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18 UNITED STATES DISTRICT COURT
19 FOR THE CENTRAL DISTRICT OF CALIFORNIA
20 WESTERN DIVISION

21 UNITED STATES OF AMERICA *ex*
22 *rel.* BENJAMIN POEHLING,

23 Plaintiffs,

24 v.

25 UNITEDHEALTH GROUP, INC., a
Delaware corporation; UNITED
26 HEALTHCARE SERVICES, INC., a
Minnesota corporation; UNITED
27 HEALTHCARE, INC., a Delaware
corporation; OVATIONS, INC., a
28 Delaware corporation; OPTUM, INC., a
Delaware corporation;
OPTUMINSIGHT, INC., a Delaware
corporation; AMERICHOICE OF NEW

No. CV 16-08697 MWF (SSx)

UNITED STATES' AMENDED
COMPLAINT-IN-PARTIAL-
INTERVENTION AND DEMAND FOR
JURY TRIAL

1 JERSEY, INC., a New Jersey
 2 corporation; ARIZONA PHYSICIANS
 3 IPA, INC., an Arizona corporation;
 4 CARE IMPROVEMENT PLUS OF
 5 MARYLAND, INC., a Maryland
 6 corporation; CARE IMPROVEMENT
 7 PLUS OF TEXAS INSURANCE
 8 COMPANY, a Texas insurance
 9 company; CARE IMPROVEMENT
 10 PLUS SOUTH CENTRAL
 11 INSURANCE CO., an Arkansas
 12 insurance company; CARE
 13 IMPROVEMENT PLUS WISCONSIN
 14 INSURANCE COMPANY, a Wisconsin
 15 insurance company; OPTUM
 16 INSURANCE CO., an Ohio corporation;
 17 CITRUS HEALTH CARE, INC., a
 18 Florida corporation; HEALTH PLAN OF
 19 NEVADA, INC., a Nevada corporation;
 20 MEDICA HEALTHCARE PLANS,
 21 INC., a Florida corporation; OXFORD
 22 HEALTH PLANS (CT), INC., a
 23 Connecticut corporation; OXFORD
 24 HEALTH PLANS (NJ), INC., a New
 25 Jersey corporation also known as Oxford
 26 Health Plans of New Jersey, Inc.;
 27 OXFORD HEALTH PLANS (NY),
 28 INC., a New York corporation;
 PACIFICARE LIFE AND HEALTH
 INSURANCE COMPANY, an Indiana
 insurance company; PACIFICARE OF
 ARIZONA, INC., an Arizona
 corporation; PACIFICARE OF
 COLORADO, INC., a Colorado
 corporation; PACIFICARE OF
 NEVADA, INC., a Nevada corporation
 also known as PacifiCare/UHC of
 Nevada; PHYSICIANS HEALTH
 CHOICE OF TEXAS, LLC, a Texas
 limited liability company; PREFERRED
 CARE PARTNERS, INC., a Florida
 corporation; ROCKY MOUNTAIN
 HEALTH MAINTENANCE
 ORGANIZATION, INC., a Colorado
 company; SIERRA HEALTH AND
 LIFE INSURANCE COMPANY, INC.,
 a Nevada corporation; SYMPHONIX
 HEALTH INSURANCE, INC., an
 Illinois insurance company;
 UNITEDHEALTHCARE OF
 CALIFORNIA, INC., a California
 corporation also known as UHC of
 California, Inc. and formerly known as
 PacifiCare of California, Inc. and
 PacifiCare of California/Secure
 Horizons; UNISON HEALTH PLAN OF

1 TENNESSEE, INC., a Tennessee
 2 corporation; UNITED HEALTH CARE
 3 INS. CO. AND UNITED NEW YORK, a
 4 New York insurance company;
 5 UNITEDHEALTHCARE BENEFITS
 6 OF TEXAS, INC., a Texas corporation
 7 formerly known as PacifiCare of Texas,
 8 Inc.; UNITEDHEALTHCARE
 9 COMMUNITY PLAN OF OHIO, INC.,
 10 an Ohio corporation formerly known as
 11 Unison Health Plan of Ohio, Inc.;
 12 UNITEDHEALTHCARE
 13 COMMUNITY PLAN OF TEXAS,
 14 L.L.C., a Texas limited liability company
 15 formerly known as Evercare of Texas,
 16 LLC; UNITEDHEALTHCARE
 17 COMMUNITY PLAN, INC., a Michigan
 18 corporation also known as Great Lakes
 19 Health Plan, Inc. and UnitedHealthcare
 20 of the Great Lakes Health Plan, Inc.;
 21 UNITEDHEALTHCARE INSURANCE
 22 COMPANY, a Connecticut insurance
 23 company also known as United
 24 Healthcare Insurance Company;
 25 UNITEDHEALTHCARE INSURANCE
 26 COMPANY OF NEW YORK, a New
 27 York insurance company also known as
 28 United Healthcare Insurance Company of
 New York; UNITEDHEALTHCARE OF
 ALABAMA, INC., an Alabama
 corporation also known as United
 HealthCare of Alabama, Inc.;
 UNITEDHEALTHCARE OF
 ARIZONA, INC., an Arizona
 corporation also known as United
 HealthCare of Arizona, Inc.;
 UNITEDHEALTHCARE OF
 ARKANSAS, INC., an Arkansas
 corporation also known as United
 Healthcare of Arkansas, Inc.;
 UNITEDHEALTHCARE OF
 FLORIDA, INC., a Florida corporation
 also known as United Healthcare of
 Florida, Inc.; UNITEDHEALTHCARE
 OF GEORGIA, INC., a Georgia
 corporation also known as United
 Healthcare of Georgia, Inc.;
 UNITEDHEALTHCARE OF NEW
 ENGLAND, INC., a Rhode Island
 corporation also known as United
 HealthCare of New England, Inc. and
 United Health Plans of New England,
 Inc.; UNITEDHEALTHCARE OF NEW
 YORK, INC., a New York corporation
 also known as AmeriChoice of New
 York, Inc. and United Healthcare of New

1 York, Inc.; UNITEDHEALTHCARE OF
2 NORTH CAROLINA, INC., a North
3 Carolina corporation also known as
4 United Healthcare of North Carolina,
5 Inc.; UNITEDHEALTHCARE OF
6 OHIO, INC., an Ohio corporation also
7 known as United Healthcare of Ohio,
8 Inc.; UNITEDHEALTHCARE OF
9 OKLAHOMA, INC., an Oklahoma
10 corporation formerly known as
11 PacifiCare of Oklahoma, Inc.;
12 UNITEDHEALTHCARE OF OREGON,
13 INC., an Oregon corporation formerly
14 known as PacifiCare of Oregon, Inc.;
15 UNITEDHEALTHCARE OF
16 PENNSYLVANIA, INC., a
17 Pennsylvania corporation formerly
18 known as Unison Health Plan of
19 Pennsylvania, Inc.;
20 UNITEDHEALTHCARE OF
21 TENNESSEE, INC., a Tennessee
22 corporation also known as United
23 Healthcare of Tennessee, Inc.;
24 UNITEDHEALTHCARE OF THE
25 MIDLANDS, INC., a Nebraska
26 corporation also known as United
27 Healthcare of the Midlands, Inc.;
28 UNITEDHEALTHCARE OF THE
MIDWEST, INC., a Missouri
corporation also known as United
Healthcare of the Midwest, Inc.;
UNITEDHEALTHCARE OF UTAH,
INC., a Utah corporation also known as
United Healthcare of Utah, Inc.;
UNITEDHEALTHCARE OF
WASHINGTON, INC., a Washington
corporation formerly known as
PacifiCare of Washington, Inc.;
UNITEDHEALTHCARE OF
WISCONSIN, INC., a Wisconsin
corporation also known as United
Healthcare of Wisconsin, Inc.;
UNITEDHEALTHCARE PLAN OF
THE RIVER VALLEY, INC., an Illinois
corporation also known as United
Healthcare Plan of the River Valley, Inc.,
UnitedHealth Care Plan of the River
Valley, Inc., and United HealthCare of
the River Valley, Inc.,

Defendants.

1 This is a civil fraud action brought by the United States of America (“United
 2 States” or “Government”) to recover treble damages and civil penalties under the False
 3 Claims Act (“FCA”), 31 U.S.C. §§ 3729-3733, as well as for restitution and common
 4 law damages, for monies unlawfully obtained and retained by Defendant UnitedHealth
 5 Group Inc. and various of its direct and indirect subsidiaries (“Defendants”) involved in
 6 Parts C and D of the Medicare Program. Defendants knowingly submitted false claims
 7 and made false statements to the Medicare Program. Moreover, Defendants have
 8 knowingly and improperly avoided their obligations to repay significant sums of money
 9 to the Medicare Program.

10 Having filed a notice of intervention pursuant to 31 U.S.C. § 3730(b)(4), the
 11 United States alleges for its amended complaint-in-partial-intervention (the “Amended
 12 Complaint”) as follows:

13 **INTRODUCTION**

14 1. Millions of elderly and disabled individuals throughout the United States receive
 15 their Medicare benefits through Parts C and D of the Medicare Program, hereinafter
 16 referred to as the Medicare Advantage (MA) Program, which is administered by the
 17 Government agency called the Centers for Medicare and Medicaid Services (“CMS”). A
 18 central, distinguishing feature of the MA Program is the provision of Medicare benefits
 19 by private healthcare insurance organizations, which are called Medicare Advantage
 20 Organizations (“MA Organizations”). Medicare beneficiaries enroll in managed
 21 healthcare insurance plans called Medicare Advantage Plans (“MA Plans”) and
 22 prescription drug plans (“PD Plans”) that are offered by these MA Organizations. The
 23 MA Plans are packages of healthcare insurance benefits and the PD Plans are packages
 24 of prescription drug benefits. Hereinafter MA Plans and PD Plans are collectively
 25 referred to as “Plans.”

26 2. The Government pays each MA Organization a fixed monthly payment for each
 27 Medicare beneficiary enrolled in its Plans. The Government adjusts these payments for
 28 various risk factors that affect expected healthcare expenditures, including the age,

1 gender, and health status of each beneficiary. The adjustments are intended to ensure
2 that MA Organizations are paid more for beneficiaries whose healthcare expenses are
3 *expected* to be more and less for beneficiaries whose health care expenses are *expected*
4 to be less. However, these adjustments to the fixed monthly payments are made
5 regardless of the actual services provided to the beneficiaries and, thus, regardless of
6 whether those beneficiaries expected to need more or more costly services actually
7 obtain more or more costly services, and whether those beneficiaries expected to need
8 less or less costly services actually obtain less or less costly services.

9 3. To obtain payments based on adjustments for health status, MA Organizations
10 submit diagnosis codes to the Government for the beneficiaries in their Plans. These
11 diagnosis codes are from the beneficiaries' medical encounters with healthcare providers
12 (*e.g.*, physician office visits and hospital stays) during the year prior to the actual
13 payment year (often referred to as the "data collection" year or the "date of service"
14 year). Payments are based on diagnoses from the prior year because they are used to
15 predict the *expected* needs of a beneficiary for more or less costly healthcare services
16 during the payment year. Using these diagnosis codes submitted by or on behalf of MA
17 Organizations, the Government calculates a risk score for each beneficiary. The
18 beneficiary's risk score is then used to calculate monthly payments to the MA
19 Organization for that beneficiary for the payment year. In general, the more numerous
20 and severe the conditions identified by the diagnosis codes, the higher the risk score for a
21 beneficiary and, thus, the greater the risk adjustment payments made to the MA
22 Organization for that beneficiary for the payment year.

23 4. This payment model creates powerful incentives for MA Organizations and their
24 owners and operators to exaggerate the expected healthcare costs for the beneficiaries in
25 their Plans by submitting invalid diagnosis codes and failing to comply with their
26 obligation to retract invalid diagnoses. In order to combat these incentives and protect
27 the Government from overpaying MA Organizations, the Government requires that
28 submitted diagnoses be unambiguously supported and, thus, validated by the

1 beneficiaries' medical records for medical encounters during the data collection year.
 2 Medical records are the "source of truth" for the purpose of receiving and retaining risk
 3 adjustment payments.

4 5. The medical records that must support the diagnosis codes are not provided to the
 5 Government as part of the payment process. Instead, the Government requires that each
 6 MA Organization expressly certify that the diagnosis codes it has submitted for risk
 7 adjustment payments are accurate and truthful based on best knowledge, information,
 8 and belief. 42 C.F.R. § 422.504(l)(2). Each MA Organization must exercise due
 9 diligence in order to make this express certification. Each MA Organization must also
 10 "[a]dopt and implement an effective compliance program, which must include measures
 11 that prevent, detect, and correct non-compliance with [the Government's] program
 12 requirements as well as measures that prevent, detect, and correct fraud, waste, and
 13 abuse." 42 C.F.R. § 422.503(b)(4)(vi).

14 6. As explained by the United States Court of Appeals for the Ninth Circuit, CMS, in
 15 2000, made clear that

16 Medicare Advantage organizations have always had "an obligation to take
 17 steps to ensure the accuracy, completeness, and truthfulness of the
 18 [medical] encounter data" [i.e., diagnoses] and "an obligation to undertake
 19 'due diligence' to ensure the accuracy, completeness, and truthfulness of
 20 encounter data submitted to [CMS]." . . . CMS made perfectly clear that
 21 Medicare Advantage organizations would be "held responsible for making
 22 good faith efforts to certify the accuracy, completeness, and truthfulness of
 23 encounter data submitted."

24 *United States ex rel. Swoben v. UnitedHealthcare Ins. Co.*, 848 F.3d 1161, 1174 (9th Cir.
 25 2016) (quoting 65 Fed. Reg. 40,170, 40,268 (June 29, 2000)). The Ninth Circuit further
 26 explained that the requirement that MA Organizations take affirmative steps to address
 27 errors in their data is further demonstrated by "§ 422.503, which since 2005 has required
 28 Medicare Advantage organizations to have effective compliance programs in place,

1 including '[p]rocedures for internal monitoring and auditing' and 'for ensuring prompt
2 response to detected offenses'." *Id.* (quoting 42 C.F.R. § 422.503(b)(4)(vi), (vi)(F),
3 (vi)(G) (2005)).

4 7. For many years, Defendant UnitedHealth Group Inc. ("UHG") has been the
5 nation's largest owner of MA Organizations. These organizations offer MA and PD
6 Plans throughout the country. Millions of elderly and disabled Medicare beneficiaries
7 throughout the United States are enrolled in MA and PD Plans that are offered by UHG
8 and the MA Organizations owned by it. In March 2017, approximately 229,000
9 Medicare beneficiaries in the Central District of California were enrolled in MA Plans
10 offered by Defendants UnitedHealthcare of California, Inc. (previously known as
11 PacifiCare of California, Inc.) and Sierra Health and Life Insurance Company, Inc.

12 8. UHG manages and operates the Defendant MA Organizations itself and through
13 its business divisions which, depending on the time period, were or are part of
14 Defendants UnitedHealthcare, Inc.; United HealthCare Services, Inc.; Ovations, Inc.;
15 Optum, Inc.; and OptumInsight, Inc. Hereinafter, UHG, UnitedHealthcare, Inc.; United
16 HealthCare Services, Inc.; Ovations, Inc.; Optum, Inc.; and OptumInsight, Inc. are
17 sometimes collectively referred to as the "UHG Managing Defendants," based on their
18 roles in managing and operating the Defendant MA Organizations, as described more
19 fully herein. When the term "UHG Managing Defendants" is used in this Amended
20 Complaint in reference to specific facts (*e.g.*, meetings and communications), it refers to
21 those Defendants that managed and operated the Defendant MA Organizations at the
22 time relating to the facts alleged.

23 9. The Government pays billions of taxpayer dollars each year to the Defendant MA
24 Organizations for the Medicare beneficiaries enrolled in the Defendant MA
25 Organizations' Plans. Risk adjustment payments account for a substantial percentage of
26 these dollars. The diagnoses submitted to the Government by the UHG Managing
27 Defendants on behalf of the Defendant MA Organizations drive a large percentage of the
28 payments that the Defendant MA Organizations receive from the Government.

1 Accordingly, it is not surprising that the UHG Managing Defendants and the Defendant
2 MA Organizations are not passive conduits of diagnoses from healthcare providers to the
3 Government. Rather, for many years, the UHG Managing Defendants have conducted
4 programs and engaged in other activities to increase the amount of risk adjustment
5 payments from the Government to the Defendant MA Organizations. This includes
6 programs and other efforts to directly influence both the number of diagnoses and the
7 severity of the medical conditions reported by providers (such as educating physicians
8 about diagnoses associated with greater risk adjustment payments). This also includes
9 programs and efforts that do not involve providers but nonetheless materially increase
10 the number of diagnoses submitted to the Government and, thus, the amount of risk
11 adjustment payments to the Defendant MA Organizations. Since 2005, the UHG
12 Managing Defendants and/or their predecessors have worked jointly to conduct these
13 programs and perform these activities.

14 10. In particular, since 2005, the UHG Managing Defendants have conducted a very
15 large national Chart Review Program to significantly increase the risk adjustment
16 payments that the Defendant MA Organizations receive from the Government. For
17 many years, this was their biggest effort aimed at increasing risk adjustment payments.
18 During the last ten years, they significantly increased the amount of risk adjustment
19 payments that the Defendant MA Organizations received from the Government by
20 collecting millions of medical records (also known as “charts”) from providers and then
21 employing diagnosis coders (also known as “chart reviewers”) to review the medical
22 records in order to mine them for diagnoses that the providers themselves did not report
23 to the Defendant MA Organizations for the beneficiaries in their Plans. The UHG
24 Managing Defendants then submitted these additional diagnosis codes (“ADDS”) to the
25 Government for billions of dollars of additional risk adjustment payments.

26 11. The UHG Managing Defendants’ national Chart Review Program was strictly a
27 one-sided revenue-generating program. The UHG Managing Defendants did not review
28 the beneficiaries’ medical records in good faith in order to obtain a true and accurate

1 picture of the health status of the beneficiaries in the Defendant MA Organizations’
2 Plans or to submit truthful and accurate risk adjustment data to the Government. They
3 used the results of the chart reviews to only increase payments, *i.e.*, to submit additional
4 diagnoses not reported by the providers. At the same time, they systematically ignored
5 the results of chart reviews that would have led to decreased payments, *i.e.*, results
6 showing that diagnoses reported by providers to them and then submitted by them to the
7 Government were not supported by the beneficiaries’ medical records.

8 12. Moreover, since at least 2005, the UHG Managing Defendants and/or their
9 predecessors have known that a significant percentage of diagnoses reported by
10 providers to them (hereinafter “provider-reported diagnoses”) are invalid because the
11 beneficiaries’ medical records do not substantiate that the beneficiaries had the medical
12 conditions identified by the diagnosis codes reported by the providers. They knew this
13 from audits conducted by the Government and from their own internal medical record
14 reviews. Despite this knowledge, they knowingly avoided “looking both ways” as part
15 of their national Chart Review Program, except for a very limited time period when they
16 “looked both ways” at some of the chart review results as part of their Claims
17 Verification (“CV”) Program. That is, they knowingly and improperly avoided
18 comparing the diagnoses reported by the providers and submitted by them to the
19 Government with the results of the coders’ chart reviews to identify those provider-
20 reported diagnoses that were not supported by the beneficiaries’ medical records. They
21 could and should have done this comparison and withdrawn their prior submission of
22 these unsupported diagnoses, that is, made “DELETES.” If they had done so, the
23 Government would not have made risk adjustment payments based on these unsupported
24 diagnoses or, if it had already made the payments, it would have recovered them from
25 the Defendant MA Organizations or the other Defendants.

