMS approach, the relationship between coding error and payment error is more complex than a simple attribution of every medical record documentation discrepancy to a level of payment error." 01:14 01:14 01:14 01:14 01:14 01:14 01:14

A. Where are you at? I'm sorry. 01:14

Q. Page 1, last paragraph, first sentence. 01:14 01:14

A. Oh, okay. I got it, yeah. 01:14

Q. Do you see that sentence? 01:14

A. Yes. 01:14

Q. Okay. What do you understand that to mean? 01:14 01:14

MS. KRIEG: Object to form. 01:14

A. Again, it's talking about extrapolation. So it's differentiating an old 01:15 01:15

approach, the old approach being we'll review medical records. If we find an error in a specific medical record, we will determine that that code is not an appropriate code and make an appropriate adjustment. So in any case where it is a determined fact that a medical record does not support a diagnosis code, that is by definition an inappropriate code not used for payment. This is done on a sample basis, so sample could be of various sizes, but only those people within the sample are determined to have an error and payment is adjusted for everyone that has an error. 01:15

In this, the new CMS approach, that is then interpreted to be representative of the entire population and that multiple individuals, those sampled and those not sampled, having a level of payment error and then saying this is the overall payment error to an entire organization based on the findings within the sample. 01:15 01:16

Q. Sir, if you would assume for a moment that there is no extrapolation; instead, there's a systematic audit of every single person and code, would there still exist an 01:16

issue with respect to payment accuracy and coding accuracy? 01:16

MS. KRIEG: Object to form. 01:16

A. I think it's a hypothetical because CMS would never do that, so -- 01:16

Q. I understand it's a hypothetical. 01:16

A. So that's not the issue we were raising. 01:16

Q. Okay. But I'm asking you to assume that there is no extrapolation, no sampling. With me so far? 01:16

A. Yes. 01:16

Q. Okay. Under those circumstances, if there is a systematic audit of every single member and deletion of unsupported codes, is there comparability between the Medicare Advantage data and fee-for-service data? 01:16

MR. HASEGAWA: Object to form. 01:17

MS. KRIEG: Object to form. 01:17

A. There definitely could be. I mean, it depends on a lot of factors, but arguably -- but again, it's a hypothetical. CMS does not conduct an audit of that nature. It's super expensive. 01:17

(Discussion held off the record.) 01:18

BY MR. QURESHI: 01:18

Q. Mr. Grant, the issue that you were highlighting in your -- in the presentation that you sent to Mr. Hutchinson in May of 2009, it was a hypothetical situation you were presenting? 01:19

MS. KRIEG: Object to form. 01:19

A. It is absolutely a hypothetical situation I'm presenting. 01:19

Q. And you were presenting it to illustrate a certain principle, I believe you testified to. 01:19

MS. KRIEG: Object to form. 01:19

A. It illustrates a principle on certain assumptions and so it's, like, hypothetical data and a set of assumptions saying if it works this way, this is what happens. 01:19

Q. Okay. And the last part of your answer, "this is what happens," what happens? 01:19

MS. KRIEG: Object to form. 01:19

A. If -- so I will be very clear. If there is a pattern where it is -- where fee for service has errors only one direction and that is overreporting of diagnosis codes and the preponderance is error is in that way, that 01:20

there should be an underprediction of the costs associated with people with the diagnosis codes that are overreported.

Q. That issue that you just highlighted, sir, that doesn't depend on whether CMS extrapolates or whether it audits every single chart. The problem is the same in either case; correct?

MS. KRIEG: Object to form.

A. That would be true if the assumption were also true. So there's a built-in assumption that is an unproven assumption in the presentation that is assuming a pattern of overcoding, which is unknown due to the lack of a fee-for-service study. And if you look at what is recommended here, it is a fee-for-service study so that you know. Lacking knowledge, it's impossible to say whether this assumption is true or not.

Q. And to your knowledge, has such a study occurred?

MS. KRIEG: Object to form.

A. To my knowledge, no. Again, I haven't worked on Medicare Advantage risk adjustment since 2010 and not within CMS since

2005 -- 2000 -- early 2006. 01:21

Q. The last sentence on page 1 of the AHIP issue paper that's part of Exhibit 1018, would you please read that to yourself. 01:21 01:22 01:22

A. Yeah. 01:22

Q. Okay. Do you agree with that statement? 01:22 01:22

MS. KRIEG: Object to form. 01:22

A. Yes, I agree with the principle of that statement. 01:22 01:22

Q. Sir, when you were at AHIP -- I'm sorry, when you were at Health Risk Partners, when did you cease working on the AHIP engagement? 01:22 01:22 01:22 01:23

A. As I previously said, I do not remember the start and end dates of the engagement. 01:23 01:23 01:23

Q. Do you recall when you left Health Risk Partners? 01:23 01:23

A. I do. 01:23

Q. When was that? 01:23

A. That was July of 2010. 01:23

Q. Do you have any recollection of the back-and-forth between AHIP and the government after submission of the AHIP issue paper that 01:23 01:23 01:23

we just looked at? 01:23

MS. KRIEG: Object to form. 01:23

A. I have -- I don't have recollection and I'm not sure if I was aware of all of it. I may or may not have been but I, you know, I don't recall at this point if I even knew what all of their back-and-forth was. 01:23

Q. And other than yourself, was there any other consultant that you're aware of that was working with AHIP in connection with this particular RADV engagement? 01:23

A. I don't believe there were any consultants contracted by AHIP, but there may have been health plans that contracted consultants rather than having staff work it. I would not have known the difference. 01:24

Q. Okay. Other than the members of the working group, there's no one else that comes to mind in terms of playing a consulting role similar to the one you played? 01:24

A. I honestly don't remember. They may have had consulting attorneys. I honestly don't remember. 01:24

Q. Okay. Mr. Grant, I'm going to ask you to turn back to Exhibit 1017. 01:24

A. This? 01:25
Q. Yes. 01:25
A. Okay. 01:25
Q. In particular, page 4. Might you 01:25
walk us through the three bullet points on page 01:25
4 of the presentation and explain to us what 01:25
you were describing? 01:25
MS. KRIEG: Object to form. 01:25
A. So this is basically the continuation 01:25
of example where we started with the plan, had 01:25
perfect knowledge, knew two individuals that 01:25
were coded as sick, were healthy, and did not 01:25
submit them. 01:25
So we are now saying -- we are now 01:26
positing a different world where a plan does 01:26
not know and so submits the two miscoded 01:26
individuals as they were coded and then 01:26
receives the payment. And what this says is 01:26
that in the end, then this adds up to being the 01:26
same amount that we were looking to see them 01:26
pay on the previous side where we said they got 01:26
less money. This makes up that difference by 01:26
submitting those two people the way they were 01:26
coded because they were coded the same way as 01:26
fee for service. 01:26

Q. Then after the first bullet there's a dash. Can you explain what the text after the dash means? 01:26

MS. KRIEG: Object to form. 01:26

A. So what you have for the difference between healthy people and sick people is $833 in this example. So you have two people now that are getting that additional $833, which is a total of $1,666, which is equal to the shortfall that had been identified on the previous slide. 01:26 01:27

Q. And what's meant by the second bullet point? 01:27

MS. KRIEG: Object to form. 01:27

A. So now this is hypothesizing a world in which the plan submitted these folks. And again, this is like in a very large population now so it's not 10. And this is very simplified example. So now you create a very large plan where this is happening systematically throughout a large plan where you're submitting data like fee for service, CMS comes behind, does a RADV, and maybe it's a small sample now, they find this difference, extrapolate it. That takes you back to the 01:27 01:28

payment levels that were identified on the previous slide and takes back the $1,666. 01:28

Q. So in your example, what you characterize as the shortfall would still exist? 01:28

MS. KRIEG: Object to form. 01:28

A. So the shortfall exists once again through this methodology, similar to what was identified in the first slide. 01:28

Q. Okay. And then -- 01:28

A. Slide 3, I should say. 01:28

Q. What is meant by the last bullet point? 01:28

MS. KRIEG: Object to form. 01:28

A. Well, essentially you've calibrated a model and come up with an amount. And the implicit assumption then is if you back up all the codes in the model that you -- the model is perfectly predicting costs for people with those conditions. So this is going from an assumption of if you code -- you know, this is going from an assumption if you submit claims data, you get paid right, to an assumption if you can back it up with a medical record, everything in a medical record is -- tells you 01:28 01:29 01:29 01:29 01:29 01:29 01:29 01:29 01:29 01:29

who has a condition, and $1,333 is the right amount for that condition as the model was calibrated. 01:29 01:29 01:29

Q. So Mr. Grant, under the assumptions you've made in your presentation, for the plan to be paid appropriately, it needs to submit the two miscoded persons. 01:29 01:29 01:29 01:29

MS. KRIEG: Object to form. 01:29

A. I mean, there's many different ways you can get there. That is one way you could get there. 01:29 01:29 01:30

Q. Okay. Mr. Grant, I'm interpreting your answer as being yes, but then suggesting there are alternative ways to get there. 01:30 01:30 01:30

A. Well, I would not interpret it as a yes, because I think that's the least appropriate way to get there. 01:30 01:30 01:30

Q. Okay. Can you explain what -- why you would not answer that question as yes? 01:30 01:30

A. Because it's suggesting that the right idea is to submit miscoded people. And, you know, it could lead somebody to even believe that the right idea would be to intentionally submit miscoded people, and that's not what this is meaning to say. This 01:30 01:30 01:30 01:30 01:30

is saying this is like how you get mathematically equivalent, but it's not suggesting that this is like really the right approach. And that is why we did the paper.

In my mind, always the right approach was a fee-for-service error rate. And then, if you got this perfect, you would be less than the fee-for-service error rate and then in a RADV extrapolation, you would get credit. That was always the conversations I had with CMS is you need a two-directional RADV extrapolation taking into account a fee-for-service error rate. And that is a different discussion about RADV extrapolation versus what is appropriate data to submit. And then actually people have an inducement to be RADV because if they actually have perfect data, then they would get credit compared to other people that might get hit.

Q. So in your view, is it possible to have perfect data without knowing what the fee-for-service error rate is?

MS. KRIEG: Objection, form.

A. It's always possible to have perfect data if you reviewed every medical record and

then submitted only the things that were backed up by medical records. It's possible to have perfect data. To get the alignment between perfect data is a discussion of kind of RADV extrapolation policy. 01:32

Q. And if there's differences between fee-for-service data and Medicare Advantage data that's subject to RADV audits or other activities, there is what you've characterized earlier, a misalignment? 01:32

MS. KRIEG: Object to form. 01:32

A. That is what argument we made there, yes. 01:32

Q. Okay. So in your presentation, Mr. Grant, Exhibit 1017, in your hypothetical example, for the payment amount to be appropriate, the plan has to be paid an amount that reflects the relative error of fee-for-service and Medicare Advantage data? 01:32

MS. KRIEG: Object to form. 01:33

A. I mean, yes, it's -- I'm trying to understand what you're asking. Can you phrase it again? I'm sorry. 01:33

Q. Sure. In order for a payment -- again, reference to Exhibit 1017 and your 01:33

assumptions and the hypotheticals you've built into the presentation -- 01:34

A. Right. 01:34

Q. -- to illustrate certain principles, in evaluating the appropriateness of a payment, you would have to take into account the relative errors in fee-for-service data and other data. 01:34

MS. KRIEG: Object to form. 01:34

A. In the context of a RADV, which is the only way you're able to evaluate this. So it is positing a future world in which a fee-for-service error rate is known, and then knowing a fee-for-service error rate and being able to compare a plan's error rate, you could make an appropriate adjustment to the extrapolation. Again, the entire context of the presentation is around RADV extrapolation. 01:34

Q. But the principle and the hypothetical world that you present in the series of slides at 1017, there's nothing in there about extrapolation; correct? 01:35

MS. KRIEG: Object to form. 01:35

A. On page 4, RADV extrapolation recovers $1,666. It is very specifically, and 01:35

the only reason for the presentation was RADV extrapolation. This was all around explaining underlying error rates, how they might impact payment, what implications it had for RADV extrapolation. This is only about RADV extrapolation. 01:35 01:35 01:35 01:35 01:35 01:35

Q. Yeah, I'm a little confused about terminology, sir. I understood your presentation to deal with a data set involving 22 people; correct? 01:35 01:35 01:35 01:35 01:35

A. Right. 01:35

Q. So what are you extrapolating? 01:35

MS. KRIEG: Object to form. 01:35

A. The 22 people is a simplified example -- 01:35 01:35

Q. And focusing -- 01:35

A. -- of model calibration just to show how overprediction and underprediction could work. 01:35 01:35 01:35

Q. And that's all I'm focused on is the simple model. I'm following along your presentation. 01:35 01:36 01:36

A. That is to show a principle. I don't, like, go through the math of exploding this out into millions and millions of people 01:36 01:36 01:36

and, you know, 100,000 or 500,000 or 20,000 plan members against which a 200-member RADV sample is taking place. 01:36 01:36 01:36

Q. And that's my point, sir, that the problem you're highlighting or the issue you're raising exists in a universe of 22 people even if you don't extrapolate it out to millions of people. Correct? 01:36 01:36 01:36 01:36

MS. KRIEG: Object to form. 01:36

A. No, I think that's -- yes and no, because like if it has 22 people, you'd review it all and you just get it right. You'd calibrate the model accurately. I mean, no, not at all. 01:36 01:36 01:36 01:36 01:36

It is taking 22 people just to make a simple math thing. I could have used 22 million people and done the same thing. It is strictly to -- the way calibration works is large groups of people, not 22 people. So this is not meant to have any applicability to the real world other than just to show through simple math a concept, a mathematical concept. 01:36 01:36 01:36 01:37 01:37 01:37 01:37 01:37

Q. The issue that you're highlighting, you know, for example, on page 4, you talk about the shortfall. That shortfall exists in 01:37 01:37 01:37

your example because there is misalignment between the fee-for-service data and the plan's data; correct? 01:37 01:38 01:38

MS. KRIEG: Object to form. 01:38

A. On page 4? 01:38

Q. Yes, sir. 01:38

A. No, not correct. 01:38

Q. Okay. 01:38

A. The plan's data in this example perfectly matches fee-for-service data. It has to do with RADV extrapolation. And then it's not even really -- it's like, because this isn't an extrapolation that's taking 22 people, it's like it's trying to point out using the 22 people is like why you have the shortfall and then you wouldn't even extrapolate on 22 people. So to take this too literally is missing the point of the presentation. 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38

The point is talking about extrapolation. And when we had conversations about this, everybody got that that's the point. That's why we say this here. But we are just using simple numbers. You don't really extrapolate to get $1,600 back. That would be a direct payment recovery, and that 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38 01:38

was all accepted as acceptable. It's when you have these 22 people now speaking for 500,000 people and extrapolating that over the entire population, that's where you start having a problem. That's what this is talking about.

Q. But the problem that you're illustrating in Exhibit 1017 is illustrated with 22 people, and your point about extrapolation is that you're magnifying the problem once you begin extrapolating?

MS. KRIEG: Object to form.

A. Yes, but you're also really creating the problem because you're paying for groups of people. So when risk adjustment is generally going to pay for a group of people, there are degrees of inaccuracy in it, all right?

Every plan's degree of inaccuracy in data is slightly different. Even CMS's fee-for-service data probably varies year to year how inaccurate it is to some degree unknown. But it's like large, large groups of people.

Here, we take this very small group of people, get very precise on them, and then extrapolate it out. So the problem is not

getting like if you identify a subgroup of people and say they're wrong, they're wrong. And that has little impact on a plan's payment. Where this became a problem was going from a process where you looked at very discrete people and said if they're wrong, they're wrong, we get the money back, to if they're wrong, they're wrong, we get their money back and then we're going to extrapolate that to 500,000 people in your plan and we're going to collect, you know, millions or billions of dollars back from you because we have found this now to be an endemic problem that means you were paid wrong by this. 01:40

From an individual basis, you're definably paid wrong when you find an error in a diagnosis code. But when we go from that to saying that error where we individually found your diagnosis code was not backed up by a record, and now we're going to say that just implies for everybody here we're going to take a whole bunch of money back. That was the problem we were pointing out here without knowing what the underlying error rate was and adjusting the extrapolation for that. So this 01:40

was always about extrapolation, not about 22 people.

Q. And in connection with not knowing the underlying error rate, you're referring to the underlying error rate in the fee-for-service data?

A. Correct.

Q. And do you know that today?

MS. KRIEG: Object to form.

A. I have never known that.

Q. Okay. Do you know whether that's been calculated?

MS. KRIEG: Object to form.

A. I am unaware of any calculation to date that has been done on that.

Q. So the problem that you're identifying in the presentation, what's been done to correct it?

MS. KRIEG: Object to form.