26 13. By failing to “look both ways,” the UHG Managing Defendants generated and
27 reported skewed data artificially inflating beneficiaries’ risk scores, avoided negative
28 payment adjustments, and caused the Defendant MA Organizations to retain payments to

1 which they were not entitled. They did this “knowingly,” as that term is defined in the
2 FCA. The Government has conservatively estimated that, if the UHG Managing
3 Defendants had “looked both ways,” they would not have submitted on behalf of the
4 Defendant MA Organizations or, if submitted, they would have withdrawn hundreds of
5 thousands of invalid diagnoses on behalf of the Defendant MA Organizations, and the
6 Government would not have erroneously paid or would have recovered substantial sums
7 of money (*e.g.*, potentially over a billion dollars in risk adjustment payments for four
8 payment years) to which the Defendant MA Organizations were not entitled.

9 14. By failing to “look both ways,” the UHG Managing Defendants and the Defendant
10 MA Organizations knowingly submitted false certifications about the accuracy and
11 truthfulness of their data and knowingly and improperly avoided or decreased
12 obligations to repay (*i.e.*, return) monies owed to the Government in violation of the
13 FCA.

14 15. In addition, Defendants engaged in other conduct (unrelated to their Chart Review
15 Program) that violated the FCA. Defendants deliberately ignored or recklessly
16 disregarded information from their Risk Adjustment Coding Compliance Review
17 (“RACCR”) Program about invalid diagnoses. This information showed that significant
18 percentages of the diagnoses reported to the UHG Managing Defendants and the
19 Defendant MA Organizations by certain “financially incentivized” providers, including
20 certain capitated and gainsharing providers, were unsubstantiated by their patients’
21 medical records.

22 16. The UHG Managing Defendants and the Defendant MA Organizations paid
23 providers who cared for the beneficiaries in the Defendant MA Organizations’ MA Plans
24 through a variety of arrangements. They paid some healthcare providers on a fee-for-
25 service basis for each service (*e.g.*, office visit) they provided to a beneficiary. However,
26 they negotiated payment arrangements with large provider groups that were intended to
27 more closely align their financial interests. For example, the UHG Managing
28 Defendants and the Defendant MA Organizations paid many large provider groups a

1 “fixed” fee for each beneficiary cared for by these providers. These “capitated” fees
2 generally were not dependent on the amount of services rendered by these providers.
3 Instead, the “capitated” fees were often based on a percentage share of the payments that
4 the Defendant MA Organizations received from the Government for the beneficiaries
5 cared for by the providers. The UHG Managing Defendants and the Defendant MA
6 Organizations also entered into “gainsharing” agreements whereby they made incentive
7 payments to some of their fee-for-service providers. These incentive payments were
8 based in whole or part on total revenues that the Defendant MA Organizations received
9 from the Government for the beneficiaries cared for by these gainsharing providers.

10 17. The UHG Managing Defendants’ and the Defendant MA Organizations’
11 agreements with capitated and gainsharing providers incentivized these providers to
12 increase the number of diagnoses that they reported to the UHG Managing Defendants
13 and the Defendant MA Organizations and to report diagnoses for more severe medical
14 conditions. The more risk adjustment payments obtained by the Defendant MA
15 Organizations for the beneficiaries cared for by these providers, the more money the
16 UHG Managing Defendants and the Defendant MA Organizations paid to these
17 providers pursuant to the capitation and gainsharing agreements.

18 18. The UHG Managing Defendants knew that these capitated and gainsharing
19 providers had a financial incentive to report invalid diagnoses in order to increase their
20 own revenues. In fact, based on the results of their own data analyses and medical
21 record reviews conducted as part of their RACCR Program, they knew which
22 incentivized providers were actually or likely engaged in over-reporting diagnoses,
23 including a significant number of providers located in this District. But the UHG
24 Managing Defendants knowingly continued to submit diagnoses from these incentivized
25 providers to the Government and knowingly and improperly avoided repaying the
26 Government for risk adjustment payments based on invalid diagnoses from these
27 providers, all in violation of the FCA.

JURISDICTION AND VENUE

19. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1345 because the United States is the Plaintiff. In addition, the Court has subject matter jurisdiction over the FCA claims for relief under 28 U.S.C. §§ 1331 and 1345 and 31 U.S.C. § 3732(a)-(b) and supplemental jurisdiction to entertain the common law and equitable claims for relief under 28 U.S.C. § 1367(a).

20. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides in, transacts business in, or has committed the alleged acts in the Central District of California.

21. Venue also lies in this District pursuant to 28 U.S.C. § 1391(b)-(c) and 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides in, and transacts business in this District, a substantial part of the events or omissions giving rise to the claims occurred in this District, and/or all of the Defendants are subject to the Court's personal jurisdiction under the FCA.

PARTIES

I. Plaintiffs

22. Plaintiff is the United States of America, suing on behalf of the United States Department of Health and Human Services ("HHS"), which includes its operating division, the Centers for Medicare and Medicaid Services ("CMS"). At all times relevant to this Complaint, CMS administered and supervised the MA Program and made risk adjustment payments to MA Organizations, including the Defendant MA Organizations in this action, under Parts C and D of the Program. The United States filed its notice of partial intervention in this action on February 14, 2017.

23. The *qui tam* plaintiff ("Relator") is Benjamin Poehling, a former employee of United HealthCare Services, Inc. who was the Director of Finance for Oventions, the group that managed the Defendant MA Organizations until approximately 2010 and, after that, the Director of Finance for UnitedHealthcare Medicare & Retirement, which was the group at UnitedHealthcare, Inc. that succeeded Oventions in managing the

1 Defendant MA Organizations. From mid-2007 until he left at the end of 2012, Poehling
2 ran the risk adjustment team at Ovations and then at UnitedHealthcare Medicare &
3 Retirement, where he was one of the management employees responsible for the
4 submission of claims (*i.e.*, diagnoses) by the UHG Managing Defendants to the
5 Government for risk adjustment payments to the Defendant MA Organizations. He was
6 also one of the management employees responsible for risk adjustment revenue-
7 generating activities, including, but not limited to, the UHG Managing Defendants’
8 national Chart Review Program. Poehling expressed concerns to fellow executives
9 about the failure of the UHG Managing Defendants’ Chart Review Program to “look
10 both ways.” In March 2011, Poehling initiated this action by filing a complaint pursuant
11 to the *qui tam* provisions of the FCA. 31 U.S.C. § 3730(b)(1).

12 **II. Defendants**

13 24. Defendant UnitedHealth Group, Inc. (“UHG”) is a publicly traded Delaware
14 corporation. It is the parent company for all other Defendants in this action. UHG, the
15 other Defendants, and their affiliates have offices in various locations throughout the
16 United States, including in the Central District of California. UHG offers a broad
17 spectrum of products and services through two distinct primary direct corporate
18 subsidiaries (each of which has numerous direct and indirect subsidiaries of its own):
19 (1) UnitedHealthcare, Inc., a health benefits (*i.e.*, insurance) company, and (2) Optum,
20 Inc., a health services company. Accordingly, UHG’s healthcare insurance products,
21 including those under Parts C and D of the Medicare Program, are offered by, and
22 UHG’s MA and PD Plans are managed by, various entities that are UHG’s direct or
23 indirect subsidiaries, including, but not limited to, the other Defendants identified below.
24 UHG controls all of these entities.

25 25. UHG and its direct and indirect subsidiaries and affiliates operate MA
26 Organizations in all fifty states and the District of Columbia. Each of these MA
27 Organizations offers one or more MA Plans, that is, one or more packages of healthcare
28 insurance benefits under Part C of the Medicare Program. Many, if not all, of these MA

1 Organizations also offer PD Plans, that is, drug benefit packages under Part D of the
2 Medicare Program. As of December 31, 2008, UHG had approximately 1.5 million
3 Medicare beneficiaries enrolled in its MA Plans under Part C of the Medicare Program
4 and millions of additional beneficiaries enrolled in its PD Plans. As of December 31,
5 2009, UHG had approximately 1.8 million Medicare beneficiaries enrolled in its MA and
6 millions of additional beneficiaries enrolled in its PD Plans. As of December 31, 2010,
7 UHG had approximately 2.1 million beneficiaries in its MA Plans and millions of
8 additional beneficiaries in its PD Plans. As of December 31, 2011, UHG had 2.2 million
9 beneficiaries in its MA Plans and millions of additional beneficiaries in its PD Plans. As
10 of December 31, 2012, UHG had approximately 2.6 million beneficiaries in its MA
11 Plans and millions of additional beneficiaries in its PD Plans. In 2013, 2014, and 2015
12 United had approximately 3 million beneficiaries in its MA Plans and approximately 8
13 million in its PD Plans. In 2016, UHG had approximately 3.6 million beneficiaries in its
14 MA Plans, and approximately 8.6 million beneficiaries in its PD Plans. Annually,
15 UHG's revenues from the MA Program have been in the tens of billions of dollars.

16 26. All Defendant MA Organizations entered into one or more agreements with the
17 Government during the relevant time period to offer MA Plans and/or PD Plans to
18 Medicare beneficiaries under Parts C and D of the Medicare Program, presented or had
19 the UHG Managing Defendants present on their behalf claims to the Government for risk
20 adjustment payments under Parts C and D of the Medicare Program, submitted or had
21 the UHG Managing Defendants submit on their behalf one or more Risk Adjustment
22 Attestations to the Government for risk adjustment payments from the Medicare
23 Program, and received risk adjustment payments from the Government. These
24 Defendant MA Organizations include all MA Organizations acquired, owned, and
25 controlled directly or indirectly by UHG after 2005, including:

26 a. AmeriChoice of New Jersey, Inc., a New Jersey corporation, doing
27 business as AmeriChoice Personal Care Plus and UnitedHealthcare Community
28 Plan.

1 b. Arizona Physicians IPA, Inc., an Arizona corporation, doing business
2 as APIPA Personal Care Plus and UnitedHealthcare Community Plan.

3 c. Care Improvement Plus of Maryland, Inc., which is or was a
4 Maryland corporation, doing business as Care Improvement Plus.

5 d. Care Improvement Plus of Texas Insurance Company, which is a
6 Texas insurance company, doing business as Care Improvement Plus.

7 e. Care Improvement Plus South Central Insurance Co., which is an
8 Arkansas insurance company, doing business as Care Improvement Plus and
9 UnitedHealthcare.

10 f. Care Improvement Plus Wisconsin Insurance Company, which is a
11 Wisconsin insurance company, doing business as Care Improvement Plus and
12 UnitedHealthcare.

13 g. Optum Insurance Co., which is an Ohio corporation.

14 h. Citrus Health Care, Inc., which is or was a Florida corporation.

15 i. Health Plan of Nevada, Inc., which is a Nevada corporation.

16 j. Medica HealthCare Plans, Inc., which is a Florida corporation.

17 k. Oxford Health Plans (CT), Inc., which is a Connecticut corporation,
18 doing business as AARP MedicareComplete from SecureHorizons; Oxford
19 Medicare Advantage; SecureHorizons; SecureHorizons by UnitedHealthCare; and
20 UnitedHealthcare.

21 l. Oxford Health Plans (NJ), Inc., which is a New Jersey corporation,
22 also known as Oxford Health Plans of New Jersey, Inc., doing business as AARP
23 MedicareComplete from SecureHorizons; AARP MedicareComplete provided by
24 SecureHorizons; Evercare; Evercare by UnitedHealthcare; Evercare Health Plans;
25 Evercare Plan H; SecureHorizons; SecureHorizons by UnitedHealthCare; and
26 UnitedHealthcare.

1 m. Oxford Health Plans (NY), Inc. which is a New York corporation,
2 doing business as Oxford Medicare Advantage; SecureHorizons; SecureHorizons
3 by UnitedHealthcare; and UnitedHealthcare.

4 n. PacifiCare Life and Health Insurance Company, which is an Indiana
5 insurance company, doing business as SecureHorizons Direct and SecureHorizons
6 MedicareDirect.

7 o. PacifiCare of Arizona, Inc., which is an Arizona corporation doing
8 business as SecureHorizons Medicare Advantage Plan; SecureHorizons by
9 UnitedHealthcare; and UnitedHealthcare.

10 p. PacifiCare of Colorado, Inc., which is a Colorado corporation doing
11 business as AARP MedicareComplete from Secure Horizons; AARP
12 MedicareComplete provided by SecureHorizons; Secure Horizons Medicare
13 Advantage Plan; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

14 q. PacifiCare of Nevada, Inc., which is a Nevada corporation, also
15 known as PacifiCare/UHC of Nevada, doing business as AARP
16 MedicareComplete provided by SecureHorizons; PacifiCare/UHC of Nevada;
17 Secure Horizons Medicare Advantage Plan; SecureHorizons by UnitedHealthcare;
18 and UnitedHealthcare.

19 r. Physicians Health Choice of Texas, LLC, which is a Texas limited
20 liability company doing business as Physicians Health Choice.

21 s. Preferred Care Partners, Inc., which is a Florida corporation doing
22 business as UnitedHealthcare.

23 t. Rocky Mountain Health Maintenance Organization, Inc., which is a
24 Colorado company.

25 u. Sierra Health and Life Insurance Company, Inc., which is a Nevada
26 corporation doing business as Erickson Advantage and UnitedHealthcare.

27 v. Symphonix Health Insurance, Inc., which is an Illinois insurance
28 company doing business as Symphonix Health.

1 w. UnitedHealthcare of California, Inc., which is a California
2 corporation, also known as UHC of California, Inc. and formerly known as
3 PacifiCare of California, Inc. and PacifiCare of California/Secure Horizons, doing
4 business as SecureHorizons by UnitedHealthcare, Secure Horizons Medicare
5 Advantage Plan, and UnitedHealthcare.

6 x. Unison Health Plan of Tennessee, Inc., which is a Tennessee
7 corporation doing business as Unison Advantage and UnitedHealthcare
8 Community Plan.

9 y. United Health Care Ins. Co. and United New York, which is a New
10 York insurance company doing business as UnitedHealthcare.

11 z. UnitedHealthcare Benefits of Texas, Inc., which is a Texas
12 corporation, formerly known as PacifiCare of Texas, Inc., doing business as
13 SecureHorizons Medicare Advantage Plan; SecureHorizons by UnitedHealthcare;
14 and UnitedHealthcare.

15 aa. UnitedHealthcare Community Plan of Ohio, Inc., which is an Ohio
16 corporation, formerly known as Unison Health Plan of Ohio, Inc., doing business
17 as Unison Advantage and UnitedHealthcare Community Plan.

18 bb. UnitedHealthcare Community Plan of Texas, L.L.C., which is a
19 Texas limited liability company, formerly known as Evercare of Texas, LLC,
20 doing business as Evercare by UnitedHealthcare and Evercare Health Plans; and
21 UnitedHealthcare.

22 cc. UnitedHealthcare Community Plan, Inc., which is a Michigan
23 corporation, also known as Great Lakes Health Plan, Inc. and UnitedHealthcare of
24 the Great Lakes Health Plan, Inc., doing business as Great Lakes Personal Care
25 Plus and UnitedHealthcare Community Plan.

26 dd. UnitedHealthcare Insurance Company, which is a Connecticut
27 insurance company, also known as United Healthcare Insurance Company, doing
28 business as AARP MedicareComplete from SecureHorizons; Erickson Advantage;

1 Evercare by UnitedHealthcare; Evercare Health Plans; Evercare Senior Care
2 Options; SecureHorizons; SecureHorizons by UnitedHealthcare; SecureHorizons
3 MedicareDirect; United Health Group; UnitedHealthcare; and UnitedHealthcare
4 Community Plan.

5 ee. UnitedHealthcare Insurance Company of New York, which is a New
6 York insurance company, also known as United Healthcare Insurance Company of
7 New York, doing business as SecureHorizons; SecureHorizons MedicareDirect;
8 SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

9 ff. UnitedHealthcare of Alabama, Inc., which is an Alabama
10 corporation, also known as United HealthCare of Alabama, Inc., doing business as
11 SecureHorizons; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

12 gg. UnitedHealthcare of Arizona, Inc., which is an Arizona corporation,
13 also known as United HealthCare of Arizona, Inc., doing business as
14 SecureHorizons; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

15 hh. UnitedHealthcare of Arkansas, Inc., which is an Arkansas
16 corporation, also known as United Healthcare of Arkansas, Inc., doing business as
17 SecureHorizons; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

18 ii. UnitedHealthcare of Florida, Inc., which is a Florida corporation, also
19 known as United Healthcare of Florida, Inc. doing business as AmeriChoice;
20 Evercare at Home; SecureHorizons; SecureHorizons by UnitedHealthcare; and
21 UnitedHealthcare.

22 jj. UnitedHealthcare of Georgia, Inc., which is a Georgia corporation,
23 also known as United Healthcare of Georgia, Inc., doing business as
24 SecureHorizons; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

25 kk. UnitedHealthcare of New England, Inc., which is a Rhode Island
26 corporation, also known as United HealthCare of New England, Inc. and United
27 Health Plans of New England, Inc., doing business as AARP MedicareComplete
28

1 provided by SecureHorizons; AARP MedicareComplete from SecureHorizons;
2 SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

3 ll. UnitedHealthcare of New York, Inc., which is a New York
4 corporation, also known as AmeriChoice of New York, Inc. and United
5 Healthcare of New York, Inc. doing business as AmeriChoice Personal Care Plus;
6 SecureHorizons; SecureHorizons by UnitedHealthcare; UnitedHealthcare; and
7 UnitedHealthcare Community Plan.

8 mm. UnitedHealthcare of North Carolina, Inc., which is a North Carolina
9 corporation, also known as United Healthcare of North Carolina, Inc., doing
10 business as SecureHorizons; SecureHorizons by UnitedHealthcare, and
11 UnitedHealthcare.

12 nn. UnitedHealthcare of Ohio, Inc., which is an Ohio corporation, also
13 known as United Healthcare of Ohio, Inc., doing business as SecureHorizons,
14 SecureHorizons by UnitedHealthcare, and UnitedHealthcare.

15 oo. UnitedHealthcare of Oklahoma, Inc., which is an Oklahoma
16 corporation, formerly known as PacifiCare of Oklahoma, Inc., doing business as
17 Secure Horizons Medicare Advantage Plan; SecureHorizons by UnitedHealthcare,
18 and UnitedHealthcare.

19 pp. UnitedHealthcare of Oregon, Inc., which is an Oregon corporation,
20 formerly known as PacifiCare of Oregon, Inc., doing business as AARP
21 MedicareComplete from SecureHorizons; AARP MedicareComplete provided by
22 SecureHorizons; SecureHorizons Medicare Advantage Plan; SecureHorizons by
23 UnitedHealthCare; and UnitedHealthcare.

24 qq. UnitedHealthcare of Pennsylvania, Inc., which is a Pennsylvania
25 corporation, formerly known as Unison Health Plan of Pennsylvania, Inc., doing
26 business as Unison Advantage; UnitedHealthcare Community Plan; and
27 UnitedHealthcare.
28

1 rr. UnitedHealthcare of Tennessee, Inc., which is a Tennessee
2 corporation, also known as United Healthcare of Tennessee, Inc., doing business
3 as AARP MedicareComplete from SecureHorizons; AARP MedicareComplete
4 provided by SecureHorizons; SecureHorizons; and SecureHorizons by
5 UnitedHealthcare.

6 ss. UnitedHealthcare of the Midlands, Inc., which is a Nebraska
7 corporation, also known as United Healthcare of the Midlands, Inc., doing
8 business as SecureHorizons by UnitedHealthcare and UnitedHealthcare.

9 tt. UnitedHealthcare of the Midwest, Inc., which is a Missouri
10 corporation, also known as United Healthcare of the Midwest, Inc., doing business
11 as SecureHorizons; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

12 uu. UnitedHealthcare of Utah, Inc., which is a Utah corporation, also
13 known as United Healthcare of Utah, Inc., doing business as SecureHorizons;
14 SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

15 vv. UnitedHealthcare of Washington, Inc., which is a Washington
16 corporation, formerly known as PacifiCare of Washington, Inc., doing business as
17 AARP MedicareComplete from SecureHorizons; Secure Horizons Medicare
18 Advantage Plan; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.

19 ww. UnitedHealthcare of Wisconsin, Inc., which is a Wisconsin
20 corporation, also known as United Healthcare of Wisconsin, Inc. doing business as
21 SecureHorizons; SecureHorizons by UnitedHealthcare; UnitedHealthcare
22 Community Plan; UnitedHealthcare Personal Care Plus; and UnitedHealthcare.

23 xx. UnitedHealthcare Plan of the River Valley, Inc., which is an Illinois
24 corporation, also known as United Healthcare Plan of the River Valley, Inc.,
25 UnitedHealth Care Plan of the River Valley, Inc., and United HealthCare of the
26 River Valley, Inc., doing business as AmeriChoice Secure Plus Complete;
27 SecureHorizons by UnitedHealthcare; UnitedHealthcare; and UnitedHealthcare
28 Community Plan.

1 yy. Any other MA Organizations acquired, owned, or controlled by UHG
2 since 2005.

3 27. Defendant United HealthCare Services, Inc. (“United HealthCare Services”) is a
4 Minnesota corporation. It is a direct subsidiary of Defendant UHG. United HealthCare
5 Services is the successor to PacifiCare Health Systems and PacifiCare Health Plan
6 Administrators, Inc., which managed some of the Defendant MA Organizations. *See*
7 *infra* paragraph 37. As previously stated, United HealthCare Services also employed
8 Relator Poehling and, on information and belief, employed other individuals who held
9 titles and positions within the other UHG Managing Defendants and who performed
10 work on behalf of the Defendant MA Organizations.

11 28. Defendant Ovations, Inc. (“Ovations”) is a Delaware corporation. It is a direct
12 subsidiary of Defendant United HealthCare Services and an indirect subsidiary of
13 Defendant UHG. Until approximately 2010, one or more of the groups that managed
14 some of the Defendant MA Organizations were located within Defendant Ovations.

15 29. Defendant UnitedHealthcare, Inc. (“UnitedHealthcare”) is a Delaware corporation,
16 and a direct subsidiary of Defendant UHG. UnitedHealthcare is the UHG business entity
17 which owns, operates, and offers health insurance plans to governmental customers.
18 Various UnitedHealthcare subsidiaries operate health benefit plans and provide
19 healthcare benefits to millions of Medicare beneficiaries under the MA Program.
20 UnitedHealthcare also is the UHG subsidiary which contracts (through its subsidiaries)
21 with the Government to provide insurance benefits to MA beneficiaries, submits the
22 annual Risk Adjustment Attestations to the Government, submits claims for payment to
23 the Government, and receives payment from the Government.

24 30. Defendants Optum, Inc. and OptumInsight, Inc. are health services companies.
25 They are Delaware corporations. They are direct or indirect subsidiaries of Defendant
26 UHG. In 2011, OptumInsight became the successor to Ingenix, Inc. (“Ingenix”).
27 Thereafter, OptumInsight operated as part of Optum. For the purposes of this Amended
28 Complaint, Optum, Inc. and OptumInsight, Inc. will be referred to as “Optum.”

1 Furthermore, to the extent that the United States is uncertain whether an act or statement
2 is attributable to Ingenix or its successor, Optum, the United States will refer to the entity
3 as “Ingenix/Optum.” Since 2007, the group within Ingenix and then Optum that
4 performed risk adjustment-related work had various names. For purposes of this
5 Amended Complaint, it is referred to as the “Risk Adjustment Group.”

6 31. Defendants United HealthCare Services, Ovations, UnitedHealthcare, and Optum
7 (and Optum’s predecessor, Ingenix) are or were “Related Entities” under the federal
8 regulations that govern the MA Program. As explained more fully below, each of them
9 has or had its own legal obligations to the MA Program relating to, among other things,
10 the submission of valid risk adjustment data and the deletion or withdrawal of invalid
11 data.

12 32. The Defendant MA Organizations were not autonomous and do not appear to have
13 had any management or any other employees who ran them or had any decision-making
14 authority (if they had any of their own management or employees at all). Instead, UHG
15 had various groups that managed and had oversight responsibilities and decision-making
16 authority for the Defendant MA Organizations. At various times relevant to this
17 Amended Complaint, these groups were located within Defendants United HealthCare
18 Services (and/or its predecessors), Ovations, and UnitedHealthcare. Depending on the
19 time period, the groups were known by the names Secure Horizons, Evercare, the Public
20 & Senior Markets Group (“PSMG”), the Public Sector Market Group (also “PSMG”),
21 Ovations, Ovations Part D, and AmeriChoice. Prior to approximately 2010, these groups
22 were located in Defendants United HealthCare Services (and/or its predecessors) and
23 Ovations. Since approximately 2010, these groups have been located within Defendant
24 UnitedHealthcare and are referred to as UnitedHealthcare Medicare & Retirement and
25 UnitedHealthcare Community & State. Among other things, these groups oversaw risk
26 adjustment-related activities such as the submission of risk adjustment data (including
27 diagnoses) to the Government on behalf of the Defendant MA Organizations, the
28 retraction of invalid data that they had submitted to the Government on behalf of the

1 Defendant MA Organizations, and the Chart Review, Claims Verification, and RACCR
2 Programs that they had conducted on behalf of the Defendant MA Organizations. As
3 explained more fully below, Defendants United HealthCare Services (and/or its
4 predecessors), Ovations, UnitedHealthcare, and any other UHG entities in which these
5 groups may have been located are “Related Entities” with their own legal obligations
6 relating to, among other things, the submission of valid risk adjustment data to the
7 Government and the deletion or withdrawal of invalid data.

8 33. Starting in 2007, the actual risk adjustment data submission work was performed
9 by the Risk Adjustment Group within Ingenix and then within Ingenix’s successor,
10 Optum. First Ingenix and then Optum operated a computer system called the Internal
11 Risk Adjustment Data System (“IRADS”) that electronically submitted risk adjustment
12 data (that is, diagnoses) to CMS’ Risk Adjustment Processing System (“RAPS”) in order
13 for the Defendant MA Organizations to claim and receive risk adjustment payments. In
14 addition, Ingenix and then Optum helped to manage the Chart Review, Claims
15 Verification, and RACCR Programs and performed the day-to-day activities necessary to
16 conduct these programs. Ingenix and then Optum performed activities relating to the
17 submission of risk adjustment data and operated the various risk adjustment-related
18 programs from offices in this District and elsewhere.

19 34. Similar to the other UHG Managing Defendants, Ingenix was and Optum is a
20 “Related Entity” because Ingenix was and Optum is related to the Defendant MA
21 Organizations by common ownership or control through Defendant UHG and performed
22 some or all of the management functions for the Defendant MA Organizations. As
23 previously explained, Optum is one of the “UHG Managing Defendants” because of the
24 role that it (and its predecessor, Ingenix) played in managing the Defendant MA
25 Organizations during the relevant time period. Any reference in this Amended
26 Complaint to the predecessors of the UHG Managing Defendants includes Ingenix.

27 35. Ingenix and then Optum also performed risk adjustment-related services for third-
28 parties which owned and operated their own MA Organizations and offered their own

1 Plans. The UHG Managing Defendants referred to these third-parties as Ingenix's and
2 then Optum's commercial clients. Ingenix and then Optum submitted risk adjustment
3 data to the Government on behalf of these commercial clients and conducted Chart
4 Review and other programs for them. Ingenix and then Optum performed this risk
5 adjustment-related work for commercial clients from offices in this District and
6 elsewhere.

7 36. UHG became the largest owner of MA Organizations in large part by acquiring
8 them. For example, in 2005, UHG (directly or through a subsidiary) acquired PacifiCare
9 Health Systems ("PacifiCare") and PacifiCare's and its affiliates' MA Organizations and
10 MA Plans, including the following MA Organization Defendants: PacifiCare of
11 Arizona, Inc., incorporated in Arizona; PacifiCare of California, incorporated in
12 California; PacifiCare of Colorado, Inc., incorporated in Colorado; PacifiCare of
13 Nevada, Inc., incorporated in Nevada; PacifiCare of Oklahoma, Inc., incorporated in
14 Oklahoma; PacifiCare of Oregon, Inc., incorporated in Oregon; PacifiCare of Texas, Inc.
15 incorporated in Texas; and PacifiCare of Washington, incorporated in Washington. Both
16 before and after the acquisition, PacifiCare of California and possibly other PacifiCare
17 MA Organizations and MA Plans referred to themselves or to their brand of MA Plans as
18 Secure Horizons. Since 2005, these PacifiCare MA Organizations have been indirect
19 subsidiaries of and controlled by UHG. Several years after the acquisition, these
20 PacifiCare plans were renamed or rebranded as UnitedHealthcare MA Organizations or
21 merged into other UHG MA Organizations. For instance, in 2011, PacifiCare of
22 California became Defendant UnitedHealthcare of California.

23 37. Defendant United HealthCare Services is the successor of PacifiCare Health
24 Systems and PacifiCare Health Plan Administrators, Inc., which were the direct or
25 indirect parents of the PacifiCare MA Organizations acquired by UHG in 2005. United
26 HealthCare Services became their successor sometime after the acquisition. For a short
27 period of time after the acquisition, PacifiCare Health Systems (and possibly also
28 PacifiCare Health Plan Administrators) was involved in the management of the

1 PacifiCare MA Organizations and perhaps other Defendant MA Organizations, including
2 the management of risk adjustment-related activities. All PacifiCare MA Organizations
3 and other entities and their successors were direct or indirect subsidiaries of Defendant
4 UHG. Any reference in this Amended Complaint to United HealthCare Services or the
5 UHG Managing Defendants includes PacifiCare Health Systems and PacifiCare Health
6 Plan Administrators.

7 38. Before UHG's acquisition of PacifiCare, the PacifiCare employees with
8 responsibilities relating to the submission of risk adjustment data to the Government and
9 responsibilities relating to other risk adjustment-related activities worked at a PacifiCare
10 office in Cypress, California, within this District. Sometime after the acquisition, this
11 office moved to Santa Ana, California, within this District, and continued to submit
12 claims and perform other risk adjustment-related activities. In 2007, the employees in
13 this Risk Adjustment Group in this District became employees of Ingenix and then they
14 became employees of Optum in 2011. A substantial part of the events or omissions
15 relevant to this litigation occurred at these and other locations within this District.

16 39. As an example of UHG's other acquisitions, UHG (directly or through a
17 subsidiary) acquired WellMed Medical Management, Inc. ("WMMI") in 2011. UHG's
18 acquisition of WMMI included its subsidiaries and affiliates, including, but not limited
19 to, WMMI's MA Organizations and MA Plans, Physician's Health Choice of Texas,
20 LLC and Citrus Health Care, Inc., which operated in Texas, Florida, New Mexico and
21 Arkansas. Citrus Health Care, Inc. was a Florida corporation and a subsidiary of PHC
22 Holdings of Florida, Inc. Sometime after the acquisition, UHG renamed or rebranded
23 these MA Organizations and MA Plans as UHG MA Organizations or MA Plans or
24 merged them with or into UHG's other MA Organizations or MA Plans in these states.

25 40. Over the last decade, UHG and its subsidiaries have also sought to vertically
26 integrate in the health care market by acquiring and/or operating large groups or
27 networks of direct providers of healthcare services and other entities that manage the
28 provision of such services to beneficiaries enrolled in the Defendant MA Organizations'

1 MA Plans. For example, UHG vertically integrated in several States when it acquired
2 WMMI in 2011. For many years, WMMI had subsidiaries and other affiliates that
3 directly managed the provision of or directly provided healthcare services. These
4 affiliates included WellMed Networks, Inc., WellMed Networks Inc. of Florida,
5 WellMed Medical Management of Florida Inc., and WellMed Medical Group, PA. After
6 the acquisition, WellMed became part of the group called OptumCare. After the
7 acquisition, WellMed also significantly expanded by acquiring more than 50 medical
8 practices in Texas and Florida. WellMed included more than 10,000 physicians that
9 provided healthcare to hundreds of thousands of Medicare beneficiaries in Texas and
10 Florida, including beneficiaries enrolled in Plans owned or operated by one or more
11 Defendant MA Organizations.

12 41. All references to “Defendants” in this Complaint include all of the Defendants
13 identified above.

14 **DEFENDANTS’ EXECUTIVES AND OTHER EMPLOYEES**

15 42. When the job titles of Defendants’ executives and other employees are provided in
16 this Amended Complaint, the United States, based on its best knowledge and belief, has
17 provided their titles at the time relating to the facts alleged. As a reference, the United
18 States also provides, based on its best knowledge and belief, the following list of the job
19 titles of Defendants’ executives and other employees who are referenced in this
20 Amended Complaint and the names of the specific business divisions or entities for
21 which they worked during the time period that they were involved in matters relevant to
22 this action (in alphabetical order by last name):

- 23 • Kyle Anderson – From 2009 to 2015, Anderson was the Director of Financial
24 Planning and Analysis at UnitedHealthcare.
- 25 • Jason Bainbridge – Bainbridge worked for UnitedHealthcare Community & State
26 in 2012.
- 27 • Paul Balthazor – From 2011 through 2015, Balthazor was the Chief Financial
28 Officer of UnitedHealthcare Community & State.

- 1 • Marc Beckmann – Beckmann worked for UnitedHealthcare Medicare &
2 Retirement in the Finance-Risk Adjustment Analysis Section.
- 3 • Paul Bihm – At PacifiCare, Bihm was a Vice President and Chief of Staff. After
4 the acquisition, he worked for Ingenix as Chief Financial Officer and Chief
5 Operating Officer from 2007 to 2010 and then for Optum’s Risk Adjustment
6 Group as a Senior Vice President of Client Management.
- 7 • Jon Bird – In 2008, Bird was hired to work for Ingenix’s Risk Adjustment Group.
8 In 2010, he became the Director of Revenue Projections for this group. In or
9 about 2011, when the Risk Adjustment Group was moved to Optum, Bird became
10 an employee of Optum. In or about 2013, Bird assumed significant responsibility
11 for the Chart Review and Claims Verification Programs. He was also a “decision
12 maker” for the Claims Verification and RACCR Programs and a member of
13 United’s Risk Adjustment Advisory Board/Council, which was chaired by
14 Defendant UHG’s Chief Executive Officer Steve Hemsley. By at least March
15 2014, Bird was the Senior Vice President of Risk and Quality Analytics at Optum.
- 16 • Gail Boudreaux – In 2008, Boudreaux became the Executive Vice President of
17 UnitedHealthcare. From 2011 to 2014, she was the Chief Executive Officer of
18 UnitedHealthcare. During Boudreaux’s time as Chief Executive Officer of
19 UnitedHealthcare, Steve Nelson, John Larsen, and Daniel Schumacher reported to
20 her. She reported to Steve Hemsley. According to a 2011 document, Boudreaux
21 was “significantly involved in the oversight and management of”
22 UnitedHealthcare’s “Medicare business.”
- 23 • Tracey Bradberry – From 2008 through 2012, Bradberry was an Operations
24 Manager at Ingenix. Since 2012, she has been an Associate Director of
25 Operations at Optum. In that role, she leads diagnosis coding teams for the Chart
26 Review Program.
- 27 • Patty Brennan – In 2008, Brennan was hired to work for Ingenix’s Risk
28 Adjustment Group. She was hired as Ingenix’s Compliance Manager for Risk

Adjustment Programs. In 2009, Brennan became the Ingenix Director of Retrospective Services relating to risk adjustment. In or about 2011, when the Risk Adjustment Group was moved to Optum, Brennan became an employee of Optum. From 2009 to 2013, Brennan oversaw the Chart Review Program. In 2013, she became the Vice President of Retrospective Services. Brennan, along with other individuals, was responsible for the development and execution of the Internal Data Validation Program, the RACCR Program, and the Claims Verification Program. She was also the Program Manager for the Claims Verification Program for several years and had strategic oversight over the RACCR Program from 2009 to 2013.

- Jonathon Bunker – In 2009, Bunker was the President of Sierra Health and Life Insurance Company, Inc. and the President of Health Plan of Nevada, Inc. Upon the close of the merger between UHG and Sierra Health Services, Bunker was the Chief Executive Officer of the southwest region of UnitedHealthcare.
- Barbara Carlson – In 2011, Carlson was a Senior Regulatory Affairs Analyst at the Regulatory Affairs Department at UnitedHealthcare Medicare & Retirement.
- Shelly Cranley – Cranley served as the Director of Regulatory Affairs for UnitedHealthcare.
- Keith Dobbins – Since 2006, Dobbins has been UnitedHealthcare's Deputy General Counsel.
- Juliet Domb – From 2012 to 2015, Domb was a Strategic Relationship Analyst at Optum. She has also served as an administrative assistant to Larry Renfro.
- Jeffrey Dumcum – At PacifiCare, Dumcum was the Chief Financial Officer. After the acquisition, he became a Vice President of Finance for Ovations. In 2007, Dumcum became a Senior Vice President at Ingenix and oversaw the Risk Adjustment Group at Ingenix and then Optum until approximately 2014.
- Karen Erickson – Since 2011, Erickson has been an Executive Vice President and the Chief Quality Officer at Optum. In this role, Erickson has reported to the

1 Chief Executive Officer of Optum, Larry Renfro. Also in 2011, Erickson was the
2 Chief Administrative Officer of Optum, and prior to that she worked for Optum
3 for 12 years in various financial and administrative roles.