A. Again, I haven't worked on MA since 2010. I don't know what they're doing to address it --

Q. When --

A. -- if anything.

Q. When you left in 2010 were you aware

of anything that had been done to address that problem? 01:41 01:41

MS. KRIEG: Object to form. 01:41

A. So I left the agency in 2008 and I was an external observer, so even if things were being done within the agency in 2010, they would not necessarily have shared them with me. It would have been deliberative process. It would have been protected. So I don't know what they were doing. And I wasn't working on risk adjustment since early 2006. So like whatever the agency was doing, I would not have -- they wouldn't have and to share that with me -- 01:41 01:42 01:42 01:42 01:42 01:42 01:42 01:42 01:42 01:42 01:42

Q. And my -- 01:42

A. -- so the -- 01:42

Q. -- question, sir, was -- 01:42

A. -- the -- up to my time in 2006 I was unaware of it, and since then, I'm unaware of it. But, I mean, since 2010 I haven't paid any attention to Medicare Advantage adjustment. 01:42 01:42 01:42

Q. Okay. You've answered my question, which was are you aware of anything that's been done to correct this problem? And I believe your answer is no. 01:42 01:42 01:42

A. But I have no basis to be aware. It's -- I'm being very clear it is not indicative of whether anything has or has not been done because I have no basis for any awareness of that.

Q. During the time you were working on risk adjustment issues were you aware of any steps the government had taken to address the problem you raise in your presentation?

MS. KRIEG: Objection to the form. And don't disclose anything that's deliberative.

THE WITNESS: Okay, so --

Q. I just need a yes or no, sir.

THE WITNESS: Is that deliberative or not?

MS. KREISEL: I think that you can to the extent that they have been made public, you know, but to the extent that --

THE WITNESS: So nothing that has been made public.

MS. KREISEL: Okay.

BY MR. QURESHI:

Q. Sir, if you could please turn to

Exhibit 1016, this is the email that you sent to Mr. Hutchinson in May of 2009. When you tell Mr. Hutchinson that the principles that you illustrate in your presentation apply to more complex models, what are you attempting to inform him of? 01:44 01:44 01:44 01:44 01:44 01:45

MS. KRIEG: Object to the form. 01:45

A. Can you rephrase that? I'm not clear what you're asking. 01:45 01:45

Q. Sure. Why did you feel it necessary to tell him that the principles illustrated in your presentation apply to more complex models? 01:45 01:45 01:45

A. Okay. 01:45

MS. KRIEG: Objection, form. 01:45

A. It kind of goes back to the discussion we just had about being super simple in a thing where you have 22 people and you know all these things and they're either sick or healthy. 01:45 01:45 01:45 01:45 01:45

First of all, you know, you have way more people in this. You do not have unitary costs. You have multiple age groups. You have -- so we have just said you're either healthy or you're sick and we have put you into one of two categories so it's a totally binary 01:45 01:45 01:45 01:45 01:45 01:45 01:45

model. You're a 1 or a 0, and that's it. 01:45

Here, what we have when we do risk 01:45

adjustment is a multivariant binary model with, 01:45

you know, over 100 variables in a model so 01:46

you're running all those through. So, you 01:46

know, the first question somebody might ask is 01:46

like, well, you know, that's really nice that 01:46

you divide the world into healthy and sick but, 01:46

you know, we have diabetics and CHF and kidney 01:46

failure and all these different things. Does 01:46

this still apply? 01:46

So I am arguing that when you run it 01:46

through -- when you take these principles and 01:46

apply them on a larger scale to a larger model, 01:46

the same principles apply. 01:46

Q. You also refer to flaws in the 01:46

calibration. Is this a reference to the 01:46

misalignment between fee-for-service data and 01:46

plan data? 01:46

MS. KRIEG: Object to the form. 01:46

A. No. I mean, it's irrespective of 01:46

plan data. It's more saying that the 01:46

calibration does not perfectly predict the cost 01:47

of a diabetic or somebody with CHF or somebody 01:47

with cancer, that there are imperfections due 01:47

to imperfections in the data, and that will cause some form of error in the prediction so that then when you're looking at all the relatives, which is what the model ultimately comes down to you, have a relative cost prediction error that does not truly reflect it if you knew every diabetic, every person with cancer, every person with CHF. 01:47

Q. And in your response, you used the word "prediction," and I believe earlier you explained that when you say -- when you wrote in your email that it pays wrong, you actually meant to say that it predicts incorrectly. 01:47

MS. KRIEG: Object to form. 01:47

A. Yes. 01:47

Q. In Roman II in your email, sticking with Exhibit 116 -- 01:48

A. Arabic numeral 2? 01:48

Q. Yeah. So you refer to perfect payment and then explain that that means replication of model calibration. So again, you're referring to the perfection of a payment with reference to model calibration; is that correct? 01:49

A. Correct. 01:49

Q. And does the issue that you're discussing in 2 have anything to do with extrapolation? 01:49

A. The entire underlying point of the entire discussion's extrapolation. 01:49

Q. And in the paragraph numbered 2, what is the connection with extrapolation? 01:49

A. It is again creating a hypothetical world, so hypothetical world in which a plan could perfectly submit like fee-for-service. And again, in the assumptions that I operate under in the presentation, that overreporting is worse than underreporting. So if you assume overreporting is greater than underreporting and a plan were to submit precisely like fee-for-service then got extrapolated against, they would be paid differently than the model calibration. It does not result in the payment accuracy that they are looking to obtain through a risk adjustment data validation with extrapolation. 01:49 01:50 01:50 01:50 01:50 01:50 01:50 01:50 01:50 01:50

Q. Just using that very same example of overreporting, and a plan submits precisely like fee-for-service, wouldn't they be paid differently than model calibration? 01:50 01:50 01:50

MS. KRIEG: Object to the form. 01:51

A. Under what circumstance? They submit it exactly like fee for service and what? 01:51

Q. If they submit exactly like fee for service and then delete unsupported codes, they would be paid differently than the model calibration even without extrapolation. 01:51

MS. KRIEG: Object to the form. 01:51

A. It would have to be on an exceptionally large scale. And in theory, yes. But that's if they -- everything they did, they did no medical record reviews to gain diagnoses, they did no home visits, they did no provider education about submitting, they did nothing to alter the -- to increase the level of diagnoses, so this is a hypothetical plan, the existence of which I am totally unaware, but in some hypothetical plan that absolutely this was -- could get perfect, pristine fee-for-service data, this could theoretically be a problem, yes. 01:51 01:52

Q. Well, I want you now to assume, sir, in this hypothetical world that the coding intensity adjuster that we talked about earlier, I want you to assume that it fully 01:52

offsets any activities that the plan undertakes to code more completely, chart reviews, home visits, whatever, but they're completely offset by the coding intensity adjuster. If the plan were to submit only the codes of people who are truly sick, to use your presentation example, then that plan would be underpaid. 01:52

MR. HASEGAWA: Object to form. 01:52

MS. KRIEG: Object to form. 01:52

A. In a hypothetical world that you are creating that does not exist because, as discussed previously, at least the initial implementation of the coding intensity adjuster was in no way going to get you there, in that world, in theory, yes. But that's hypothetical again. 01:52 01:53

Q. Are you aware of any study in which CMS has evaluated whether the coding intensity adjuster fully offsets the plan activities that are done to code more fully? 01:53

MS. KRIEG: Object to form. 01:53

A. And again, it's the same answer for anything on Medicare Advantage. I really would have no basis to know that. 01:53

MR. QURESHI: May we take a break? 01:54

THE VIDEOGRAPHER: Going off the record. The time is 13:54. 01:54

(Recess taken.) 01:54

THE VIDEOGRAPHER: Going back on the record. The time is 14:50. 02:15

BY MR. QURESHI: 02:15

Q. Mr. Grant, I want you to again assume that the coding intensity adjuster fully offsets all the activities that a plan might undertake to code more fully. I also want you to assume that a plan audits every one of its charts and deletes every unsupported code. The problem that you highlight in your slide presentation, Exhibit 1017, would still exist in that scenario? 02:15 02:16 02:16

MS. KRIEG: Object to form. 02:16

A. In my opinion, if you could have that scenario, yes. 02:16

Q. The problem would still exist? 02:16

A. The problem would still exist if you have that scenario. 02:16

Q. Okay. Now I'd like to change the assumption slightly. Once again, the coding intensity adjuster fully offsets all activities that the plan undertakes that code more fully, 02:16

but now the plan audits 50 percent of a chart, of its charts, and deletes the unsupported codes in that set. Would the problem still exist? 02:16 02:16 02:16 02:16

MS. KRIEG: Object to form. 02:16

A. Okay, we have multiple assumptions right? So we have the assumption that overcoding is the bias in the data. We have the assumption of perfect adjustment for plan coding activities. To a degree, it exists. It exists to a smaller amount. 02:16 02:17 02:17 02:17 02:17

Q. Same assumption regarding the coding intensity adjuster, but now the plan is auditing 25 percent of its charts and deleting the unsupported codes. Does the problem still exist? 02:17 02:17 02:17 02:17 02:17

MS. KRIEG: Object to form. 02:17

A. Again, assumption of overcoding, endemic in fee for service, and assumption of plan -- plan coding activities being 100 percent offset in theory it exists to the degree that diagnosis codes are deleted. But at some point, that stops. It's not clear where because there's still variability in there. No plan submits exactly like fee for 02:17 02:17 02:17 02:17 02:18 02:18 02:18 02:18

service so, I mean, we are, like, creating a very artificial world, but that artificial world again doesn't exist. There is a world full of errors. Errors are not the same level of error between fee for service and any plan even if you didn't touch the data let alone after you've touched the data, and coding intensity is not unitary among all plans. 02:18

Q. So Mr. Grant, are you suggesting that, putting aside our assumptions, that there are a lot of variables that would impact any evaluation of the magnitude of the problem you're highlighting in Exhibit 1017? 02:18 02:19

MS. KRIEG: Object to the form. 02:19

A. Oh, there are a large number of variables. That is very simplified example with a lot of assumptions baked into it and a very simplified risk adjustment model. 02:19

Q. Are you able to itemize the various real-world facts that you would need to know to assess the extent of the problem? 02:19

MS. KRIEG: Object to the form. 02:19

A. On the fly, I would hesitate to brainstorm every fact you would need to know. 02:19

Q. And I -- 02:20

A. You would have to do a lot of thinking and lay it all out and probably peer review it before you would be -- I mean, I don't trust myself on anything in risk adjustment without checking with like five other people on it because it's complicated and there's a lot of factors that go into it.

Q. Okay. And I certainly don't expect you to provide a comprehensive listing of all real-world facts, but if you might highlight some that are on your mind that would impact the extent and existence of the problem in Exhibit 1017.

MS. KRIEG: Object to the form.

A. So I think -- so there's, first of all, just the real-world -- not knowing the real-world fee-for-service coding issue that is outlined here, so this is based on an assumption of what that issue is. That is an unproven assumption. So it is a perception, but it may or may not be, if you were to study it, borne out by reality.

Within any plan from year to year, when you conduct repeated RADVs you see highly variable results just within a plan. You have

sample variants in RADVs. You have all sorts of things that go on. So it's really hard to put your finger on like this is this plan's coding propensity, this is that plan's coding propensity, whether it's actual changes the plans undertake.

And then plans through time are changing. They code differently. They engage their doctors differently. They have, you know, the degree to which any plan depends upon its own data for risk adjustment versus people from other plans, people from fee for service. There are all kinds of things that we talked about in our discussions of this that created numerous differences between plans.

So there isn't kind of like this is how plans are, this is how fee for service is. Fee for service is constantly change and plan data is probably even more highly variable between plans and even plans year to year depending on the characteristics of their population.

You also have health risk differences. So health risk mix is not the same in plans as in fee for service necessarily

and between plans there's still a significant amount of variance if you look at the average risk scores, and that is going to change how accurate coding is. So that may be reflective of different levels of accuracy of coding, different levels of amount of coding, and some may reflect underlying risk differences. But even with underlying risk differences, then you get coding differences. You have regional variation in coding accuracy. So all kinds of things could factor into this. 02:22

Q. I take it from your answer that, among other things, it needs to be a very highly individualized analysis. 02:22 02:23 02:23

MS. KRIEG: Object to the form. 02:23

A. Well, and I think -- well, it's more complicated than that. I think an analysis is very hard to do if you are talking about MA data. Fee-for-service data at least has kind of a common way of coming in and operates under common sets of assumptions. 02:23 02:23 02:23 02:23 02:23

As soon as you start paying for something and then plans are submitting based on the fact you pay for it and plans engage in individual development activities for diagnosis 02:23 02:23 02:23

development, so some go and do home visits, others do not, you're going to get differences right there just by what development activities, how much influence they have over their provider network. And being able to like study a plan and understand what a plan's coding intensity would be very difficult to do to attribute diagnosis coding differences specifically at a plan level to coding intensity. 02:23

Q. Sir, you've talked a couple of times today about the error rate in fee-for-service data and your unawareness of a error rate ever being calculated. Is that accurate? 02:24

A. Correct for diagnosis codes, similar to risk adjustment. 02:24

Q. Okay. 02:24

A. Yes. 02:24

Q. Now, did CMS ever talk about doing it? 02:24

MS. KRIEG: Object to the form. And to the extent you're, you know, asking for deliberative process, you can't reveal that. 02:24

A. Yeah. So, I mean, I talked with CMS 02:24

when I was outside of CMS about doing that. So we definitely engaged in discussions when I was outside of CMS. And, you know, during that time, I got significant pushback of like the challenges with doing it, how to construct a RADV-like study when you don't have a health plan, for instance.

Q. This is during the 2008-to-2010 --

A. Correct.

Q. -- period when you were with Health Risk Partners?

A. Yeah.

Q. While you're with the government, either prior to joining Health Risk Partners or after, did you participate in any discussions regarding the calculation of an error rate for fee-for-service data?

MS. KRIEG: I'm going to instruct you not to answer to the extent that it reveals deliberative process.

MR. QURESHI: I just want to know if he was in those discussions.

Q. Did you participate in any discussions on that topic? Yes or no.

MS. KREISEL: I don't think CMS has

said anything publicly on this topic, so -- 02:25

MS. KRIEG: We might be able to handle this pretty quickly. Why don't we take a break and step out? 02:25

MR. QURESHI: Okay. 02:26

THE VIDEOGRAPHER: Going off the record. The time is 14:25. 02:26

(Recess taken.) 02:26

THE VIDEOGRAPHER: We are going back on the record. The time is 14:32. 02:32

BY MR. QURESHI: 02:32

Q. Before we took the break, Mr. Grant, I believe I'd asked a question about whether you had participated in any discussions on the calculation of a fee-for-service error rate while you were with the government. 02:32

A. Yes. 02:32

Q. With whom? 02:32

THE WITNESS: I can say that too, right? 02:32

MS. KRIEG: You can say who. 02:32

A. With my staff when I ran the risk adjustment division, and with Tom Hutchinson, who I worked for. 02:32

Q. Anyone else? 02:32
A. Yeah, I have -- that's who I recall. 02:32
I'm not going to say it was not with anybody 02:32
else. I'm not sure. 02:32
Q. And was this one meeting or several 02:32
meetings? 02:32
A. With Tom on one occasion. I don't 02:33
know how many times with staff. 02:33
Q. In either your meetings with 02:33
Mr. Hutchinson or with your staff were there 02:33
written materials distributed? 02:33
A. No. 02:33
Q. Do you recall the substance of those 02:33
discussions? 02:33
A. The general substance, yes. 02:33
Q. Okay. What do you recall about those 02:33
discussions? 02:33
MS. KRIEG: I object and instruct 02:33
him not to answer to the extent that it 02:33
would reveal deliberative process. 02:33
MR. QURESHI: Is he able to tell me 02:33
anything about those discussions? 02:33
Because your objection is qualified 02:33
because it's only to the extent that it 02:33
would reveal the deliberative process. 02:33

Q. What can you tell me that doesn't reveal deliberative process?

MS. KRIEG: Well, he has the recollection of the meetings. I believe that they are protected by the deliberative process from my understanding of speaking with Mr. Grant.

MR. QURESHI: Okay. So is he going to answer or not?

MS. KRIEG: I'm instructing him not to answer on my understanding that the meetings are all protected by the deliberative process.

Q. When did the meetings occur? I just need an approximate time frame.

A. With Tom Hutchinson, it would have been in 2008 just before I left. And with my staff, when I ran the risk adjustment division. I'm not sure when.

Q. Did you ever ask -- did you ever speak with Mr. Hutchinson about that topic after you left the government?

A. Frequently.

Q. And what do you recall about those

discussions?

A. That's kind of the nature of the things we have been previously discussing, that I was objecting to the RADV extrapolation being applied without knowledge of what the underlying error in the fee-for-service data was.

Q. While you were with the government and having these conversations with your staff and Mr. Hutchinson, did the government commence calculating a fee-for-service error rate?

MS. KRIEG: Object and instruct the witness not to answer on the basis of deliberative process privilege.

Q. In connection with these discussions with Mr. Hutchinson and your staff, did the government ever do a RADV-like audit of medical records in a fee-for-service population?

MS. KRIEG: Object and instruct the witness not to answer on the basis of deliberative process privilege.