- 4 • Ronnie Grower – From 2008 to 2010 Grower was a Vice President of Market
5 Consultation and a Vice President of Account Management at Ingenix.
- 6 • Joseph Haferman – Haferman was the Chief Financial Officer of Ovations in 2005
7 and the Chief Financial Officer of Secure Horizons in 2007 and possibly for some
8 time thereafter. Relator Poehling reported to Haferman from early 2007 to late
9 2008.
- 10 • Kimberly Halva – In 2009, Halva was an attorney for UnitedHealthcare Medicare
11 & Retirement. From 2010 to 2013, Halva was the UnitedHealthcare Medicare &
12 Retirement’s Finance Compliance Officer. She also had the title Director of
13 Compliance. From 2010 to 2103, she reported to Jennifer O’Brien.
- 14 • Mary Hammond – From 2010 to 2013, Hammond was an Associate Director of
15 Strategy and Support who worked for the risk adjustment team at
16 UnitedHealthcare Medicare & Retirement. She reported to Relator Poehling until
17 he left at the end of 2012.
- 18 • Charles Hanson – From 2008 to 2013, Hanson was a Vice President of
19 Underwriting and Finance at UnitedHealthcare Medicare & Retirement.
- 20 • Steve Hemsley – Hemsley is currently the Executive Chairman of UHG’s Board
21 of Directors. He was the Chief Executive Officer of UHG from 2006 to 2017.
22 According to a 2011 document, Hemsley was “significantly involved in the
23 oversight and management of” UHG’s “Medicare business.”
- 24 • James Higgins – Higgins was the Finance Director at PacifiCare. After the
25 acquisition, Higgins became a Director for Revenue Analytics.
- 26 • William Hnath – Hnath was the financial controller for UnitedHealthcare
27 Medicare & Retirement.

- 1 • Pam Holt – Holt was a Project Manager for Network Management Operations at
2 PacifiCare. After the acquisition, she became a Manager of Provider Outreach for
3 the Risk Adjustment Program.
- 4 • Scott Hughes – Starting in mid-2012, Hughes was a Senior Project Manager at
5 Optum.
- 6 • Michael Jacobson – Jacobson was a Program Business Analyst/Project Manager at
7 Optum.
- 8 • Donald James – James was a Director of Program Strategy at Optum from 2012 to
9 2015.
- 10 • Thad Johnson – Johnson is an attorney for UnitedHealthcare and is the current
11 Chief Legal Officer for the company.
- 12 • Joseph Keen – Keen was a Vice President and Chief Compliance Audit Officer for
13 UnitedHealthcare Medicare & Retirement in 2011.
- 14 • Gerald (Jerry) Knutson – Knutson was the Chief Financial Officer of Ovations
15 from 2003 to 2009 and the Chief Financial Officer of OptumInsight from 2009 to
16 2012.
- 17 • John Larsen – Larsen was the Chief Financial Officer of UnitedHealthcare
18 Medicare & Retirement (previously called Ovations-PSMG) until 2010, when
19 Scott Theisen succeeded him in that position. Larsen reported to Larry Renfro
20 when Renfro was the Chief Executive Officer of Ovations-PSMG. Relator
21 Poehling reported to Larsen in 2010. In August 2012, Larsen became the Chief
22 Executive Officer of UnitedHealthcare Medicare & Retirement. In early 2014,
23 Steve Nelson took over that position.
- 24 • Pam Leal – Leal was the Executive Director of Provider Training and
25 Development at PacifiCare. After the acquisition, she became a Regional Vice
26 President for Market Consultation at Ingenix.
- 27 • Rebecca Martin – In 2010, Martin became the Director of Encounter Operations at
28 Ingenix. From 2011 to 2015, Martin was the Director of Data Remediation at

1 Optum. In 2015, she became the Director of Data Management Strategies at
2 Optum.

- 3 • Jay Matushak – From 2013 to 2015, Matushak was a Vice President of Financial
4 Planning and Analysis for UnitedHealthcare Medicare & Retirement. He reported
5 to Brian Thompson.
- 6 • Michael McCarthy – Starting in November 2011, McCarthy was the Executive
7 Director of UnitedHealthcare Medicare & Retirement. In 2013, he also served as
8 a Regional Vice President for Southern California for UnitedHealthcare Medicare
9 Solutions.
- 10 • Marybeth Meyer – Since 2013, Meyer has been a Vice President of Operations at
11 UnitedHealthcare Medicare & Retirement where she oversees risk adjustment
12 programs and activities. Meyer reported to Theisen and then to Brian Thompson.
- 13 • Bill Miller – Miller was the Chief Executive Officer of OptumInsight from 2012
14 to 2017.
- 15 • Eric Murphy – Murphy was the President of Payer Solutions at Optum.
- 16 • Randall Myers – Myers worked for PacifiCare and, after the acquisition, for
17 Ingenix and then Optum as a Director of Encounter Operations.
- 18 • Timothy Noel – Noel was the Vice President of Finance for Ovations and then
19 UnitedHealthcare Medicare & Retirement from 2007 to 2013 and reported to the
20 Chief Financial Officers of those groups. Poehling reported to Noel from the fall
21 of 2010 until his departure in December 2012.
- 22 • Steve Nelson – Since 2017, Nelson has been the Chief Executive Officer of
23 UnitedHealthcare. From 2014 to 2017, he was the Chief Executive Officer of
24 UnitedHealthcare Medicare & Retirement.
- 25 • Jennifer O’Brien – O’Brien was the Chief Medicare Compliance Officer of
26 Ovations and then UnitedHealthcare Medicare & Retirement. She reported to
27 David Orbuch. She was part of the UnitedHealthcare Medicare & Retirement
28 “Executive Leadership Team.”

- 1 • Karin O'Hara – O'Hara worked at UnitedHealthcare Community & State.
- 2 • David Orbuch – Orbuch was the Chief Compliance Officer for PSMG and
- 3 UnitedHealthcare Medicare & Retirement.
- 4 • Thomas Paul – In the 2009 to mid-2010 time period, Paul was the Chief Executive
- 5 Officer and Chief Operating Office of Ovations and, in the mid-2010 to August
- 6 2012 time period, Paul was the Chief Executive Officer of UnitedHealthcare
- 7 Medicare & Retirement. He reported to Renfro and then to Gail Boudreaux. He
- 8 was part of the UnitedHealthcare Medicare & Retirement "Executive Leadership
- 9 Team."
- 10 • Karen Petroff – Petroff was the Senior Vice President of Business Development at
- 11 Optum.
- 12 • Cindy Polich – Polich was the President of Ovations and then UnitedHealthcare
- 13 Medicare & Retirement. She reported to Larry Renfro and Thomas Paul. She was
- 14 part of the UnitedHealthcare Medicare & Retirement "Executive Leadership
- 15 Team."
- 16 • Patricia Rasmussen – Rasmussen was Manager of Encounter Submissions at
- 17 Ingenix.
- 18 • Janice Redmond – Prior to 2012, Redmond was Senior Vice President of Provider
- 19 Outreach at Optum. Since 2012, Redmond has been a Vice President of Market
- 20 Consultation for Optum's Western Region.
- 21 • Anne Reis – In 2013, Reis was an Associate Director of Revenue for
- 22 UnitedHealthcare Medicare & Retirement.
- 23 • Larry Renfro – During the 2009 to 2011 time period, Renfro served in various
- 24 roles, including the Executive Vice President of Defendant UHG, the Chief
- 25 Executive Officer of Defendant Ovations, and the Chief Executive Officer of the
- 26 Public & Senior Markets Group. Since July 2011, Renfro has been the current
- 27 Chief Executive Officer of Defendant Optum. Since November 2014, he has also
- 28 been Vice Chairman of Defendant UHG.

- 1 • Sandy Rick – Rick was a Senior Regulatory Affairs Analyst at UnitedHealthcare
2 Medicare & Retirement.
- 3 • Kara Rios – Rios was the Chief Financial Officer of AmeriChoice, one of the
4 groups that managed some of the Defendant MA Organizations.
- 5 • Justin Roth – Roth was the Chief Financial Officer of Evercare, one of the groups
6 that managed some of the Defendant MA Organizations.
- 7 • Daniel Schumacher – Since 2017, Schumacher has been the President and Chief
8 Operating Officer of UnitedHealthcare. Prior to that, he was the Chief Financial
9 Officer of UnitedHealthcare.
- 10 • Melissa Sedor – Sedor worked in UnitedHealthcare’s controller’s office, in the
11 area of revenue accounting. Sedor was an accounting manager and reported to
12 Bill Hnath, the controller for UnitedHealthcare Medicare & Retirement.
- 13 • Matt Shors – Shors is UHG’s Senior Deputy General Counsel.
- 14 • Marianne Short – Short is UHG’s Executive Vice President and Chief Legal
15 Officer.
- 16 • Andy Slavitt – Slavitt was the Chief Executive Officer for OptumInsight and an
17 Executive Vice President for Optum.
- 18 • Scott Theisen – From 2010 to 2013, Theisen was the Chief Financial Officer of
19 UnitedHealthcare Medicare & Retirement. In 2011, he was part of the
20 UnitedHealthcare Medicare & Retirement “Executive Leadership Team” reporting
21 to Tom Paul. In 2014, Theisen moved to Optum, but, during that year, his
22 responsibilities continued to include the risk adjustment-related work that Optum
23 performed for UnitedHealthcare Medicare & Retirement.
- 24 • Brian Thompson – Since 2017, Brian Thompson has been the Chief Executive
25 Officer of UnitedHealthcare Medicare & Retirement. From 2013 to 2017, he was
26 the Chief Financial Officer of UnitedHealthcare Medicare & Retirement. He was
27 also previously the Chief Financial Officer of UnitedHealthcare Community &
28 State.

- 1 • Carol Thompson – Until 2009, Carol Thompson was a National Manager for Risk
2 Adjustment Programs at Ingenix. From 2009 to 2011, she was a Manager of the
3 ChartSync operations (part of the Chart Review Program) at Ingenix. From 2011
4 to 2014, she was a Manager and Analyst of Encounter Operations at Optum.
- 5 • Pam Thomsen – Thomsen worked for Optum in Data Validation Operations and
6 Clinical Performance & Compliance.
- 7 • Lee Valenta – At various times, Valenta was the Chief Financial Officer, the Chief
8 Operating Officer, the President of Life Sciences, and an Executive Vice President
9 at Ingenix and then OptumInsight.
- 10 • Emily Vue – From 2009 to 2014, Vue was a Senior Regulatory Analyst and later a
11 Manager of Regulatory Affairs at Ovations-PSMG and then UnitedHealthcare.
- 12 • Karen Wagor – Wagor was the Manager of the National Medical Coder Team and
13 the National Coding Trainer at Ingenix and then Optum. She previously worked
14 at PacifiCare.
- 15 • David Walsh – In 2011, Walsh was the Director for Regulatory Affairs for and, in
16 2012, became the Senior Director of Regulatory Affairs for UnitedHealthcare
17 Medicare & Retirement.
- 18 • John Way – Way was Chief Financial Officer of Secure Horizons. Relator
19 Poehling reported to Way from late 2008 to early 2010.
- 20 • Christopher Webb – Webb worked with Payer Operations at Optum in 2014.
- 21 • Timothy Wicks – Wicks served in a senior management position at Optum.
- 22 • Stephanie Will – Will had been a Principal Analyst at PacifiCare. After the
23 acquisition, she joined Ovations as the Program Manager for the national Chart
24 Review Program. In 2007, she became the Vice President of Risk Adjustment
25 Programs at Ingenix.

THE MEDICARE PROGRAM

I. The Medicare Statute

43. Medicare is a federally-operated health insurance program administered by CMS. Medicare benefits individuals age 65 and older and the disabled. 42 U.S.C. § 1395c *et seq.* Parts A and B of the Medicare Program are known as “traditional” Medicare.

Medicare Part A covers inpatient and institutional care. Medicare Part B covers physician, hospital outpatient, and ancillary services and durable medical equipment.

44. Under Medicare Parts A and B, CMS reimburses healthcare providers (*e.g.*, hospitals and physicians) using what is known as a “fee-for-service” (“FFS”) payment system. Under an FFS payment system, healthcare providers submit claims to CMS for reimbursement for each service actually rendered, such as a physician office visit or a hospital stay. CMS then pays the providers directly for each service based on payment rates pre-determined by the Government.

45. Under Medicare Part C, Medicare beneficiaries can opt out of the traditional Medicare Program (Parts A and B) and instead enroll in MA Plans and receive health care services managed by those MA Plans. MA Plans must provide Medicare beneficiaries all the services that they are entitled to receive from the traditional Medicare Program.

46. Under Medicare Part D, Medicare beneficiaries can elect to enroll in either a Prescription Drug plan (known as a PD Plan) or an MA Plan that provides prescription drug coverage in addition to the physician office visit and hospital outpatient and inpatient coverage provided under Part C (known as an MAPD Plan). For simplicity, in this Amended Complaint, the Government refers to Parts C and D collectively as the MA Program and refers collectively to MA, PD, and MAPD Plans as Plans.

47. MA Organizations are “risk-bearing” entities that must be licensed by the State in which they are located. 42 C.F.R. §§ 422.2 & 422.503(b)(2). Each MA Organization agrees to bear the risk that the amount that it pays providers for the health services for a

1 particular beneficiary in one of its Plans may exceed the amount that it was paid to
2 insure the beneficiary.

3 48. Medicare beneficiaries who enroll in an MA, PD or MAPD Plan are considered
4 members of and enrollees in that Plan. In this Amended Complaint, the terms
5 beneficiaries, members, enrollees, and patients are used interchangeably, but mean the
6 same thing, that is, individuals enrolled in Plans.

7 49. MA Organizations' obligations to the MA Program and the requirements for them
8 to participate in the Program are set forth in federal regulations and, each year, the MA
9 Organizations must agree in writing to comply with those regulations and to other terms
10 and conditions in order to participate in the MA Program. 42 C.F.R. §§ 422.504 &
11 422.505 (Part C); 42 C.F.R. §§ 423.504 & 423.505 (Part D). In addition, MA
12 Organizations must comply with requirements set forth in statutes, such as the FCA, and
13 guidance documents, such as the Medicare Managed Care Manual, the Medicare
14 Prescription Drug Benefit Manual, the Risk Adjustment Participant Guides, and
15 Medicare Advantage operating instructions.

16 50. Related Entities include those entities that are related to an MA Organization by
17 common ownership or control and perform at least some of the MA Organization's
18 management functions. 42 C.F.R. §§ 422.2 & 422.500. As previously explained, the
19 UHG Managing Defendants are or were Related Entities.

20 51. First Tier Entities include those providers or provider groups that enter into a
21 written arrangement with an MA Organization to provide healthcare services to the
22 beneficiaries in the organization's Plan(s). 42 C.F.R. §§ 422.2 & 422.500. The capitated
23 providers in the RACCR Program were First Tier Entities.

24 52. The obligations of Related Entities and First Tier Entities to the MA Program are
25 also set forth in the MA Program regulations. Related Entities and First Tier Entities
26 must, among other things, (i) perform their services in a manner that complies with the
27 MA Organization's contractual obligations to the Government, *id.* at 422.504(i)(3)(iii);
28 agree to "comply with all applicable Medicare laws, regulations, and CMS instructions,"

1 *id.* at 422.504(i)(4)(v); and receive effective compliance training and education relating
2 to preventing fraud, waste, and abuse. *Id.* at § 422.503(b)(4)(vi)(C)(1). Furthermore, if
3 a Related Entity or First Tier Entity generates data relating to an MA Organization’s
4 claims for payments from the MA Program, it (as well as the MA Organization) must
5 certify the accuracy and truthfulness of the data. *Id.* at § 422.504(l)(3).

6 53. An MA Organization, however, cannot evade its legal and contractual obligations
7 to the Government by using Related Entities to manage it or by contracting with First
8 Tier Entities to provide services to its beneficiaries. An MA Organization “maintains
9 ultimate responsibility for adhering to and otherwise fully complying with all terms and
10 conditions of its contract with CMS.” 42 C.F.R. § 422.504(i)(1). Thus, an MA
11 Organization cannot delegate away its ultimate responsibility for its obligations to the
12 Government.

13 **II. Medicare Parts C and D Risk Adjustment Payments**

14 54. Under Part C, the Government pays each MA Organization a predetermined base
15 monthly amount for each Medicare beneficiary in its MA Plans. This monthly payment
16 is known as a “per-member, per-month” payment. This predetermined base payment
17 varies for each MA Plan depending on various factors, including amounts set forth in the
18 MA Plan’s bid submitted to the Government, the scope of medical services covered by
19 the Plan’s benefit package (all packages must cover at least those services offered by
20 Parts A and B of the Medicare Program), and the amount of premiums, deductibles, and
21 co-pays for which an enrollee in the Plan is responsible (Plans have different premiums,
22 deductibles and co-pays such that Plans with higher deductibles and co-pays may have
23 lower premiums).

24 55. Since 2000, Congress has also required that the payments be risk adjusted for each
25 beneficiary based on “such risk factors as age, disability status, gender, institutional
26 status, and *such other factors as [the Secretary of the United States Department of*
27 *Health and Human Services] determines to be appropriate, including adjustment for*
28 *health status . . . to ensure actuarial equivalence.”* 42 U.S.C. § 1395w-23(a)(1)(C)

1 (emphasis added). By risk adjusting for health status, the Government pays MA
2 Organizations more for beneficiaries with certain serious chronic medical conditions
3 and, thus, higher risk scores than for beneficiaries who do not have those conditions and,
4 thus, have lower risk scores.

5 56. Pursuant to 42 U.S.C. § 1395w-23(a)(1)(C), the Secretary has the authority to
6 determine how to adjust for health status. For example, the Secretary has the authority to
7 decide to risk adjust only for serious chronic medical conditions and to risk adjust by
8 requiring the submission of diagnoses from medical encounters that occurred the year
9 preceding each payment year and projecting the possibility of additional costs for each
10 payment year. The Secretary also has authority to decide what historical cost and/or
11 utilization data it should consider in projecting how much more it may cost an MA
12 Organization to provide services to a beneficiary who has been assigned a diagnosis
13 relating to a serious chronic medical condition.

14 57. From 2000 to 2004, the Secretary employed a Principal Inpatient Diagnostic Cost
15 Group (“PIP-DCG”) model that took into account diagnoses from inpatient hospital
16 stays to determine the risk scores of beneficiaries in MA Plans. The PIP-DCG model
17 was prospective. Diagnoses for one year were used to determine each beneficiary’s risk
18 score for the following payment year. During the 2000 to 2004 time period, MA
19 Organizations (which were then called Medicare + Choice Organizations) had many of
20 the same obligations that they have had since 2004. For instance, they had the obligation
21 to design and implement effective systems to monitor and review the accuracy and
22 truthfulness of the diagnoses they submitted for risk adjustment payments in order to
23 certify the accuracy and truthfulness of that data. See Medicare Managed Care Manual,
24 Chapter 7, Section 110.2 (entitled “Certification of Data Accuracy, Completeness, and
25 Truthfulness”) (Rev. 2, 10-01-01).

26 58. Since 2004, the Secretary has employed the Hierarchical Conditions Category
27 (“HCC”) model, which takes into account both demographic factors (such as age and
28 gender) and health status to determine the risk scores for beneficiaries in MA Plans.