BY MR. QURESHI:

Q. Mr. Grant, I'm going to hand you a document that's been marked --

MS. KRIEG: Can we go off the

record for one minute? 02:36

MR. QURESHI: Sure. 02:36

THE VIDEOGRAPHER: Going off the 02:36
record. The time is 14:36. 02:36

(Recess taken.) 02:54

THE VIDEOGRAPHER: Going back on 02:54
the record. The time is 14:54. 02:54

MS. KRIEG: I think we may have 02:54
obviated the need to assert privilege on 02:54
some of the prior questions that you 02:54
asked. My understanding of the 02:54
questions that you wanted to ask 02:54
Mr. Grant are whether he's aware from 02:54
when he was in government of whether 02:54
there were discussions of the need for a 02:54
fee-for-service error rate, what that 02:54
error rate should be, and whether there 02:54
was ever a RADV-like review of 02:54
fee-for-service data. Is that correct? 02:54

MR. QURESHI: I believe those are 02:54
the questions I've asked thus far, yes. 02:54

MS. KRIEG: Okay. So we don't 02:54
think we need to assert privilege over 02:55
those questions if you want to go ahead 02:55
and ask him. 02:55

MR. QURESHI: Okay. 02:55

BY MR. QURESHI: 02:55

Q. Mr. Grant, during the period of time you were at the government, prior to leaving to go to HRP, did you learn of a fee-for-service error rate? 02:55

A. No. 02:55

Q. Okay. Were there discussions about calculating such an error rate? 02:55

A. Not to my knowledge. 02:55

Q. Your meetings with Mr. Hutchinson and your staff involving the fee-for-service error rate, did they include coming up with a methodology to calculate that error rate? 02:55

MS. KRIEG: I think that is beyond the scope of what we intended him to testify on. 02:56

MR. QURESHI: So you're going to assert privilege about it? 02:56

MS. KRIEG: Yes. 02:56

MR. QURESHI: Okay. Is there anything about your meeting with Mr. Hutchinson and your meetings with staff about the fee-for-service error rate that you will allow him to testify 02:56

about? 02:56

MS. KRIEG: Yeah, I think if you ask specific questions we can go from there rather than having him give a narrative. 02:56

BY MR. QURESHI: 02:56

Q. What were those meetings about, Mr. Grant? 02:56

A. They were about how we would conduct RADV. 02:56

Q. And during discussions about how to conduct RADV, the topic of fee-for-service error rate came up? 02:56

A. It did. 02:56

Q. Who introduced it? 02:56

A. I did. 02:56

Q. And what was your position? 02:56

MS. KRIEG: And that's -- at that point, we instruct him not to answer. 02:56

Q. Did others weigh in on that topic? 02:57

A. They did. 02:57

Q. Including Mr. Hutchinson? 02:57

A. I'm not sure that he did. 02:57

Q. All right. Now let's focus on the period of time that you came back to the 02:57

government in 2010, July, after working for Health Risk Partners. Were you aware of any discussions involving a fee-for-service error rate calculation by the government? 02:57

A. Only to the extent that, like, the industry had raised the issue and I knew it was a subject of discussion. 02:57

Q. Did anyone with the government talk to you about what was being done with respect to that issue? 02:57

A. No. 02:57

Q. In your presentation, Exhibit 1017 and the accompanying email 1016, you express a certain position regarding the fee-for-service error rate; is that correct? 02:58

A. That is correct. 02:58

Q. And that position includes the need for such an error rate to be calculated. 02:58

A. That was my position, yes. 02:58

Q. Okay. Did your position change over time? 02:58

MS. KRIEG: Object to form. 02:58

A. Again, I think that depends on what time we're talking about whether this can -- is subject for the -- 02:58

MS. KRIEG: Are you asking him his personal opinion as he sits here today or for discussions he had while he was at CMS? 02:58 02:58 02:59 02:59

MR. QURESHI: I didn't ask about discussions. I want to know if his position on the need to calculate the fee-for-service error rate changed over time. 02:59 02:59 02:59 02:59 02:59

MS. KRIEG: Object to form. 02:59

A. Yeah, I don't know when I first thought about it this but from the time I thought about it, I think the general opinion has not changed. I'm sure, like, precisely what I think about it has obviously grown through time, and understanding changes through time. 02:59 02:59 02:59 02:59 02:59 02:59

Q. And when you were with the government and had not yet left to join Health Risk Partners, you had thought about it? 02:59 02:59 02:59

A. Yes. 02:59

Q. So when you were with the government before joining Health Risk Partners, you had the same opinion regarding a fee-for-service adjuster rate or a fee-for-service error rate 02:59 02:59 02:59

that you then put in your email at 1016; correct? 02:59 03:00

MS. KRIEG: Object to form. 03:00

A. In the context of extrapolated RADV, yes. 03:00

Q. Okay. 03:00

A. So that was -- that was how -- that's the context, yes. 03:00

(Exhibit No. 1019 was marked for identification.) 03:00

BY MR. QURESHI: 03:00

Q. Mr. Grant, I'm going to hand you a document that's been marked 1019. You're welcome to flip through as much of it as you like before I focus on a specific page, and that's the page Bates numbered 201 in the lower right-hand corner. And the Bates number for the page that I'm most interested in is CMS0006201. 03:00 03:00 03:00 03:00 03:01 03:01

MS. KRIEG: We object, for the record, to the use of this. We can't stop you, but we have made clear that this is a deliberative document. 03:02 03:02 03:02 03:02

MR. QURESHI: Right. And I think we've made our position clear that these 03:02 03:02

documents were released by the government under FOIA and produced with redactions, indicating that the government had undertaken some analysis of it before releasing it. And I think when you asked for these documents to be returned, we asked you to point to any authority that allowed documents released pursuant to FOIA to be returned, and I don't know you've ever provided any such authority. Is that consistent with your recollection? 03:02

MS. KRIEG: That's consistent with our recollection. 03:02

THE WITNESS: Okay. 03:05

BY MR. QURESHI: 03:05

Q. Have you had a chance to review Exhibit 1019, sir? 03:05

A. I have. 03:05

Q. Have you ever seen it before? 03:05

A. I have not. 03:05

Q. Do you know who prepared it? 03:05

A. I have no idea. 03:05

Q. If you turn to the page that I mentioned earlier, it ends in 201. 03:05

A. I'm there.
Q. There's a reference in the sixth bullet point regarding an estimation of a fee-for-service adjuster to be 8.1 percent.
Do you see that?
A. I do.
Q. Had you ever heard that before?
A. I have not.
Q. Do you understand what a fee-for-service adjuster is?
MS. KRIEG: Object to the form.
A. I have my understanding of what it is.
Q. What is your understanding?
MS. KRIEG: Object to the form.
A. That you make some form of adjustment to RADV extrapolation results based on underlying error rates in fee for service.
Q. Mr. Grant, if you look at the bullet point sort of in the middle of the page that begins "Risk adjustment." See that?
A. Oh, yes.
Q. I'll read that and then ask you some questions about it. It says: "In risk adjustment, we are estimating the average cost

of any given condition given the people who are reported to have it." Did I read that correctly? 03:06

A. You did. 03:06

Q. Do you agree with that statement? 03:06

MS. KRIEG: Object to the form. 03:06

A. In the context of average cost within fee for service, yes. 03:06

Q. Okay. At any point in time did anyone with the government consult with you regarding the fee-for-service error rate or the fee-for-service adjuster rate calculation? 03:06

A. With respect to this that was done here? 03:07

Q. Yes, sir. 03:07

A. No. 03:07

Q. Putting aside 1019, Exhibit 1019, did anyone in the government ever consult with you about a methodology for calculating the fee-for-service error rate? 03:07

A. Certainly, I discussed it with them when I was outside. I suggested many different ways it could be done. 03:07

Q. What about when you were with the government? 03:07

A. Well, I came back in 2010. I haven't really been working on MA. 03:07 03:08

Q. So the answer to my question is no? 03:08

A. So I don't recall. I mean, I might have had an informal discussion with someone, but I don't recall -- there was no formal consultation where I sat down and said this is what I would do and help them to structure it, if that's what you mean. 03:08 03:08 03:08 03:08 03:08

Q. I mean both formal and informal sir. 03:08

A. I couldn't tell you on informal. Formally, no. 03:08 03:08

Q. And informally, you don't remember the names or times or anything like that? 03:08 03:08

A. I'm not even sure if we did. That's what I'm saying. I know I had many informal discussions outside. I'm not sure if any of those continued informally when I was back. 03:08 03:08 03:08 03:08

Q. And who are the people with whom you had those discussions while you were with HRP? 03:08 03:08

A. Tom Hutchinson, Jennifer Harlow, probably Sean, Rebecca Paul, Sean Creighton. 03:08 03:08

Q. Do you recall anything about those discussions with any of the individuals you mentioned? 03:09 03:09 03:09

MS. KRIEG: Object to form. 03:09

A. Yes. 03:09

Q. What do you recall? 03:09

MS. KRIEG: Object to form. 03:09

A. As kind of all of the other exhibits show, I was advocating the right way to do extrapolation in RADV would be to start with underlying errors that exist regardless in all fee-for-service data. And that is kind of baked into an actuarial model as an underlying assumption that's not openly acknowledged and you have to go from an underlying assumption that there may be some error rate to knowing what that error rate is. 03:09

And then we talked about the challenges of doing it. They would protest that it -- you know, we run RADV, we run it a very specific way. They would tell me they go to a health plan, they have the health plan get the records, then the health plan picks the one best medical record, etc., etc. And here we have fee-for-service, we have no health plan, just really -- I mean, the early objections was you can't do something that is RADV-like because it's a different world. It's 03:09 03:10 03:10 03:10 03:10

fee-for-service; it's not Medicare Advantage. The same dynamics don't apply.

And I would suggest you could still as a government go to people that you have paid claims to and request medical records similar to plans, and that was kind of the nature of the give-and-take on that.

Q. Were these oral conversations or written or both?

A. There were certainly obviously written things I submitted. I don't know how many different emails they may have received from me versus oral conversations, but clearly I submitted an email to them, at least one. There were written documents that I was part of producing that were also given to them, some, at least. I don't know which all made it into their hands. And then there were certainly a number of verbal discussions with them.

Q. And when did those discussions cease?

MS. KRIEG: Object to form.

A. They ceased when I came back to government, at least. It may have stopped before that, but certainly when I came back to work on the Affordable Care Act.

Q. So none of the people that you've mentioned, Mr. Hutchinson, Ms. Harlow, Sean Creighton, Rebecca Paul, ever reconnected with you when you came back to talk about this topic? 03:11

MS. KRIEG: Object to form. 03:11

A. This is what I kind of already said. I don't know if they might have, you know, asked me a follow-up question informally. They're still acquaintances of mine so they may have asked me informal follow-up questions. We didn't have like a sit-down formal meeting to go through this nor did we have -- like, I was busy on the Affordable Care Act implementation. That was basically a full-time-plus job. 03:11

Q. Do you recall exchanging emails with them on this topic after you came back? 03:12

A. I do not. 03:12

Q. Mr. Grant, when we adjourned your deposition on March 20 and then reconvened today did you do anything in that interim time period to prepare for the deposition? 03:12

MS. KRIEG: Object to form. 03:12

A. I met with the attorneys yesterday. 03:12

Q. Okay. Other than meeting with the 03:12

attorneys for the government yesterday, did you do anything else? 03:12

A. No. 03:12

Q. Did you review any documents? 03:12

A. Oh, I -- well, I reviewed the transcript of the original deposition. 03:12

Q. When did you do that? 03:13

A. Over this past weekend. 03:13

Q. Okay. And the original deposition, you mean the portion of the transcript from March 20? 03:13

A. Correct. 03:13

Q. Did you look at any of the exhibits? 03:13

A. I'm not -- 03:13

Q. During the March 20 deposition I showed you a series of exhibits. 03:13

Do you remember that? 03:13

A. Right. I don't think I was given any exhibits to take with me, I don't think. All I got was a deposition in the -- 03:13

Q. And so you reviewed the transcript over the weekend. Did you discuss the transcript with your lawyers? 03:13

A. I did. 03:13

Q. And when did that discussion take 03:13

place? 03:13
A. Yesterday. 03:13
Q. Other than the activities you've mentioned, did you do anything else to prepare for today's deposition? 03:13
A. No. 03:13
Q. Okay. Did you talk to anyone at CMS other than the attorneys? 03:13
Did you talk to anyone in the government other than the people who are here about your deposition? 03:14
A. No, I mean, other than the fact that I had one, but not the contents. 03:14
Q. Mr. Grant, is Health Risk Partners, is it still in existence? 03:15
A. No. 03:15
Q. Was it acquired by another entity? 03:15
A. Yes. 03:15
Q. Okay. What was that entity that acquired it? 03:15
A. Verisk. 03:15
Q. Are you still in contact with any of your colleagues who formerly worked at Health Risk Partners? 03:15
A. I have infrequent contacts with some 03:15

of my former colleagues.

Q. Sir, while you were at Health Risk Partners, 2008 through I think July 2010, did that entity engage in chart review on behalf of plans?

MS. KRIEG: Object to form.

A. Yes.

Q. And were you involved in that activity?

MS. KRIEG: Object to form.

A. To the extent that it was again something that we provided for clients. I don't review charts, to be clear. I'm not a clinical coder. But, you know, it was one of the many services that we offered our clients. It was an important part of our business, so to the extent that there were kind of overriding client issues around it.

Q. And can you describe for us during this time period when you had some involvement with chart review activities at Health Risk Partners how chart review worked?

MS. KRIEG: Object to form.

A. Could you be more specific?

Q. I would like to understand the

process of how Health Risk Partners conducted chart review during this time. 03:16

MS. KRIEG: Object to form. 03:16

A. Again, that's really super general. I mean, I have not clear -- you know, with regard to what we -- I mean, the basic process of a chart review is you have a set of charts you're looking for, depending on what the purpose of the chart review is, or maybe you already have the chart so you might be doing a re-review of charts. There are many different chart review projects. So you review a chart, medical record. Well, you get the chart. You get your hands on the chart. We would put it into a Sharepoint data -- database, so it was a scanned chart, and then we had an application in which you could enter the codes found on the chart. And then kind of what happens next depends on what you're doing it for. Are you supporting a RADV? Are you doing a coding quality initiative to review somebody else's coding? I mean, there's all sorts of different ways you do chart review. 03:16 03:16 03:16 03:16 03:17 03:17 03:17 03:17 03:17 03:17 03:17 03:17 03:17 03:17 03:17 03:17 03:17 03:17

Q. And in the example that you provided, it was an additive undertaking? There would be 03:17 03:18

a review of the chart electronically to add codes? 03:18

A. I didn't say that. 03:18

MS. KRIEG: Object to form. 03:18

A. I did not say that. 03:18

Q. I'm asking. 03:18

A. You would do a review of a chart, and again, it was -- you could be doing it to a support a RADV, then you were trying to figure out -- you would code the chart, then you were trying to figure out the best medical record. This is the back in the days of you got one medical record to submit to get a RADV so you're going through as many charts as possible in a sample of 200 people trying to find the one best medical record to submit to Medicare. 03:18

In the case of the question is, you know, did Joanna code these charts correctly, we hired her as a coding entity to code the charts. Now we want you to do a quality assurance check on Joanne's coding. It's like we are blind coding the charts and then they're going to look at the differences and say Joanna found all these codes you didn't find, and then we're going to discuss it with the prior 03:18 03:19

coders. Or we could be doing it to add; we could be doing it to also delete. I mean, there are any number of reasons you could do a chart review. 03:19

Q. Do you recall any instance during this time period in which Health Risk Partners undertook a chart review solely to identify additional codes for an MA plan? 03:19

MS. KRIEG: Object to form. 03:19

A. I'm pretty sure we probably did at least one of those. 03:19

Q. At least one? 03:19

A. At least that was the general intent of it, yeah. Whether we only added codes I think is a more complex question. 03:20

Q. Do you understand what is meant by the phrase "blind coding"? 03:20

A. I do. 03:20

Q. Okay. What do you understand that to mean? 03:20

MS. KRIEG: Object to form. 03:20

A. It's basically meaning that you're going to give a chart to a clinical coder with no expectation as to what they may or may not find in that chart. So they don't have a 03:20

roster of diagnosis codes that they're coding against.

MR. QURESHI: Take a break? I think we are close to wrapping up here.

THE VIDEOGRAPHER: Going off the record. The time is 15:20.

(Recess taken.)

THE VIDEOGRAPHER: Going back on the record. The time is 15:30.

BY MR. QURESHI:

Q. Mr. Grant, I believe you testified earlier there was at least one plan for which you recall HRP performed a chart review while you were there; is that correct?

A. Well, there's --

MS. KRIEG: Object to form.