1 With respect to health status, the model takes into account diagnoses from physician
2 office visits and hospital outpatient encounters as well as hospital inpatient stays. Like
3 the PIP-DCG model, the HCC model is prospective, meaning that it relies on diagnoses
4 assigned to a beneficiary in one year (referred to by CMS as the “data collection” year
5 but also generally known as the “date of service” or “DOS” year) to determine the risk
6 score for the beneficiary for the following year (often referred to as the “payment year”
7 or “PY”). The medical conditions included in the model are grouped into HCCs, which
8 are categories of clinically-related medical diagnoses. *See* 42 C.F.R. § 422.2. The
9 diagnoses grouped into HCCs include major, severe, and/or chronic illnesses. Related
10 groups of diagnoses are ranked on the basis of disease severity and the cost associated
11 with their treatment. Between 2004 and 2013, the CMS-HCC model included 70 HCCs.
12 Starting in 2014, the CMS-HCC model included 79 HCCs.

13 59. Under Medicare Part D, payments to PD or MAPD Plans for prescription drug
14 benefits are also risk-adjusted based on health status. As with Part C, Part D employs a
15 health-based risk adjustment model known as the Rx Hierarchical Condition Categories
16 (“RxHCC”) model. Like HCCs, RxHCCs are also groups of clinically-related medical
17 diagnoses that are ranked by disease severity and the cost associated with the
18 pharmaceutical drugs used to treat them.

19 60. The Government assigns a relative numerical value (also known as a relative
20 factor, multiplier, or coefficient) to each HCC and RxHCC group that correlates to the
21 predicted incremental costs of care associated with treating the medical conditions in
22 each category. It currently determines the relative values based on an analysis of the
23 additional amounts that it paid on average for the treatment of these major, severe, and
24 chronic medical conditions under Parts A and B of the Medicare Program. Higher
25 relative values are assigned to HCCs and RxHCCs that include diagnoses with greater
26 disease severity and greater costs associated with their treatment.

27 61. As previously stated, the HCC and RxHCC risk adjustment models are
28 prospective and a beneficiary’s risk score for a particular payment year is determined by

1 his or her medical conditions during the previous year (*i.e.*, the date of service year). For
2 risk adjustment payment purposes, these medical conditions must be documented by a
3 qualified healthcare provider (*e.g.*, a doctor) in the beneficiary's medical record during
4 the previous year. Accordingly, for risk adjustment payment purposes, the diagnosis
5 codes that the healthcare provider, his or her administrative or billing support staff, or
6 anyone else (such as the MA Organization or a Related Entity) assigns to a beneficiary
7 must be supported by the beneficiary's medical record.

8 62. Each beneficiary's risk score is calculated anew for each payment year. For
9 example, a beneficiary's risk score for payment year 2012 is determined by the
10 diagnoses that his or her qualified healthcare providers documented in his or her medical
11 records during medical encounters during date of service year 2011.

12 63. MA Organizations obtain diagnosis data from the healthcare providers that treat
13 the beneficiaries in their plans (as well as through other means and sources such as the
14 MA Organizations' own medical record reviews). Healthcare providers can transmit
15 diagnosis codes to MA Organizations with claims for payment for services rendered, in
16 encounter records reporting the services rendered, or by alternative means. In this
17 Amended Complaint, the United States refers to diagnosis codes reported by providers
18 through any means as "provider-reported diagnoses."

19 64. MA Organizations submit risk adjustment data, including diagnoses, to CMS
20 using CMS' Risk Adjustment Processing System ("RAPS"). Each RAPS submission
21 must include the following information: the Medicare beneficiary's identification
22 number (called a "HIC number" or "HICN"); the date(s) of the medical encounter (the
23 physician office visit, hospital outpatient visit, or hospital inpatient stay); the type of
24 provider (physician or hospital); and the diagnosis code(s) reported by the provider for
25 the encounter. Each RAPS submission is a claim for payment. If the data submitted is
26 invalid, the claim is false.

27 65. RAPS also has a field that is called a "Delete Indicator" and allows MA
28 Organizations and Related Entities to comply with their obligation to delete invalid

1 diagnoses that they previously submitted in order to withdraw or retract the invalid
2 diagnoses. That is, the RAPS system enables MA Organizations and Related Entities to
3 withdraw or retract their false claims for risk adjustment payments.

4 **DEFENDANTS' AGREEMENTS**

5 **I. The Annual Parts C and D Agreements**

6 66. As previously explained, in order to participate in the MA Program, the Defendant
7 MA Organizations were required to agree in writing to comply with the Part C and D
8 regulations and any other terms and conditions CMS deemed appropriate. 42 C.F.R.
9 §§ 422.504 & 422.505 (Part C); 42 C.F.R. §§ 423.504 & 423.505 (Part D). Each year
10 during the relevant time period, one or more executives of one or more of the UHG
11 Managing Defendants or their predecessors executed these written agreements or
12 renewals of these written agreements between the Defendant MA Organizations and
13 CMS.

14 67. The regulations specifying the terms and conditions of the contractual relationship
15 between MA Organizations and CMS have remained the same for many years.
16 Accordingly, from year to year, the terms and conditions of these written agreements
17 between the Defendant MA Organizations and CMS remained very similar, if not
18 identical.

19 68. The terms and conditions of the Part C agreements are exemplified by the attached
20 contract that Defendant UnitedHealthcare Plan of River Valley, Inc. entered into with
21 CMS relating to its participation in Medicare Part C in 2010. *See* Exhibit 1, attached
22 hereto. The terms and conditions of these Part C contracts include, among many other
23 things, that each of the MA Organizations agrees to (i) operate its Plans “in compliance
24 with the requirements of [the] contract and applicable Federal statutes, regulations, and
25 policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual,
26 etc.)” (Article II, Section A); (ii) “implement a compliance plan in accordance with the
27 requirements of § 422.503(b)(4)(vi)” (Article III, Section F); (iii) “[a]s a condition of
28 receiving a monthly payment under” the contract, “request payment under the contract

1 on the forms attached” to the contract, including “Attachment B (risk adjustment data)
2 which attest[s] to *(based on best knowledge, information and belief, as of the date*
3 *specified on the attestation form)* the accuracy, completeness, and truthfulness of the
4 data identified on” Attachment B (Article IV, Section C) (emphasis in the original); (iv)
5 ensure that related entities, contractors, and subcontractors that generated risk adjustment
6 data also attest to the accuracy and truthfulness of the data (Article IV, Section C.2); (v)
7 ensure that all agreements with related entities, contractors, and subcontractors specify
8 that the related entities, contractors, and subcontractors “must comply with all applicable
9 Medicare laws, regulations, and CMS instructions” (Article V, Section D(5)); and (vi)
10 comply with “Federal laws and regulations designed to prevent or ameliorate fraud,
11 waste, and abuse, including, but not limited to, applicable provisions of the Federal
12 criminal law [and] the False Claims Act (31 USC 3729 et seq.)” (Article IX, Section
13 A.1). In accordance with 42 C.F.R. § 422.510, the agreements also provided that CMS
14 may terminate the MA Organization’s participation in the MA Program if it determines
15 that the organization has submitted false data to it or “fail[ed] to provide CMS with valid
16 risk adjustment data.” Article VIII, Section B.1(a)(iv) & (vii).

17 69. The agreements for other years were very similar, if not identical. For example, in
18 September 2010, Tom Paul, the Chief Executive Office of UnitedHealthcare Medicare &
19 Retirement, executed a new agreement between Defendant UnitedHealthcare of
20 California (the successor to PacifiCare of California) and CMS relating to this MA
21 Organization’s participation in Medicare Part C in 2011. *See* Exhibit 2, attached hereto.
22 By executing this contract, UnitedHealthcare of California agreed to, among many other
23 things, (i) operate its Plans “in compliance with the requirements of [the] contract and
24 applicable Federal statutes, regulations, and policies (e.g., policies as described in the
25 Call Letter, Medicare Managed Care Manual, etc.)” (Article II, Section A); (ii)
26 “implement a compliance plan in accordance with the requirements of §
27 422.503(b)(4)(vi)” (Article III, Section F); (iii) “[a]s a condition of receiving a monthly
28 payment under” the contract, “request payment under the contract on the forms attached”

1 to the contract, including “Attachment B (risk adjustment data) which attest[s] to *(based*
2 *on best knowledge, information and belief, as of the date specified on the attestation*
3 *form)* the accuracy, completeness, and truthfulness of the data identified on” Attachment
4 B (Article IV, Section D); (iv) ensure that related entities, contractors, and
5 subcontractors that generated risk adjustment data also attest to the accuracy and
6 truthfulness of the data (Article IV, Section D.2); (v) ensure that all agreements with
7 related entities, contractors, and subcontractors specify that the related entities,
8 contractors, and subcontractors “must comply with all applicable Medicare laws,
9 regulations, and CMS instructions” (Article V, Section D.5); and (vi) comply with
10 “Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse,
11 including, but not limited to, applicable provisions of the Federal criminal law [and] the
12 False Claims Act (31 USC 3729 et seq.)” (Article IX, Section A.1). The agreement also
13 provided that CMS had the right to terminate the agreement with the MA Organization if
14 it determined that the organization had submitted false data to it or “fail[ed] to provide
15 CMS with valid risk adjustment data.” Article VIII, Section B.1(a)(iv) & (vii). In
16 September 2010, Paul also executed an agreement with CMS relating to
17 UnitedHealthcare of California’s offering of prescription drug benefits under Medicare
18 Part D. This Part D agreement was, in all respects relevant to this Amended Complaint,
19 very similar to the one described above for the offering of healthcare insurance benefit
20 packages under Part C. Furthermore, in September 2010, Tom Paul executed the same
21 Part C and D agreements on behalf of other of the Defendant MA Organizations. All
22 these agreements were very similar, if not identical, to the ones he executed for
23 UnitedHealthcare of California.

24 70. In September 2011, August 2012, and August 2013, Scott Theisen, the Chief
25 Financial Officer of UnitedHealthcare Medicare & Retirement, executed agreements for
26 many of the Defendant MA Organizations relating to their participation in Medicare
27 Parts C and D for 2012, 2013, and 2014, respectively. *See, e.g.,* Exhibits 3, 4, & 5,
28 attached hereto (Defendant UnitedHealthcare of California’s Parts C agreements for

1 these years). In August 2014 and 2015, Brian Thompson, the Chief Financial Officer of
2 UnitedHealthcare Medicare & Retirement, executed agreements for many of the
3 Defendant MA Organizations relating to their participation in Medicare Parts C and D
4 for 2015 and 2016. See, e.g., Exhibits 6 & 7, attached hereto (Defendant
5 UnitedHealthcare of California's Part C agreements for these years). These agreements
6 were, in all respects relevant to this Amended Complaint, very similar, if not identical, to
7 the agreements described in the preceding paragraphs relating to the agreements for 2010
8 and 2011 and imposed the same contractual obligations on the Defendant MA
9 Organizations as the earlier agreements.

10 71. The annual Attestations executed in order to renew existing contracts were also
11 very similar as shown by the following: In the fall of 2006, Jerry Knutson, the Chief
12 Financial Officer of Ovations and Jeff Putnam, the Chief Financial Officer of Secure
13 Horizons, executed Attestations renewing (for calendar year 2007) the existing contract
14 between PacifiCare of California (the predecessor of Defendant UnitedHealthcare of
15 California) and CMS. Knutson and Putnam attested that PacifiCare of California would
16 "comply with all applicable program guidance that CMS has issued to date and will issue
17 during the remainder of 2006 and 2007 pursuant to Medicare program authorizing
18 statutes and regulations, including but not limited to, . . . the CMS memoranda issued
19 through the Health Plan Management System (HPMS)." (HPMS is one of the web-
20 based systems used by CMS to provide program information to MA Organizations and is
21 used to communicate program requirements.) In September 2007, Joseph Haferman, the
22 Chief Financial Officer of Secure Horizons, executed another Attestation renewing the
23 existing contract for PacifiCare of California (this time for calendar year 2008).
24 Haferman thereby attested that PacifiCare of California would comply "with all
25 applicable program authorizing statutes and regulations and program guidance that CMS
26 has issued to date and will issue during the remainder of 2007 and 2008, including but
27 not limited to, . . . the Medicare Managed Care Manual, and CMS memoranda issued
28 through the Health Plan Management System (HPMS)." In September 2008, Kenneth

1 Burdick, the Chief Executive Officer of Secure Horizons at the time, executed another
2 Attestation renewing the existing contract for PacifiCare of California (this time for
3 calendar year 2009). Burdick thereby attested that PacifiCare of California would
4 comply “with all applicable Medicare program authorizing statutes and regulations and
5 program guidance that CMS has issued to date and will issue during the remainder of
6 2008 and 2009, including but not limited to, . . . the Medicare Managed Care Manual,
7 and the CMS memoranda issued through the Health Plan Management System
8 (HPMS).” In September 2009, both Tom Paul, the Chief Executive Officer of Ovations,
9 and John Way, the Chief Financial Officer of Secure Horizons, executed an Attestation
10 renewing the existing contract for PacifiCare of California (this time for calendar year
11 2010). They thereby attested that PacifiCare of California would comply “with all
12 applicable Medicare program authorizing statutes and regulations and program guidance
13 that CMS has issued to date or will issue during the remainder of 2009 and 2010,
14 including but not limited to, . . . the Medicare Managed Care Manual, and the CMS
15 memoranda issued through the Health Plan Management System (HPMS).”

16 72. The United States hereby incorporates by reference as if they were recited herein
17 and attached hereto all of the agreements that all of the Defendant MA Organizations
18 entered into with CMS relating to their participation in Medicare Parts C and D for 2007
19 to present date. All of these agreements were, in all respects relevant to this Amended
20 Complaint, very similar, if not identical, to the agreements described in the preceding
21 paragraphs.

22 **II. The Electronic Data Interchange Agreements**

23 73. In addition, since at least 2003, MA Organizations and entities that submit risk
24 adjustment data on their behalf have been required to execute Electronic Data
25 Interchange (“EDI”) agreements prior to submitting risk adjustment data. These EDI
26 agreements are considered contracts by which the MA Organizations attest to the
27 accuracy of the data submitted. Even if another entity submits the data, the MA
28 Organizations are still responsible for the content of the submissions. See 2003 Regional

1 Risk Adjustment Training for Medicare+Choice Organizations Participant Guide, §
2 6.1; 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations
3 Participant Guide, § 4.1; 2005 Risk Adjustment Data Basic Training for Medicare
4 Advantage Organizations Participant Guide § 4.1; 2006 Risk Adjustment Data Basic
5 Training for Medicare Advantage Organizations Participant Guide § 4.1; 2007 Risk
6 Adjustment Data Training for Medicare Advantage Organizations Participant Guide §
7 4.1; 2008 Risk Adjustment Technical Assistance for Medicare Advantage Organizations
8 Participant Guide § 4.1; Risk Adjustment 101 Participant Guide § 2.1 (2013). See also
9 Medicare Managed Care Manual, Chapter 7, § 111.6.1 (Rev. 57, 08-13-04); *id.* § 120.2.1
10 (Rev. 114, 06-07-13). By executing these EDI forms, the MA Organizations agree that
11 (i) they will be responsible for all risk adjustment data submitted to CMS by themselves,
12 their employees, and their agents; (ii) they will submit risk adjustment data that is
13 accurate, complete, and truthful based on best knowledge, information, and belief; (iii)
14 *they will research and correct risk adjustment data discrepancies*; and (iv) CMS has the
15 right to audit and confirm the risk adjustment data, including diagnoses, submitted by the
16 MA Organization and the right of access to the beneficiaries' medical records to conduct
17 such audits.

18 74. Each of the Defendant MA Organizations and Defendants Optum (and its
19 predecessor, Ingenix) and Ovations executed these EDI agreements and submitted them
20 to the MA Program in order to submit risk adjustment data to and receive risk adjustment
21 payments from the MA Program. Pursuant to the express terms of these EDI
22 agreements, these Defendants promised to submit valid risk adjustment data to the MA
23 Program and *to research and correct any data discrepancies*.

24 75. For instance, in 2005, Joseph Haferman, the Chief Financial Officer of Defendant
25 Ovations, executed and submitted to CMS an EDI agreement in order to obtain a
26 "submitter ID" permitting Ovations to submit risk adjustment data on behalf of various
27 of the Defendant MA Organizations. See Exhibit 8, attached hereto. By executing this
28 agreement and submitting it to CMS on behalf of the "eligible organization," which was

1 identified as “United Health Group – Ovations” on the form, Defendants UHG and
2 Ovations and the Defendant MA Organizations each agreed that they would (i) be
3 responsible for all risk adjustment data submitted to CMS by themselves, their
4 employees, or their agents; (ii) submit accurate and truthful risk adjustment data; and
5 (iii) *research and correct discrepancies with its risk adjustment data*. In addition, each
6 of them agreed that CMS could audit the data and have access to medical records to
7 conduct such audits.