A. -- more than one plan that we performed chart reviews for, yes.

Q. Yeah. For the purpose of adding codes, you recall at least one plan?

A. Yes.

Q. And do you recall the identity of that plan?

A. I do.

Q. Okay. What is the identity?

A. It was Coventry. 03:30

Q. And in connection with that project, were you the relationship manager with Coventry? 03:30

A. I was the overall relationship manager for Coventry, like all clients. We had different people that managed the -- the very specific project because we had a chart retrieval process and we had a coding process. So our coder managed the relationship with respect to the coding and our chart retrieval person was managing the relationship with respect to -- I mean, we had -- I was actually over all of them so we also had a client rep for each one. So my client services rep would be the day-to-day, manage the relationship and keep track of, like, chart retrievals and go back and forth with them on, like, do you want to pay 20 bucks for this inpatient chart kind of thing. 03:31

Q. Is it fair to say that you were involved in that engagement? 03:31

A. Right. And I oversaw all of our client engagements. I was the senior vice president for client services. I had client 03:31

services rep that did the day-to-day for any client, and then if it was a special project that involved special skills, we might have people that were further managing the relationship with respect to that skill set because it required specialized skill.

Q. Understood.

The one instance in which you recalled in which there were review of charts to add codes, do you recall whether there were any efforts to reconcile those codes against previously submitted claims data?

MS. KRIEG: Object to form.

A. So from a coding perspective, we did totally blind coding, so the coders had no idea what was previously submitted. We did have the capacity not to duplicate submit diagnoses. We weren't going one for one and trying to look at claims data and see if every claim was one-for-one backed by a diagnosis on that date.

Q. Again, I'm focused on this one project for Coventry. As part of this effort, did HRP compare the codes identified in the blind coding effort against the claims data that was submitted by providers and delete

codes that HRP's coders did not identify? 03:34

MS. KRIEG: Object to form. 03:34

A. I'm not sure. I believe we may have 03:34
done -- not systematically, not on a 03:34
large-scale basis, but I believe there were 03:34
cases where we did. 03:34

Q. And at that time, did you have a 03:34
belief that not engaging in such a systematic 03:34
effort was improper? 03:34

MS. KRIEG: Object to form. 03:34

A. At that time, no. 03:34

Q. Okay. At that time, did you think it 03:34
was fraud? 03:34

MS. KRIEG: Object to form. 03:34

A. No, I did not knowingly participate 03:34
in the fraudulent activity. 03:34

MR. QURESHI: I have nothing else. 03:34

MS. KRIEG: Okay. I think 03:34
relator's counsel have questions. 03:34

EXAMINATION 03:35

BY MR. HASEGAWA: 03:35

Q. Mr. Grant, I'm Steve Hasegawa. I 03:35
represent the relator, Ben Poehling, in this 03:35
case. I want to follow up on the last series 03:35
of questions that Mr. Qureshi just asked you. 03:35

Was there ever an occasion when you were in private practice that you advised a client not to delete a code that your group had determined was invalid? 03:35

A. Not that I can recall. 03:35

Q. Do you have an opinion on whether a plan should delete codes that it determines are invalid, specific codes? 03:35

A. A code that one -- that you know for a fact the code is invalid? 03:35

Q. Yes. 03:35

A. You're supposed to delete it. 03:35

Q. When did you first hold that opinion? 03:35

A. Oh, when we created the system for submitting diagnosis codes back in the early, mid 2000s. 03:35

Q. Have you ever held a contrary opinion? 03:36

A. Not with respect to codes where you know they are wrong. 03:36

Q. Okay. I think you have in front of you somewhere Exhibit 1017. It's the Risk Adjustment For Dummies presentation. 03:36

A. Okay. 03:36

Q. Was this presentation based on 03:36

empirical data? 03:36
A. No. 03:36
Q. Is it based on any statistical study 03:36
of the characteristics of errors in 03:36
fee-for-service data? 03:36
A. No. 03:36
Q. Is there anything in the model that 03:36
calculates the effect of fee-for-service 03:36
undercoding errors on an MA plan payment? 03:36
A. In which model? 03:36
Q. In the model reflected in 03:36
Exhibit 1017, the hypothetical model. 03:36
A. No. 03:36
Q. On page 3, you are calculate the 03:36
effect on a hypothetical plan of certain 03:37
hypothetical fee-for-service overcoding errors; 03:37
is that correct? 03:37
A. That is correct. 03:37
Q. Could the effect on plan payment as 03:37
represented in the presentation be different if 03:37
you were also to include the effect of 03:37
undercoding errors? 03:37
A. Yes. 03:37
Q. And could the effect on plan payment 03:37
as represented in the presentation be different 03:37

depending on whether there were more or fewer undercoding errors than overcoding errors in the fee-for-service data? 03:37

A. Yes. 03:37

Q. Could the effect on plan payment as represented in the presentation be different depending on the characteristics of the MA plan's members? 03:37

A. I mean, I think that's what I said before too so that it -- every plan is going to have -- even if you knew what happened in fee-for-service, there are many different variables that affect how that would look for a plan, even if they submitted data some other fee-for-service because they have underlying differences in health risk. 03:38

Q. And could the conclusion of whether the plan is or isn't underpaid as a result of the fee-for-service errors, the hypothetical errors reflected in here, be answered differently depending on the plan's coding intensity? 03:38

A. So you're saying like if somebody is -- coding intensity, meaning other things done to make them different than 03:38

fee-for-service. 03:38

Q. Yes. 03:38

A. The answers definitely vary with variance in coding intensity. 03:38

Q. Okay. Can you turn, please, to Exhibit 1018. About three pages in, it begins -- the header is "Revised Draft," and there's some red-lining, but ultimately it's January 4, 2010. 03:38

Do you see that page? 03:39

A. I do. 03:39

Q. At the bottom there's a section that begins "Extrapolation," that has the header "Extrapolation," and the second-to-last sentence of that paragraph reads "Therefore" -- actually, can you read that sentence that begins "Therefore"? 03:39

A. "Therefore, in order to extrapolate accurately and fairly, it is critical for CMS to take into account the level of inaccuracy or documentation shortcomings in the data that were used in the model," in red-line. "Methods that could be used to accomplish this goal include." 03:39

Q. When you worked on this document and 03:39

the other documents that are attached to this Exhibit 1018, did you have any understanding that you -- that AHIP was addressing anything other than RADV extrapolation? 03:39

A. No. 03:39

Q. And do any of the concepts in here apply in the absence of extrapolation? 03:39

A. I don't know. 03:40

Q. Okay. If you turn to -- there are a number of different page numbers at the bottom, but there's one that begins page 2 and it has a couple of methods listed on it. I think it's maybe the eighth page of the presentation, the eighth page of the document. 03:40

A. Now are we in the clean version of it? 03:40

Q. Yes. Sorry. 03:40

A. There's two versions. 03:40

Q. Yes. 03:40

A. It's the same document. 03:40

Q. You're right, you're right. I'm looking at a page. It's the clean version. It says page 2 at the bottom and it has a method number 1 and the beginning of method number 2 -- 03:40

A. Yeah. 03:40

Q. -- at the bottom. Do you see that page? 03:40

A. Yeah. 03:40

Q. Were either of these methods -- well, were these methods proposals for the determination of either the level of error present in Medicare fee-for-service data used to develop the Part C risk adjustment model or proxies for that data? 03:40

A. Well, I would say very -- to be very specific, the first I would say is to develop a measure. Of course, it is an estimate, so every estimate is somewhat of a proxy. But it is considered to be a statistically valid error example that would be considered a very valid proxy that would represent what we thought was the best estimate of a fee-for-service error rate. 03:41

The other one is the other methods that are suggested in here with option A and option B under method 2 are, by definition, complete proxies. They do not involve the use of any fee-for-service data. They are using other data sources to back into an answer. 03:41

Q. Okay. Were any of the methodologies as you understood them at the time this document was being drafted intended to provide a basis to recalibrate the entire Part C risk adjustment model? 03:41 03:41 03:41 03:42 03:42

A. No. 03:42

Q. Well, why not just use this, the data acquired using these methods, to recalibrate the model? 03:42 03:42 03:42

A. So the problem with this is -- so calibration's a complex set of calculations that take millions of individuals, but each individual is getting an individualized calculation. But then it's -- you're doing a least squares regression so you're trying to figure out the explanation across millions of individuals, the best explanation that tells you what each thing is worth. 03:42 03:42 03:42 03:42 03:42 03:42 03:42 03:42 03:42

What you have here is a very small sample. So, you know, I think if we were to take the example in the other document we looked at and said even 10,000 people, which is a much larger sample than a RADV sample, but even if you took 10,000 people, compare them to 10 million people or 20 million people, they're 03:42 03:42 03:42 03:43 03:43 03:43 03:43

going to be overwhelmed by the people that were not in the sample. 03:43

You have no basis on which to alter anything about a person that's not in the sample because again, you're running all these calculations. You can't just make up -- you can't just fudge for all the people that aren't in the sample some kind of randomly assigned error rate because the error rates are actually not random. Our expectation is that if you overreport a diagnosis that the error will be that you would underpredict the cost; if you underreport a diagnosis, that you would over -- that you would have some other kind of error that would occur. 03:43

And so that's only knowable for the 10,000 people you have, but you don't calibrate the model on those 10,000. You're going to calibrate the model on 10 million people, 20 million people. And then we'll get all overwhelmed and you don't have a way to tell out of the 20 million people who else needs to have their data altered in the way that you would alter data for the 10,000 that you know facts about. 03:44

So this is useful for extrapolation, which again is using a similar principle. You know, you're having a 200-person sample speak for an entire plan enrollment. So this is taking, like, a similar thing, saying, okay, we're going to extrapolate an error rate, so in either -- you're taking two extrapolation methodologies, and that makes sense. But calibration and extrapolation are very different things so you don't extrapolate in calibration.