8 76. Additional examples include the EDI agreements that James Higgins, the Finance
9 Director of PacifiCare Health Systems, executed on behalf of the following Defendant
10 MA Organizations or their predecessors: On September 14, 2006, Higgins signed EDI
11 agreements for UnitedHealthcare Insurance Company of New York (contract numbers
12 H5515 and R5342); UnitedHealthcare Insurance Company (the name for a number of
13 different MA Organizations with contract numbers R3175, R5287, H1717, H2803,
14 H2001, H2003, H2111, H2408, H0624, H0620, H1303, H1509, H3921, H0319, H5500,
15 H2406, H4106, H3812, H3209, H5918, H5697, H5754, H0315, H2228, H1108, H4522,
16 H5532, H5516, H5507, H5440, H5417, H5424, H5008, H5527, H2226 and H5518);
17 PacifiCare of Nevada, Inc. (contract number H2949); PacifiCare of Arizona, Inc.
18 (contract number H0303); UnitedHealthcare of Alabama, Inc. (contract number H0151);
19 UnitedHealthcare of the Midwest, Inc. (contract number H2654); Oxford Health Plans
20 (CT), Inc. (contract number H0752); Oxford Health Plans (NJ), Inc. (contract numbers
21 H3113 and H3107); UnitedHealthcare of Ohio, Inc. (contract numbers H3659 and
22 H5678); UHC of California, then known as PacifiCare of California (contract number
23 H0543); UnitedHealthcare of Florida, Inc. (contract number H1080 and H9011);
24 UnitedHealthcare Benefits of Texas, Inc. (contract number H4590); UnitedHealthcare of
25 Utah, Inc. (contract number H4604); UnitedHealthcare of Arizona, Inc. (contract number
26 H0316); UnitedHealthcare of Arkansas, Inc. (contract number H0401); UnitedHealthcare
27 of Georgia, Inc. (contract number H1111); UnitedHealthcare of Tennessee, Inc. (contract
28 number H4406); UnitedHealthcare of New England, Inc. (contract number H4102);

1 UnitedHealthcare of Oregon, Inc. (contract number H3805); UnitedHealthcare of
2 Oklahoma, Inc. (contract number H3749); UnitedHealthcare of New York, Inc. (contract
3 number H3379); Oxford Health Plans (NY), Inc. (contract number H3307);
4 UnitedHealthcare of the Midlands, Inc. (contract number H2802); UnitedHealthcare of
5 North Carolina, Inc. (contract number H3456); PacifiCare of Colorado, Inc. (contract
6 number H0609); Sierra Health and Life Insurance Company, Inc. (contract number
7 H5652); UnitedHealthcare of Washington, Inc. (contract number H5005);
8 UnitedHealthcare of Wisconsin, Inc. (contract number H5253); and UnitedHealthcare
9 Community Plan of Texas, L.L.C. (contract number H4514). On November 2, 2006,
10 Higgins signed EDI agreements for UnitedHealthcare of the Midwest, Inc. (contract
11 number H3887), UnitedHealthcare Insurance Company of New York (contract number
12 H4720), and UnitedHealthcare Insurance Company (contract numbers H9418, H8000,
13 and H4779). On December 13, 2006, Higgins signed EDI agreements for
14 UnitedHealthcare Insurance Company (the name for a number of MA Organizations
15 with contract numbers H0408, H1286, H3435, H7274, H7254, H0410, and H6717) and
16 UnitedHealthcare of Wisconsin, Inc. (contract number H7187). On January 1, 2007,
17 Higgins signed an EDI agreement for UnitedHealthcare Insurance Company (contract
18 number H5435). On January 14, 2008, Higgins signed an EDI agreement for
19 UnitedHealthcare Insurance Company (contract numbers H3912 and H0710). *See, e.g.,*
20 Exhibit 9, attached hereto (September 14, 2006 EDI for PacifiCare of California).
21 Pursuant to these EDI agreements, each of these MA Organizations agreed that it would
22 (i) be responsible for all risk adjustment data submitted to CMS by itself, its employees,
23 or its agents; (ii) submit accurate and truthful risk adjustment data; and (iii) *research and*
24 *correct discrepancies with its risk adjustment data*. In addition, each of them agreed that
25 CMS could audit the data and have access to medical records to conduct such audits.
26 77. In addition, on January 14, 2008, Patricia Rasmussen, who worked as a manager
27 for Ingenix, signed EDI agreements for UnitedHealthcare Insurance Company (contract
28 numbers H4971, H0710, H3912, H7698, H4971, H0710, H6793, H5749, and H6228),

1 UnitedHealthcare of New England, Inc. (contract number H1944), and UnitedHealthcare
2 Insurance Company of New York (contract number H4720). On June 18, 2008,
3 Rasmussen signed an EDI agreement for PacifiCare of Nevada, Inc. (contract number
4 H7949). In January 2009, Rasmussen signed additional EDI agreements for
5 UnitedHealthcare Insurance Company (contract numbers H7444, H8748, H2182, and
6 H1949). Pursuant to these EDI agreements, each of these MA Organizations agreed that
7 it would (i) be responsible for all risk adjustment data submitted to CMS by itself, its
8 employees, or its agents; (ii) submit accurate and truthful risk adjustment data; and (iii)
9 *research and correct discrepancies with its risk adjustment data*. In addition, each of
10 them agreed that CMS could audit the data and have access to medical records to
11 conduct such audits.

12 78. On December 15, 2010, Timothy Noel, who was Vice President of Finance for
13 UnitedHealthcare Medicare & Retirement, signed an EDI agreement for Oxford Health
14 Plans (CT), Inc. (contract number H0755). On September 22, 2011, Noel signed an EDI
15 agreement for UnitedHealthcare Insurance Company of New York (contract number
16 H1537). Pursuant to these EDI agreements, each of these MA Organizations agreed that
17 it would (i) be responsible for all risk adjustment data submitted to CMS by itself, its
18 employees, or its agents; (ii) submit accurate and truthful risk adjustment data; and (iii)
19 *research and correct discrepancies with its risk adjustment data*. In addition, each of
20 them agreed that CMS could audit the data and have access to medical records to
21 conduct such audits.

22 79. On April 27, 2011, Scott Theisen, the Chief Financial Officer of UnitedHealthcare
23 Medicare & Retirement, submitted an EDI agreement for PacifiCare of California, which
24 included all the same promises. On October 21, 2013, Theisen also signed EDI
25 agreements for Care Improvement Plus Wisconsin Insurance Company (contract number
26 H3794) and Care Improvement Plus South Central Insurance Co. (contract number
27 H5322). Accordingly, each of these Defendant MA Organizations also agreed that it
28 would (i) be responsible for all risk adjustment data (which includes encounter data)

1 submitted to CMS by itself, its employees, or its agents; (ii) submit accurate and truthful
2 risk adjustment data; and (iii) *research and correct discrepancies with its risk adjustment*
3 *data*. In addition, each of them agreed that CMS could audit the data and have access to
4 medical records to conduct such audits.

5 80. Patricia Rasmussen also executed and submitted an EDI agreement so that Ingenix
6 could submit risk adjustment data on behalf of the Defendant MA Organizations. *See*
7 Exhibit 10, attached hereto. By doing this, Ingenix also agreed that it would (i) be
8 responsible for all risk adjustment data submitted to CMS by itself, its employees, or its
9 agents; (ii) submit accurate and truthful risk adjustment data; and (iii) *research and*
10 *correct discrepancies with its risk adjustment data*. In addition, it agreed that CMS
11 could audit the data and have access to medical records to conduct such audits. When
12 Ingenix became OptumInsight, Rasmussen also notified CMS (that is, CMS' contractor
13 Palmetto, which helped operate RAPS) that its records should be updated to reflect that
14 OptumInsight was making the risk adjustment submissions for the Defendant MA
15 Organizations. Rasmussen identified OptumInsight as "part of Optum." *See* Exhibit 11,
16 attached hereto.

17 81. Jeffrey Dumcum, a Senior Vice President at Optum, also executed an EDI
18 agreement in May 2011 in order to submit risk adjustment data (also known as encounter
19 data) to the MA Program on behalf of many of the Defendant MA Organizations,
20 including those MA Organizations listed in a letter sent by Theisen to CMS' contractor
21 in April 2011. By doing this, Dumcum agreed that Optum would be responsible for the
22 data it submitted, submit valid data, and *research and correct data discrepancies*. *See*
23 Exhibit 12, attached hereto.

24 82. All EDI agreements executed by the UHG Managing Defendants on their own
25 behalf and on behalf of the Defendant MA Organizations are incorporated by reference
26 in this Amended Complaint as if they were recited in full and attached hereto.

III. The Ingenix/Optum Service Agreements

83. Depending on the time period, Ingenix or Optum entered into internal agreements with Ovation or UnitedHealthcare regarding the risk adjustment-related services that Ingenix or Optum would provide to the Defendant MA Organizations. These services included, among other things, the submission of risk adjustment data to CMS and the management of the Chart Review, Claims Verification, and RACCR Programs. These internal agreements further confirm the parties' joint and several obligations to the MA Program to submit accurate and truthful risk adjustment data and to investigate and correct any data discrepancies. These agreements also exemplify the UHG Managing Defendants' understanding of their joint and several obligations to the MA Program. All of these agreements are incorporated herein by reference.

84. By way of example, the Memorandum of Understanding ("MOU") entered into between Optum and UnitedHealthcare for risk adjustment-related services rendered by Optum in 2011 exemplifies the obligations undertaken by Optum not only to UnitedHealthcare but to the MA Program. That MOU was executed by Jerry Knutson, Chief Financial Officer of Optum, and Scott Theisen, Chief Financial Officer of UnitedHealthcare Medicare & Retirement. Paul Bihm at Optum, Relator Poehling at UnitedHealthcare Medicare & Retirement, and Jason Bainbridge at UnitedHealthcare Community & State were copied on the MOU. (The MOU referred to UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community & State collectively as "UnitedHealth Group's Public and Senior Markets Group ("PSMG")." This is but one of many examples of the confusion that Defendants have created by the way they used names of groups and entities interchangeably.) Pursuant to the MOU, Optum was compensated for its services through an "intercompany allocation of fees paid pursuant to [a separate] Management Agreement."

85. Pursuant to this 2011 MOU, Optum provided many risk adjustment-related services to the Defendant MA Organizations, including, but not limited to the submission of risk adjustment data to CMS "pursuant to CMS risk adjustment rules and

1 requirements” and conducting the Chart Review, Claims Verification, and RACCR
2 Programs. Importantly, Optum also agreed to (i) conduct “[p]rovider engagement and
3 education regarding accurate and complete diagnostic coding and documentation”; (ii)
4 “[c]ontribute (along with PSMG) to the level of accuracy and completeness of diagnostic
5 coding for a respective population by identifying opportunities to improve
6 documentation and coding for accuracy, facilitating improvement in accuracy by
7 working directly with providers to improve documentation and coding practices, and
8 executing the timely and accurate submission of claim coding information to CMS,
9 thereby ensuring appropriate revenues are being paid by CMS for the underlying risk
10 inherent within the member population;” (iii) “[m]onitor[] the appropriateness and
11 accuracy of provider coding;” and (iv) conduct “[i]nternal validation testing of outlier
12 providers, internal validation testing of other sample populations and support CMS
13 validation requirements.”

14 86. The 2011 MOU also included a “Medicare Advantage Regulatory Requirements
15 Appendix.” This Appendix included Optum’s agreement to (i) “comply with all
16 applicable federal and Medicare laws, regulations, and CMS instructions, including but
17 not limited to . . . federal laws and regulations designed to prevent or ameliorate fraud,
18 waste, and abuse, including but not limited to, applicable provisions of federal criminal
19 law [and] the False Claims Act (31 U.S.C. § 3729 et seq.);” (ii) “perform services and
20 provide the products set forth in the MOU in a manner consistent with and in compliance
21 with [the Defendant MA Organizations’] obligations under the CMS Contact[s]; “ and
22 (iii) certify in writing that the risk adjustment data it submitted to CMS was “accurate,
23 complete, and truthful, based on [its] best knowledge, information and belief.” The
24 Appendix further specified that UnitedHealthcare and the Defendant MA Organizations
25 were accountable to CMS for fulfilling their regulatory and contractual obligations under
26 the MA Program, including those that they had delegated to Optum under the MOU and,
27 thus, that they were responsible for overseeing and monitoring Optum’s performance
28 under the MOU.

DEFENDANTS' DATA INTEGRITY OBLIGATIONS

I. Obligation to Submit Valid Diagnoses

87. MA Organizations are entitled to risk adjustment payments based on the diagnosis codes that they submit to CMS *only* if the codes are from face-to-face medical encounters between the Medicare beneficiary and provider, the encounter occurred during the relevant date of service year, the provider was of a type and specialty acceptable for risk adjustment purposes, and at the time of the encounter, the provider documented the medical conditions identified by the diagnosis codes in the medical record based on acceptable documentation. In addition, codes should be based on documented conditions that require or affect patient care treatment or management. *See* Medicare Managed Care Manual, Chapter 7, Exhibit 30 (August 13, 2004) (stating that diagnosis codes submitted for risk adjustment payments should be for documented conditions that “require or affect patient care treatment or management”). *See also* 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide (“2008 RA Participation Guide”) at § 6.4.1.

88. Risk adjustment claims are valid, and the resulting risk adjustment payments are therefore proper and justified, only to the extent that the diagnosis codes submitted by the MA Organizations are valid. The diagnoses must be coded according to the *International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting* (“ICD-9-CM” & “ICD-10-CM”) and documented with sufficient clinical specificity. *See* Medicare Managed Care Manual, Chapter 7, Exhibit 30 (August 13, 2004). In addition, codes cannot be submitted for diagnoses that are only probable or suspected, for diagnoses that are questionable, or for a condition that the provider is trying to rule out. *Id.*

89. Moreover, all diagnosis codes submitted by MA Organizations must be supported by medical record documentation. The 2004 Medicare Managed Care Manual stated that “M+C organizations [now known as MA Organizations] must submit risk adjustment data that are substantiated by the physician or provider’s full medical record.” Medicare

1 Managed Care Manual, Chapter 7, § 111.8 (August 13, 2004). A later version of the
2 Manual similarly states that MA Organizations “must . . . [e]nsure the accuracy and
3 integrity of risk adjustment data to CMS. All diagnosis codes submitted must be
4 documented in the medical record” Medicare Managed Care Manual, Chapter 7, §
5 40 (June 2013). Also similarly, the 2003 Participant Guide stated that MA
6 Organizations “must submit risk adjustment data that are substantiated by the patient’s
7 medical record.” 2003 Regional Risk Adjustment Training for Medicare+Choice
8 Organizations Participant Guide, § 4.1. This requirement was reiterated in the following
9 CMS training guides and materials since 2003: 2003 Regional Risk Adjustment
10 Training for Medicare+Choice Organizations Participant Guide, §§ 12.3, 12.6; 2004
11 Regional Risk Adjustment Training for Medicare+Choice Organizations Participant
12 Guide, §§ 5.1, 5.5, 6.1.3; 2005 Risk Adjustment Data Basic Training for Medicare
13 Advantage Organizations Participant Guide §§ 4.1, 5, 5.1, 5.5, 8.7.3, 9.1, 9.2; 2006 Risk
14 Adjustment Data Basic Training for Medicare Advantage Organizations Participant
15 Guide §§ 5.1, 5.4, 5.5, 7.7.3, 8.1, 8.2; 2007 Risk Adjustment Data Training for Medicare
16 Advantage Organizations Participant Guide §§ 6.1, 6.4, 7.1, 7.2, 8.7.3; 2008 Risk
17 Adjustment Technical Assistance for Medicare Advantage Organizations Participant
18 Guide §§ 5.6, 6, 6.1, 6.4, 6.5, 7.1, 7.2; 2012 Regional Technical Assistance Participant
19 Guide § 2.2; Risk Adjustment 101 Participant Guide §§ 3.2.4; 4.3 (2013); Risk
20 Adjustment Webinar at p. 48 (July 1, 2014). Furthermore, in a 2003 Regional Risk
21 Adjustment Training for Medicare+Choice Organizations presentation, organizations
22 were advised to “[t]ake steps to ensure that medical documentation supports submitted
23 diagnoses.” *Id.* at §8-19.

24 90. In connection with the requirement that the patient’s medical record support the
25 diagnosis(es) reported for him or her, the 2004 Medicare Managed Care Manual also
26 provided that “M+C organizations must maintain sufficient information to trace the
27 submitted diagnosis back to the hospital or physician that originally reported the
28 diagnosis. Since M+C organizations may submit summary level transactions without a

1 link to a specific encounter or claim, establishing an appropriate audit trail to the original
2 source of the data requires diligent information management on the part of the M+C.”
3 Medicare Managed Care Manual, Chapter 7, § 111.8 (August 13, 2004). Again, in the
4 2005 Risk Adjustment Data Basic Training for Medicare Advantage Organizations
5 Participant Guide § 8.7.3, CMS advised that “MA organizations should take steps to
6 ensure that they have, or have access to, the proper medical documentation to support
7 diagnoses being submitted for risk adjustment. MA organizations are responsible for the
8 accuracy of the data they submit to CMS. Where necessary, they should obtain the
9 proper documentation to support diagnoses and maintain an efficient system for tracking
10 diagnoses back to medical records.” This requirement was also reiterated in the
11 following CMS training guides: 2003 Regional Risk Adjustment Training for
12 Medicare+Choice Organizations Participant Guide, § 12.2; 2004 Regional Risk
13 Adjustment Training for Medicare+Choice Organizations Participant Guide, § 6.1.3;
14 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations Resource
15 Guide at p. 20; 2005 Risk Adjustment Data Basic Training for Medicare Advantage
16 Organizations Participant Guide §§ 5.1, 9.1.3; 2006 Risk Adjustment Data Basic
17 Training for Medicare Advantage Organizations Participant Guide §§ 5.1, 7.7.3, 8.7.3;
18 2007 Risk Adjustment Data Training for Medicare Advantage Organizations Participant
19 Guide §§ 6.1, 7.1.4, 8.7.3; 2008 Risk Adjustment Technical Assistance for Medicare
20 Advantage Organizations Participant Guide §§ 5.6.3, 6.1; 2012 Regional Technical
21 Assistance Participant Guide § 2.2.

22 91. Furthermore, the medical record relied on by an MA Organization to support
23 payment cannot be ambiguous. See 2008 RA Participation Guide at § 7.2.4.1 (stating
24 that risk adjustment claims and payments cannot be based on questionable diagnoses).

25 92. CMS recognizes that risk adjusting based on health status creates a strong
26 incentive for MA Organizations to report invalid diagnoses. Thus, CMS engages in a
27 variety of program integrity activities, including training MA Organizations about their
28 obligations to submit valid data and withdraw invalid data. For example, in a 2003

1 Regional Risk Adjustment Training for Medicare+Choice Organization Questions &
2 Answers document, CMS stated all information that is submitted must be correct. “If a
3 plan identifies incorrect or invalid information that has been submitted, it must delete
4 that information.” Likewise, in an August 9, 2005 Regional Training presentation made
5 jointly by CMS and its contractor, Aspen Systems Corporation, called “Risk Adjustment
6 Data Basic Training,” MA Organizations were told that they “must . . . Delete a
7 diagnosis cluster [that is, a RAPS submission] when any data in that cluster are in error.”

8 93. In addition, for many years, CMS has conducted audits of diagnoses submitted by
9 MA Organizations, known as Risk Adjustment Data Validation (“RADV”) audits. In
10 2001, when the old PIP-DCG model was in place, CMS alerted M+C organizations that
11 they were “required to submit medical records for validating encounter data” and that
12 “[m]edical record reviews of a sample of hospital encounters may be audited to ensure
13 the accuracy of diagnostic information.” Medicare Managed Care Manual, Chapter 7, §
14 110.3 (October 2001). In 2004, CMS revised the Manual to provide that “[a] sample of
15 risk adjustment data used for making payments may be validated against hospital
16 inpatient, hospital outpatient, and physician medical records to ensure the accuracy of
17 medical information. Risk adjustment data will be validated to the extent that the
18 diagnostic information justifies appropriate payment under the risk adjustment model.”
19 Medicare Managed Care Manual, Chapter 7, § 111.8 (August 13, 2004). The Manual
20 further explained that the MA Organizations must be prepared to locate and produce the
21 medical records to support the diagnoses codes that they submitted. *Id.* Federal
22 regulations also require MA Organizations and their providers to provide medical
23 records to CMS to validate the diagnoses they submitted for risk adjustment payments.
24 *See* 42 C.F.R. § 422.310(e).

25 94. When making risk adjustment payments, CMS relies on MA Organizations to
26 exercise due diligence to ensure that provider-reported diagnoses are supported by
27 beneficiaries’ medical records and are otherwise accurate and truthful. This is why
28 insurance companies that want to participate in the MA Program must agree, through

1 their Part C and D agreements and their EDI agreements, to provide valid diagnostic data
2 and investigate and delete invalid data. Moreover, this is why insurance companies that
3 want to participate in the MA Program must (i) establish and implement effective
4 compliance programs to ensure the integrity of their payment data, 42 CFR
5 § 422.503(b)(4)(vi) (Part C compliance program regulation); 42 C.F.R.
6 § 423.504(b)(4)(vi) (Part D compliance program regulation); (ii) annually attest to the
7 accuracy and truthfulness of the diagnosis data that they submit for risk adjustment
8 payments, 42 C.F.R. § 422.504(l) (Part C regulation); 42 C.F.R. § 423.505(k) (Part D
9 regulation); and (iii) “comply with . . . Federal laws and regulations designed to prevent
10 or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions
11 of Federal criminal law [and] the False Claims Act (31 USC §§ 3729 et seq.).” 42
12 C.F.R. § 422 (Part C regulation); 42 C.F.R. § 423 (Part D regulation).

13 **II. Obligation to Implement an Effective Compliance Program**

14 95. The implementation of an effective compliance program is a prerequisite to an
15 MA Organization’s obtaining and retaining payments under both Parts C and D of the
16 Medicare Program. *Id.* §§ 422.503(a) (Part C) & 423.504(b)(4)(vi) (Part D). One
17 purpose of requiring a compliance program is to ensure that MA Organizations submit
18 accurate and truthful information to CMS. 65 Fed. Reg. 40170-01 at 40264 (June 29,
19 2000).

20 96. Specifically, each MA Organization must “[a]dopt and implement an effective
21 compliance program, which must include measures that prevent, detect, and correct non-
22 compliance with CMS’ program requirements as well as measures that prevent, detect,
23 and correct fraud, waste, and abuse.” 42 C.F.R. § 422.503(b)(4)(vi) (Part C); 42 C.F.R.
24 § 423.504(b)(4)(vi) (Part D). The compliance program “must, at a minimum, include
25 [certain] core requirements,” including (but not limited to):

26 (F) Establishment and implementation of an effective system for routine
27 monitoring and identification of compliance risks. The system
28 should include internal monitoring and audits and, as appropriate,

external audits, to evaluate the MA organization[’s], including first tier entities’, compliance with CMS requirements and the overall effectiveness of the compliance program.

(G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements.

(1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.

(2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(G)(1) of this section.

(3) The MA organization should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee.

97. A compliance program is not effective unless the MA Organization devotes adequate resources to the program.

III. Obligation to Attest to Validity of Risk Adjustment Data

98. After the final deadline for their submission of risk adjustment data but before their receipt of their final reconciliation payments for a given payment year, MA Organizations must attest to the validity of their risk adjustment data, including diagnoses, in a Risk Adjustment Attestation submitted to CMS. Specifically, the chief

1 executive officer, chief financial officer, or another individual with delegated authority
2 to sign on behalf of one of these officers, and who reports directly to such an officer,
3 must certify that the risk adjustment data that the MA Organization submitted to CMS
4 was accurate, complete, and truthful.

5 99. An MA Organization must request payment on a document that contains this
6 Attestation and the submission of this Attestation to CMS is a condition of receiving
7 Risk Adjustment payments.

8 100. The Part D regulations include a similar attestation for risk adjustment data,
9 including diagnoses, submitted for risk adjustment payments under the prescription drug
10 program. Under the applicable Part D regulation, these attestations are referred to as
11 certifications. 42 C.F.R. § 423.505(k).

12 101. Every year, each MA Organization agrees in writing that:

13 [a]s a condition for receiving a monthly payment under paragraph B of this
14 article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its
15 chief executive officer (CEO), chief financial officer (CFO), or an
16 individual delegated with the authority to sign on behalf of one of these
17 officers, and who reports directly to such officer, must request payment
18 under the contract on the form[] attached hereto as . . . Attachment B (risk
19 adjustment data) which attest to (based on best knowledge, information and
20 belief, as of the date specified on the attestation form) the accuracy,
21 completeness and truthfulness of the data identified on these attachments.

22 . . .

23 2. Attachment B requires the CEO, CFO, or an individual delegated with
24 the authority to sign on behalf of one of these officers, and who reports
25 directly to such officer, must attest to (based on best knowledge,
26 information and belief, as of the date specified on the attestation form) that
27 the risk adjustment data it submits to CMS under 42 CFR § 422.310 are
28 accurate, complete, and truthful. The MA Organization shall make annual

1 attestations to this effect for risk adjustment data on Attachment B and
2 according to a schedule to be published by CMS. If such risk adjustment
3 data are generated by a related entity, contractor, or subcontractor, then such
4 related entity, contractor, or subcontractor must also attest to (based on best
5 knowledge, information, and belief, as of the date specified on the
6 attestation form) the accuracy, completeness, and truthfulness of the data.
7 [422.504(l).]

8 102. MA Organizations have an obligation to acquire knowledge, information, and
9 belief about their risk adjustment data, including diagnoses, in order to both submit such
10 data and attest to the accuracy and truthfulness of the data. Nearly 17 years ago, CMS
11 put MA Organizations on notice that they were “responsible for making *good faith*
12 *efforts* to certify the accuracy, completeness, and truthfulness of the encounter [*i.e.*, risk
13 adjustment] data submitted” for payments from the Medicare Program. 65 Fed. Reg.
14 40,170, 40,268 (June 29, 2000) (emphasis added); *see also* Medicare Managed Care
15 Manual, Chapter 7, § 110.2 (October 2001) (stating, under section titled “Certification of
16 Data Accuracy, Completeness, and Truthfulness,” that “CMS expects M+C
17 organizations [now known as MA Organizations] to design and implement effective
18 systems to monitor the accuracy, completeness, and truthfulness of encounter data [that
19 is, diagnoses from hospital inpatient stays under the old PIP-DCG risk adjustment
20 model] and to exercise due diligence in reviewing the information provided to CMS”);
21 Medicare Managed Care Manual, Chapter 7, § 111.7 (August 2004) (stating, under
22 section titled “Certification of Data Accuracy, Completeness, and Truthfulness,” that
23 “CMS expects M+C organizations [now known as MA Organizations] to design and
24 implement effective systems to monitor the accuracy, completeness, and truthfulness of
25 risk adjustment data and to exercise due diligence in reviewing the information provided
26 to CMS”). When MA Organizations fail to act in good faith and deliberately ignore or
27 recklessly disregard information about their submission of inaccurate or untruthful data,
28 their Risk Adjustment Attestations are false.

IV. Obligation to Delete Invalid Diagnoses

103. MA Organizations are obligated to delete invalid diagnoses previously submitted by them to RAPS or to use other available means to return risk adjustment payments based on invalid diagnoses. Their deletion of invalid diagnoses is the principal mechanism by which CMS is able to recalculate beneficiaries' risk scores and ensure that the Government does not make improper risk adjustment payments to MA Organizations or that it recovers improper payments that were already made. In particular, the submission of diagnoses that are not supported by the beneficiaries' medical records and, thus, are invalid directly and necessarily causes CMS to make risk-adjustment payments that it would not have made but for the submission of that false data. Conversely, the "deletion" of previously-submitted diagnoses that are invalid because they are not supported by the beneficiaries' medical records directly and necessarily causes CMS either to avoid paying for previously-submitted false diagnoses or to recover payments it made for those false diagnoses. As a result, an MA Organization's failure to "DELETE" invalid diagnoses results in that MA Organization's retention of payments to which it was not entitled. Thus, both the submission of false diagnostic data and the failure to correct false diagnosis data influence CMS' payment, including the amount of the risk-adjustment payment, if any, that it makes for any given beneficiary based on his or her health status.

104. The obligation to delete invalid diagnoses previously submitted to RAPS or to otherwise return risk adjustment payments based on invalid diagnoses arises from the contractual relationship between MA Organizations and the Government, from regulation, and from the retention of an overpayment and, thus, constitutes an "obligation to pay . . . the Government" under the reverse false claims act provision of the FCA. 31 U.S.C. §§ 3729(a)(1)(G) & (b)(3). The obligation is imposed on MA Organizations by the following, among other things:

- The MA Organizations' execution of EDI agreements pursuant to which they agree to "research and correct risk adjustment data discrepancies." *See supra*

1 paragraphs 73-82 (describing these agreements). *See also* Exhibits 8-11, attached
2 hereto (examples of EDI agreements that the Defendant MA Organizations
3 executed).

- 4 • Regulations requiring MA Organizations to implement effective compliance
5 programs and to “detect and correct non-compliance with CMS’ program
6 requirements as well as . . . [to] prevent, detect, and correct fraud, waste, and
7 abuse.” *See supra* paragraphs 95-97 (describing these regulations). Plus, the MA
8 Organizations’ execution of agreements with CMS under Parts C and D pursuant
9 to which they agree to implement effective compliance programs. *See* 42 C.F.R.
10 § 422.504(a) (stating that the agreement between an MA Organization and CMS
11 must include a provision by which the MA Organizations agree to comply with
12 the Part C regulatory requirements and general instructions issued by CMS). *See*
13 *also supra* paragraphs 66-72 (describing the Part C and D agreements); Exhibits 1-
14 7, attached hereto (examples of Part C agreements between the Defendant MA
15 Organizations and CMS by which the Defendant MA Organizations agreed to
16 implement effective compliance programs).
- 17 • The regulations requiring the submission of the Risk Adjustment Attestations. *See*
18 *supra* paragraphs 98-102 (describing those regulations). Plus, the requirements set
19 forth in the Medicare Managed Care Manual and elsewhere that MA
20 Organizations exercise both good faith and due diligence in order to submit
21 truthful Risk Adjustment Attestations to the Government certifying that their risk
22 adjustment data is accurate and truthful. *See supra* paragraph 102. In addition,
23 the separate contractual requirement to submit Risk Adjustment Attestations and
24 to comply with the Medicare Managed Care Manual. *See, e.g.*, Exhibits 1-7,
25 attached hereto (examples of the Defendant MA Organizations’ Parts C
26 agreements with CMS by which they agree to submit such Attestations and to
27 comply with the Medicare Managed Care Manual).

- 1 • The requirement in the CMS' Participant Guides that MA Organizations delete
2 erroneous diagnosis data submitted to CMS. See 2003 Regional Risk Adjustment
3 Training for Medicare+Choice Organizations Participant Guide, § 6.1;
4 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations
5 Participant Guide, §§ 4.12 to 4.16; 2005 Risk Adjustment Data Basic Training for
6 Medicare Advantage Organizations Participant Guide §§ 4.12 to 4.16; 2006 Risk
7 Adjustment Data Basic Training for Medicare Advantage Organizations
8 Participant Guide §§ 4.12 to 4.16; 2007 Risk Adjustment Data Training for
9 Medicare Advantage Organizations Participant Guide §§ 4.12 to 4.16; 2008 Risk
10 Adjustment Technical Assistance for Medicare Advantage Organizations
11 Participant Guide §§ 4.12 to 4.16. This requirement is also included in 2014 and
12 2016 CMS training presentations. See *infra* paragraph 108. Plus, the regulatory
13 and contractual requirement that MA Organizations' comply with CMS'
14 instructions and policies. See 42 C.F.R. § 422.504(a) (stating that the agreement
15 between an MA Organization and CMS must include a provision by which the
16 MA Organizations agree to comply with the Part C regulatory requirements and
17 general instructions issued by CMS) (emphasis added). See also, e.g., Exhibits 1-
18 7 hereto (examples of the Defendant MA Organization's agreements to comply
19 with the CMS instructions and policies).
- 20 • The requirement in the Medicare Managed Care Manual that "[i]f upon
21 conducting an internal review of submitted diagnosis codes, the [MA
22 Organization] determines that any ICD-9-CM diagnosis codes that have been
23 submitted do not meet risk adjustment submission requirements [which includes
24 medical record support for all diagnoses], the [MA Organization] is responsible
25 for deleting the submitted ICD-9-CM diagnosis codes as soon as possible."
26 Medicare Managed Care Manual, Chapter 7, § 40 (June 2013). Plus, the
27 regulatory requirement that MA Organizations' comply with the Manual and MA
28 Organizations' contractual agreements to comply with the Manual. See 42 C.F.R.

1 § 422.504(a) (stating that the agreement between an MA Organization and CMS
2 must include a provision by which the MA Organizations agree to comply with
3 the Part C regulatory requirements and general instructions issued by CMS). *See*
4 *also, e.g.*, Exhibits 1-7 hereto (examples of the Defendant MA Organization's
5 agreements to comply with the Medicare Managed Care Manual).

6 105. Related Entities are also obligated to delete invalid diagnoses previously
7 submitted by them to RAPS or to use other available means to return risk adjustment
8 payments based on invalid diagnoses. Like the MA Organizations to which they are
9 related, they are required to comply with the Part C and D regulations, the Medicare
10 Managed Care Manual, the Participant Guides, and the other general instructions issued
11 by CMS. In addition, when they submit risk adjustment data to the MA Program on
12 behalf of their related MA Organizations, they are obligated to execute separate EDI
13 agreements and Risk Adjustment Attestations, both of which impose an obligation to
14 delete invalid diagnoses.

15 106. As previously explained, RAPS provides a means for MA Organizations and
16 others submitting data on their behalf (such as Ingenix and then Optum) to withdraw or
17 retract invalid diagnoses that they previously submitted to RAPS for risk adjustment
18 payments. The process of withdrawing or retracting invalid diagnosis codes is often
19 referred to as making "DELETES" because the field in RAPS that enables this to be
20 accomplished is called a "Delete Indicator." The withdrawal or retraction of a diagnosis
21 codes is also often referred to as a "DELETE."

22 107. CMS began instructing MA Organizations on the use of RAPS in the early 2000s
23 in order to facilitate the phase in, during the 2004 to 2007 time period, of the use of
24 diagnoses from physician office visits and hospital outpatient encounters to risk adjust
25 for health status using the HCC model. It issued Risk Adjustment Training Participant
26 Guides in order to provide instructions relating to, among other things, the use of RAPS
27 to submit and delete data. The 2003 Risk Adjustment Training Participant Guide stated:
28 "Now that the RAPS system is operational, effective October 1, 2002, the new system

1 allows for correction of risk adjustment data via the deletion process.” 2003 Regional
2 Risk Adjustment Training for Medicare+Choice Organizations Participant Guide, § 6.11
3 (titled “Modifying Risk Adjustment Data”). The 2003 Guide listed various reasons why
4 risk adjustment data may need to be deleted, including in order to withdraw an erroneous
5 diagnoses code. *Id.* at § 6.12.1. Finally, it stated that M+C organizations “must submit
6 delete records” to correct erroneous diagnosis data. *Id.* at § 6.12.3. The Guide made
7 very clear that deleting erroneous diagnoses was mandatory. Subsequent versions of the
8 Guide have included the same mandatory deletion requirement and instructions. *See*
9 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations
10 Participant Guide, §§ 4.12 to 4.16; 2005 Risk Adjustment Data Basic Training for
11 Medicare Advantage Organizations Participant Guide §§ 4.12 to 4.16; 2006 Risk
12 Adjustment Data Basic Training for Medicare Advantage Organizations Participant
13 Guide §§ 4.12 to 4.16; 2007 Risk Adjustment Data Training for Medicare Advantage
14 Organizations Participant Guide §§ 4.12 to 4.16; 2008 Risk Adjustment Technical
15 Assistance for Medicare Advantage Organizations Participant Guide §§ 4.12 to 4.16.
16 108. The same mandatory requirement and instructions about deletions of invalid
17 diagnoses were also set forth in other CMS instructional materials used to train MA
18 Organizations. For instance, a 2003 presentation titled “Regional Risk Adjustment
19 Training for Medicare+Choice Organization Questions & Answers” instructed that “all
20 information that is submitted must be correct. If a plan identifies incorrect or invalid
21 information that has been submitted, it must delete that information.” These instructions
22 were also provided in CMS’ presentation slides for a July 1, 2014 Risk Adjustment
23 Webinar used to provide training to MA Organizations and others about how risk
24 adjustment operates. A training presentation that CMS made to MA Organizations and
25 others on June 23, 2016, also stated that it was the responsibility of each MA
26 Organization to “delete each instance of unsupported diagnoses from” RAPS. All of the
27 above-mentioned Participant Guides and other instructional materials also describe an
28 alternative method for deleting erroneous data using a Direct Data Entry system.

1 109. All of the above-mentioned Participant Guides and other instructional materials
2 have been and continue to be available to all MA Organizations and others on a website
3 hosted by a CMS contractor. *See* www.csscooperations.com. The 2003 to 2011 material
4 is in the Training subsection under Risk Adjustment Processing System in the Archives
5 and the 2012 to 2016 material is in the Training subsection under Risk Adjustment
6 Processing System on the Home page.

7 110. MA Organizations can delete invalid diagnoses both before and after the final
8 deadline for RAPS data submissions, which is sometime during the year following the
9 payment year at issue. The final deadline is only a submission deadline; it does not
10 pertain to deleting invalid diagnoses in order to withdraw them. *See* 42 C.F.R.
11 § 422.310(g)(2)(ii) (codifying pre-existing process permitting, after the final deadline,
12 only corrections to delete diagnoses from previously-submitted risk adjustment data).
13 Diagnoses deleted before the deadline for RAPS data submissions for a payment year are
14 known as “open-period deletes” and diagnoses deleted after the deadline for RAPS data
15 submissions for a payment year are known as “closed-period deletes.”

16 111. Because the final submission deadline is after the completion of the payment year,
17 monthly payments made during the payment year are interim payments. After the final
18 submission deadline, CMS determines if any adjustments to these interim monthly
19 payments are necessary based on all diagnoses submitted (and not deleted) for each
20 beneficiary up until the final submission deadline and re-calculates each beneficiary’s
21 risk score for the payment year to determine if it has changed and whether a plus or
22 minus adjustment to the payment for the beneficiary is necessary. If the beneficiary’s
23 risk score is higher because of the submission of additional diagnoses for that
24 beneficiary, CMS makes a final reconciliation payment of any additional payment owed
25 to the Plan for that beneficiary for that payment year. Conversely, if the beneficiary’s
26 risk score is lower because of the deletion of diagnoses for that beneficiary prior to the
27 final submission deadline, CMS recovers the payments associated with the deleted
28 diagnoses as part of this final reconciliation payment process.

1 112. Accordingly, if, prior to the final submission deadline, an MA Organization is in
2 possession of or has access to information about invalid diagnoses, it should delete
3 invalid diagnoses prior to that deadline to ensure that the final reconciliation payment
4 that it is claiming is correct. If, however, an MA Organization comes into possession or
5 otherwise gains access to information about invalid diagnoses after the final submission
6 deadline, it must still delete the invalid diagnoses, and CMS will still recover the risk
7 adjustment payments associated with the deleted diagnoses as part of additional risk
8 score rerun and reconciliation processes it has in place to recover overpayments.

9 113. The UHG Managing Defendants knew how to make deletes in RAPS. They also
10 knew the difference in making “open-period” and “closed-period” deletes. The
11 individuals who knew about the delete process and the difference between “open-period”
12 and “closed-period” deletes included, but were not limited to: Rebecca Martin, the
13 Director of Encounter Operations for Ingenix and then the Director of Data Remediation
14 for Optum; Jon Bird at Optum; and Scott Theisen and Brian Thompson at
15 UnitedHealthcare Medicare & Retirement.