Q. Could you use either of the or any of the methodologies in this document to determine with precision the exact effect of all fee-for-service errors on payments to each individual MA plan?

A. Absolutely not.

Q. Is calibration of the Part C risk adjustment model without any errors at all a realistic goal within the government's financial constraints?

A. No.

Q. Why not?

A. Well, I think for two fundamental reasons. First of all, the model itself has a

large degree of unexplained costs built into it. Forget errors that go into it. Even if you have no errors, you again do not have unitary costs across a population. 03:45

So every diabetic does not cost the same amount. Even every diabetic of the exact same age does not cost the same amount. So you're going to have some explained costs, and that's what you're trying to get to. You're trying to predict large groups of people accurately. You're not trying to predict one individual's cost accurately. You're trying to get a reasonable relative risk score for people that have health conditions, people that don't have health conditions, people that have a mix of health conditions. And you accept the fact that there is no perfect way to do that and it's a predictive model in the first place. 03:45 03:45 03:45 03:45 03:45 03:45 03:45 03:45 03:45 03:46 03:46 03:46 03:46

So underlying that in addition to all other errors you have some amount of error in the model that is induced by fee-for-service error of an unknown magnitude, and it would cost I don't even know what to -- to review over a billion claims to get them 100 percent accurate, only then to still have a lot of 03:46 03:46 03:46 03:46 03:46 03:46 03:46 03:46 03:46

unexplained variation in the model, that the gain is not worth the cost that you had put in it because there would still be plenty of unexplained variation that doesn't get fixed by doing this elaborate study. 03:46

Q. Does the existence of error within the MA Part C risk adjustment model mean that MA providers can submit knowingly incorrect data? 03:46

A. No. 03:46

Q. Have you ever held the opinion that it does? 03:46

A. No. 03:46

Q. Have you ever told anybody that the existence of error within the model means that MA providers can submit knowingly incorrect data? 03:47

A. And can we define terms? 03:47

Q. Okay. 03:47

A. When you say "knowingly incorrect," it is a very specific submission of a very specific data element saying that I know is wrong. 03:47

Q. A specific diagnosis code that is known to be wrong. 03:47

A. Right. No.
Q. Does the existence of error within the model mean that MA providers can refuse to correct errors that they didn't know about when they were submitted but that they later learned were errors?
A. No.
Q. Have you ever told anybody that the existence of error within the model means that MA providers don't need to correct errors that they know about?
A. No.
MR. HASEGAWA: I have nothing further.
MR. QURESHI: Short redirect.
EXAMINATION
BY MR. QURESHI:
Q. Mr. Grant, if HRP in the instance that you highlighted did the blinded review and didn't do a systematic reconciliation with the provider-submitted codes, is it your understanding that HRP knew it was submitting specific bad codes?
MS. KRIEG: Object to form.
A. We were not submitting any bad codes.

Q. Were you facilitating the submission of specific bad codes by the plan in that instance? 03:48

MS. KRIEG: Object to form. 03:48

A. No. I think -- that's not how we looked at it. We -- the codes were already in. We were not doing a review to systematically do a complete audit of a plan and determine the accuracy of codes. We were sometimes asked to do that, and if we were asked to do that, we could do a very careful review. 03:48

I mean, it's a different style review when you want to put in the effort that you need to to absolutely make sure that a code is backed up. 03:49

Q. The calibration of the Part C model that you were discussing in response to Mr. Hasegawa's questions, are you aware that the model is calibrated using a sample? 03:49

A. I believe it's a very large sample, but I believe it is a sample, yes. 03:49

Q. Do you know what the percentage size of the sample is? 03:49

Is it 25 percent? 30 percent? 03:49

A. I'm not -- 03:49

MS. KRIEG: Object to form. 03:49

THE WITNESS: Oh, sorry. 03:49

A. I'm not sure what the size of the sample is. 03:49

Q. I see. Is it the CERT sample, C-E-R-T? 03:49

A. Again, I do not know what sample is used to calibrate the model. 03:49

Q. Did your responses to Mr. Hasegawa's questions assume that there was no sampling occurring? 03:50

MS. KRIEG: Object to form. 03:50

A. No. 03:50

Q. Have you ever heard that it's -- the CERT sample is a 5 percent sample? Have you ever been made aware of that? 03:50

A. I've heard of the 5 percent sample. I haven't heard it called the CERT sample. 03:50

Q. And are you aware that it's the 5 percent sample that's used to calibrate the model? 03:50

MR. HASEGAWA: Object to form. 03:50

MS. KRIEG: Object to form. 03:50

A. I -- it may have been. I'm not sure if it always has been. It may have been. It 03:50

may still be. I don't know. 03:51

Q. And would that impact the responses 03:51

you provided to Mr. Hasegawa's questions? 03:51

MS. KRIEG: Object to form. 03:51

A. No. 03:51

MR. QURESHI: I have nothing 03:51

further. 03:51

MS. KRIEG: The government has 03:51

nothing, okay, so the deposition is 03:51

closed. 03:51

THE VIDEOGRAPHER: This marks the 03:51

end of the deposition. Going off the 03:51

record at 10:51. 03:51

03:51

(Deposition adjourned at 10:51 p.m.) 03:51

_____

Subscribed and sworn to before me

this _____ day of _____, 20__.

_____

NOTARY PUBLIC

C E R T I F I C A T E

DISTRICT OF COLUMBIA:

I, MARY ANN PAYONK, shorthand reporter, do hereby certify that the witness whose deposition is hereinbefore set forth was duly sworn, and that such deposition is a true, correct, and full record of the testimony given.

I further certify that I am not related to any of the parties to this action by blood or by marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 29th day of May, 2018.

_____

MARY ANN PAYONK, Shorthand Reporter

- INDEX TO WITNESSES -

WITNESS	PAGE
JEFFREY GRANT	
Examination by Mr. Qureshi	159, 322
Examination by Mr. Hasegawa	310

- INDEX TO EXHIBITS -

NO.	DESCRIPTION	MARKED
Exhibit No. 1014	2008 document re: rates	167
Exhibit No. 1015	Document re: coding intensity adjustment	180
Exhibit No. 1016	5/29/2009 email	191
Exhibit No. 1017	PowerPoint presentation	224
Exhibit No. 1018	Email and attached AHIP Issue Paper	242
Exhibit No. 1019	Document re: risk adjustment	293

- INDEX TO CERTIFIED QUESTIONS -

Page/Line	Text of the Question
286 1	What can you tell me that doesn't reveal deliberative process?

INDEX TO CERTIFIED QUESTIONS (Cont'd.)

Page/Line		Text of the Question
287	8	While you were with the government and having these conversations with your staff and Mr. Hutchinson, did the government commence calculating a fee-for-service error rate?
287	15	In connection with these discussions with Mr. Hutchinson and your staff, did the government ever do a RADV-like audit of medical records in a fee-for-service population?
289	11	Your meetings with Mr. Hutchinson and your staff involving the fee-for-service error rate, did they include coming up with a methodology to calculate that error rate?
290	17	And what was your position?

<<INDEX END>>

NAME OF CASE: USA vs. UnitedHealth Group

DATE OF DEPOSITION: May 16, 2018

1. To clarify the record.
2. To conform to the facts.
3. To correct transcription error.

Page _____ Line _____ Reason _____
From _____ to _____

Page _____ Line _____ Reason _____
From _____ to _____

Page _____ Line _____ Reason _____
From _____ to _____

Page _____ Line _____ Reason _____
From _____ to _____

Page _____ Line _____ Reason _____
From _____ to _____

Page _____ Line _____ Reason _____
From _____ to _____

Page _____ Line _____ Reason _____
From _____ to _____

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JEFFREY GRANT

SUBSCRIBED AND SWORN TO BEFORE ME

THIS _____ DAY OF _____, 2018.

_____

(Notary Public)

My Commission expires: _____