16 114. However, Defendants violated the FCA by knowingly and improperly failing to
17 delete many invalid diagnoses and, thus, failing to repay risk adjustment payments to
18 which they were not entitled.

19 **THE FALSE CLAIMS ACT**

20 115. The FCA reflects Congress’s objective to “enhance the Government’s ability to
21 recover losses as a result of fraud against the Government.” S. Rep. No. 99-345, at 1
22 (1986), available at 1986 U.S.C.C.A.N. 5266. First, a defendant violates the FCA when
23 it “knowingly presents, or causes to be presented, a false or fraudulent claim for payment
24 or approval.” 31 U.S.C. § 3729(a)(1)(A). Under the FCA, a claim includes a request for
25 money. *Id.*, § 3729(b)(2). Further, a claim is “false or fraudulent” under the FCA if the
26 entity or person submitting the claim was not entitled to payment.

27 116. Second, after the 2009 amendments to the FCA by the Fraud Enforcement and
28 Recovery Act of 2009 (“FERA”), Pub.L. 111-21 (May 20, 2009), a defendant violates

1 the FCA when it “knowingly makes, uses, or causes to be made or used, a false record or
2 statement material to a false or fraudulent claim.” 31 U.S.C. § 3729(a)(1)(B). Prior to
3 FERA, a defendant violated this provision of the FCA when it “knowingly [made],
4 use[d], or cause[d] to be made or used, a false record or statement to get a false or
5 fraudulent claim paid or approved by the Government.”

6 117. Third, in May 2009, Congress amended the “reverse false claims act” provision of
7 the FCA to provide that a defendant violates the FCA when it “knowingly conceals *or*
8 knowingly and improperly avoids *or* decreases an obligation to pay or transmit money or
9 property to the Government.” 31 U.S.C. § 3729(a)(1)(G) (emphasis added). Prior to
10 FERA, this provision of the FCA provided that a defendant violates the FCA when it
11 “knowingly makes, uses, or causes to be made or used, a false record or statement to
12 conceal, avoid, or decrease an obligation to pay or transmit money or property to the
13 Government.” After FERA, a defendant violates this provision of the FCA when it
14 “knowingly makes, uses, or causes to be made or used, a false record or statement
15 material to an obligation to pay or transmit money or property to the Government, *or*
16 knowingly conceals *or* knowingly and improperly avoids *or* decreases an obligation to
17 pay or transmit money or property to the Government.” 31 U.S.C. § 3729(a)(1)(G)
18 (emphasis added).

19 118. Under the FCA, the terms “knowing” and “knowingly” mean that the defendant
20 had actual knowledge of or acted in deliberate ignorance or reckless disregard of
21 information relating to the truth or falsity of its claims for payment or its false records or
22 statements. *Id.* § 3729(b)(1)(A). Proof that the defendant had specific intent to defraud
23 the Government is not required. *Id.* § 3729(b)(1)(B). Congress included “deliberate
24 ignorance” in its definition of the terms “knowing” and “knowingly” to hold a defendant
25 accountable for failing to make the inquiry that a reasonable and prudent person or entity
26 would have made under the circumstances to be reasonably certain that he, she, or it was
27 entitled to the money that he, she, or it sought from the Government. S. Rep. No. 99-
28 345, at 21 (1986), as reprinted in 1986 U.S.C.A.N. 5266, 5286. The terms “knowing”

1 and “knowingly” used in this Amended Complaint have the meaning ascribed to them by
2 the FCA. Similarly, the terms “knowledge,” “knows” and “knew” are used in this
3 Amended Complaint to have the same meaning.

4 119. In 2009, Congress also amended the FCA to provide a definition of the term
5 “obligation” for the purpose of the new “reverse false claims act” provision of the
6 statute, section 3729(a)(1)(G). *See* FERA, Pub. L. 111-21, 123 Stat. 1617, 1621-25
7 (2009). It defined the term to mean “an established duty, *whether or not fixed*, arising
8 from an express or implied contractual ... relationship, from a fee-based or similar
9 relationship, from statute or regulation, or from the retention of any overpayment.” 31
10 U.S.C. § 3729(b)(3) (emphasis added). Congress promulgated this definition to reflect
11 its long-held view that an “obligation” under the FCA’s reverse FCA provision, 31
12 U.S.C. § 3729(a)(1)(G), encompasses non-fixed and contingent duties to pay or repay
13 monies to the Government. S. Rep. 111-10, 14, 2009 U.S.C.C.A.N. 430, 441.

14 120. Under the FCA, “material” means “having a natural tendency to influence, or
15 capable of influencing, the payment or receipt of money or property.” *Id.* § 3729(b)(4).

16 121. Under the FCA, the Government is entitled to recover three times the amount of
17 damages which it sustained because of a defendant’s violation of the statute and, for each
18 act by the defendant violating the statute, a civil penalty. For violations that occurred
19 before November 2, 2015, the FCA imposes a penalty for each violation of not less than
20 \$5,500 and not more than \$11,000. For violations occurring after November 2, 2015, all
21 civil statutory penalties, including the FCA, are subject to an annual adjustment for
22 inflation pursuant to Section 701 of the Bipartisan Budget Act of 2015, Public Law 114-
23 74 (No. 2, 2015) (“BBA”). At this time, by operation of the BBA, for violations that
24 occurred after November 2, 2015, the FCA imposes a penalty of not less than \$10,957
25 and not more than \$21,916 per violation, and these amounts are subject to annual
26 adjustment for inflation in future years. *See* 28 C.R.F. § 85.5 (identifying applicable
27 inflation adjustments on an annual basis).

THE FACTS

122. Since at least 2005, Defendants knew that diagnoses submitted to Medicare for risk adjustment payments had to satisfy various criteria and be supported and validated by the medical records of the beneficiaries in their MA Plans. Defendants also knew that many provider-reported diagnoses were not supported and validated by the beneficiaries' medical records and that they were obliged to undertake good faith efforts to identify and delete those unsupported and invalid diagnoses. Moreover, Defendants knew that they were obligated to "look both ways" at the results of their chart reviews and delete unsupported provider-reported diagnoses. Nonetheless, Defendants conducted millions of medical record reviews as part of their revenue-generating national Chart Review Program, turned a blind eye to the negative results of those reviews showing hundreds of thousands of unsupported diagnoses that the UHG Managing Defendants had previously submitted to Medicare on behalf of the Defendant MA Organizations, and knowingly and improperly avoided repaying Medicare for at least over a billion dollars in risk adjustment payments to which they were not entitled. Similarly, Defendants disregarded information from their RACCR Program about invalid coding practices by their incentivized capitated and gain-sharing providers and failed to repay Medicare for additional erroneous payments based on their invalid diagnoses.

I. Defendants Knew That Many Provider-Reported Diagnoses Were Invalid And That They Were Obligated To Undertake Good Faith Efforts To Identify And Delete Them

123. As part of its 2005 acquisition of PacifiCare, UHG retained the PacifiCare employees with knowledge about the requirements for the submission of valid diagnoses, the obligation to delete invalid diagnoses, and the various problems relating to the invalidity of provider-reported diagnoses. UHG retained these PacifiCare employees to continue performing work relating to risk adjustment.

124. For example, Jeffrey Dumcum, Stephanie Will, Pam Holt, and Pam Leal were all former PacifiCare employees knowledgeable about risk adjustment and were retained by

1 UHG to run its risk adjustment programs. Dumcum had been PacifiCare's Chief
2 Financial Officer and, after the acquisition, became Vice President of Finance for
3 Oventions. Will had been a Principal Analyst at PacifiCare who designed risk adjustment
4 programs and, after the acquisition, joined Oventions as the Program Manager for the
5 national Chart Review Program. Holt had been a Project Manager for Network
6 Management Operations at PacifiCare and, after the acquisition, became the Manager of
7 Provider Outreach for the Risk Adjustment Program. Leal had been an Executive
8 Director of Provider Training and Development for PacifiCare and, after the acquisition,
9 became a Regional Vice President for Market Consultation.

10 125. From 2005 to 2007, Dumcum, Will, Holt, and Leal worked at the PacifiCare
11 office in the Central District of California. Thereafter, Holt and Leal continued to work
12 for Ingenix at its office in the Central District of California.

13 126. The PacifiCare employees obtained their knowledge about risk adjustment from
14 various sources, including CMS. Will attended CMS training programs focused on the
15 Risk Adjustment Participant Guide and was also familiar with the content of this
16 document based on her reading of it. Prior to the acquisition, PacifiCare also conducted
17 various risk adjustment programs, including a chart review program, and provided
18 training to healthcare professionals concerning medical record documentation and
19 diagnosis coding.

20 127. In addition, PacifiCare had been a member of an industry association called the
21 Industry Collaboration Effort ("ICE") and ICE's Risk Adjustment Data Acquisition &
22 Reporting ("RADAR") team. ICE was an association of MA Organizations and provider
23 groups in California that served beneficiaries in MA Plans. ICE focused on risk
24 adjustment issues and other matters of particular importance to the managed care
25 industry. After PacifiCare became part of UHG, the PacifiCare employees continued to
26 participate in ICE and its RADAR team. During the 2006 and 2007 time period (perhaps
27 longer), Leal was the President and a member of the Board of Directors of ICE. Leal
28 continued in a leadership role at ICE until 2013. During that time period, she worked for

1 Ingenix and then Optum. At the ICE Annual Conferences in 2006 and 2007, Leal made
2 presentations about “[p]rovider coding [being] highly inaccurate and incomplete,” CMS
3 reviews showing that 30 percent of the provider-reported diagnoses were not supported
4 by medical records, and the use of chart reviews to generate larger risk adjustment
5 payments. Furthermore, throughout the time period relevant to this Amended
6 Complaint, one or more of the Defendants were members of ICE and, at various times,
7 employees of Ingenix, Optum, UnitedHealthcare of California, and UnitedHealthcare
8 participated in the activities of the RADAR team. As reflected in the meeting minutes of
9 the RADAR team, these Defendants included Ingenix (*e.g.*, August 2011),
10 UnitedHealthcare of California (*e.g.*, March 2014), Optum (*e.g.*, November 2014, June
11 2015, and March 2016), and UnitedHealthcare (*e.g.*, June 2015 and March 2016).

12 128. The former PacifiCare employees knew that a beneficiary’s medical record was
13 the “source of truth” for purposes of submitting valid diagnostic data to the MA Program
14 for risk adjustment payments. For example, in a March 2006 email, Will acknowledged
15 that diagnosis data had to be “fully supported by medical record documentation.” As
16 another example, in 2008, Ingenix sent notices to capitated provider groups in California
17 instructing them that they should only report to Ingenix “diagnosis codes that can be
18 supported by the documentation in the medical record.” Furthermore, according to
19 Randall Myers at Ingenix, these providers, when they submitted diagnoses through a
20 web portal referred to as the Alternate Submission Method, were required to attest that
21 their diagnostic data complied with CMS requirements for the submission of valid data.
22 Other employees of the UHG Managing Defendants also understood these requirements,
23 including Patty Brennan who, when she was Director of Retrospective Services
24 (including chart review services) at Ingenix and then Optum, acknowledged that CMS’
25 Risk Adjustment Participant Guide established that the medical record was the “one
26 source of truth” for MA Organizations to ensure that they were submitting accurate data
27 to CMS for risk adjustment payments. In addition, Kimberly Halva, the Compliance
28

Officer for UnitedHealthcare Medicare & Retirement from 2010 to 2013, was aware that “[a] medical record must substantiate all diagnostic information provided to CMS.”

129. In addition, those Defendants and their employees involved in ICE and its RADAR team knew or should have known that enrollees’ medical records are the “source of truth” based on guidance documents issued by the RADAR team about this fundamental payment requirement. In 2010, ICE’s RADAR team issued a guidance document highlighting that CMS requires complete and accurate documentation of medical conditions for the submission of diagnoses, that only diagnoses depicting documented medical conditions which required or affected patient care are valid, and that diagnosis codes cannot be submitted “until [the provider] is sure the patient has the condition.” The ICE RADAR Physician Education Work Group also issued a similar document called “Best Practices for Risk Adjustment,” which advised that “ICD-9-CM coding requires documentation of the diagnosis in the medical record as well as evaluation and management. Documentation should indicate how this diagnosis impacted this episode of care.” In 2012, ICE also issued a Medical Record Documentation Tips sheet, which once again warned MA Organizations and providers not to code diagnoses that are probable, suspected, questionable, or “working diagnoses,” and also not to code diagnoses when medical records use “other similar terms indicating uncertainty.” More recently, in 2013, ICE issued a “Documentation Newsletter” that repeated earlier advice and also cautioned that “[c]oding guidelines **prohibit coders from making assumptions**” regarding whether a diagnosis is or is not substantiated by a patient’s medical record. (Emphasis in the original.) That is, the medical record must “clearly reflect” the medical condition.

130. The former PacifiCare employees also were aware that provider-reported diagnoses often did not comply with CMS requirements and were often inconsistent with the information in their patients’ medical records. According to Dumcum, when he was the Chief Financial Officer of PacifiCare, he and others there knew “in Medicare Advantage that the claims did not always match the medical record documentation. So

1 ... we were concerned that it should be a place that we try to improve, that we try to
2 educate and try to identify things to make that better.” In addition, Will, Holt and other
3 former PacifiCare employees were aware of common diagnosis coding errors made by
4 providers. They learned of these problems from PacifiCare employees working in the
5 field with physicians, reports of physician-coding trends, and reports from PacifiCare-
6 employed certified coders. For example, a June 2003 PacifiCare PowerPoint
7 Presentation by Will, Holt, and other PacifiCare employees identified diabetes as a
8 medical condition that was often miscoded.

9 131. In 2005, the PacifiCare employees, including Dumcum, Will, Leal, and Holt, were
10 also aware of a data validation review conducted by the Government of diagnosis codes
11 previously submitted for medical encounters that occurred in 2003 (*i.e.*, encounters with
12 2003 dates of service). The PacifiCare employees were aware that the results of CMS’
13 medical record reviews showed that approximately 30 percent of the provider-reported
14 diagnoses were invalid and, after UHG acquired PacifiCare, Dumcum, Will, and Leal
15 shared this information with other individuals who worked for various UHG Managing
16 Defendants such as Jerry Knutson, Lee Valenta, Cynthia Polich, Relator Poehling, Paul
17 Bihm, Janice Redmond, and Carol Thompson. Furthermore, the results from this CMS
18 review also put the former PacifiCare employees on notice that providers were reporting
19 codes that were just plain wrong, were coded from laboratory reports, and did not reflect
20 current medical conditions – all of which was in breach of the fundamental rules that the
21 diagnosis codes submitted to Medicare must be accurate and truthful, based on face-to-
22 face visits (*e.g.*, not lab reports), reflect current conditions, and otherwise be valid.

23 132. Moreover, the former PacifiCare employees were aware that MA Organizations
24 are not entitled to risk adjustment payments based on diagnoses that are unsupported by
25 the beneficiaries’ medical records, and that CMS expected health plans to delete
26 incorrect diagnoses submitted for risk adjustment payments. They also knew, based on
27 their experiences at PacifiCare, that CMS could audit the diagnoses MA Organizations
28 submitted for risk adjustment payments.

1 133. In fact, in April 2005, Holt participated in a “CMS data validation call” in which
2 CMS explained that it expected MA Organizations to correct invalid diagnoses
3 submitted to Medicare for risk adjustment payments. Holt reported this to Will and
4 suggested creating a spreadsheet to give to providers for providers to use to inform
5 PacifiCare of invalid diagnoses and allow PacifiCare to delete them. As part of this
6 discussion, Leal explained to Will that, if provider groups “during their chart audits find
7 that physicians have documented rule-out or history-of but coded as if the member had
8 [the medical condition,] they want to be able to fix it so when we get audited again by
9 CMS it is fixed.” Leal further stated that “[o]bviously, as issues are identified there will
10 need to be education to physician[s] on changing their practice of coding incorrectly (as
11 you remember Dr. Norman mentioned habits doctors have, that we will need to break).”
12 Holt agreed that provider groups

- 13 • need something ‘standardized and formalized’ so they know what fields to report
14 if and when they find any obvious discrepancies. They are the type of thing that
15 Pam [Leal] stated in her email below, the code of the actual disease when the
16 documentation clearly only supports ‘history of’ or ‘suspected’ (and then it was
17 not confirmed), or an obvious miscode; the things that Melissa [Ferron] is finding
18 in the data validation. Provider groups will find this during their own chart audits.
- 19 • and CMS “was very firm that we need to be doing this, so I would expect [CMS]
20 will look for our process when they get around to more formally auditing our
21 oversight of this process.”

22 134. In addition, in August 2006, a year after the April 2005 CMS validation call, Will
23 and Holt knew that CMS had confirmed, in responses to questions about its RADV
24 audits, that it would invalidate diagnoses submitted to Medicare that were not supported
25 by the beneficiaries’ medical records.

26 135. After PacifiCare became part of UHG, the former PacifiCare employees began
27 educating others at the UHG Managing Defendants about risk adjustment. In particular,
28 Dumcum made a series of presentations to various employees, including senior

1 management employees of the UHG Managing Defendants such as Ovations' Jerry
2 Knutson, where he explained that "[p]rovider coding is highly inaccurate and
3 incomplete" and that "more than 30% of coded conditions are not supported by CMS
4 validation findings." Other senior executives or managers of the UHG Managing
5 Defendants that were recipients of the slide presentation with this information included
6 Cynthia Polich at Ovations (who was emailed a copy of the presentation in March 2007),
7 Lee Valenta at Ingenix (to whom Knutson emailed a copy of the presentation in May
8 2007), and Relator Poehling.

9 136. Furthermore, Defendants' own data revealed and confirmed problems with
10 provider-reported diagnoses. In September 2006, Will, Holt, Leal, and others generated
11 a list of providers that were outliers, which, at that time, they defined as providers with
12 significantly above average patient risk scores. This information made them "question
13 the validity" of these providers' codes. These provider groups included Healthcare
14 Partners Medical Group, Edinger Medical Group, WellMed, and other incentivized
15 provider groups which, based on subsequent reviews conducted as part of the RACCR
16 Program, submitted significant numbers of invalid diagnoses. After 2006, Ingenix and
17 then Optum continued to track risk scores of beneficiaries cared for by various provider
18 groups and saw risk scores they considered to be outliers. They also generated
19 prevalence reports that identified the provider groups with abnormally high average risk
20 scores. These prevalence reports also identified specific medical conditions (or
21 categories of medical conditions, that is, HCCs) that were reported by various provider
22 groups at rates significantly above average.

23 137. In 2007, Dumcum and other former PacifiCare employees were given the
24 responsibility for creating and then managing a risk adjustment service group within
25 Ingenix, the predecessor to Optum. This enabled UHG to move the risk adjustment
26 operations to Ingenix. Ovations and later UnitedHealthcare became Ingenix's internal
27 "client." This move also enabled Ingenix to offer its risk adjustment services to other
28 MA Organizations which it referred to as its "commercial clients." Dumcum became

1 Senior Vice President and Will became Vice President of Risk Adjustment Programs for
2 this new risk adjustment service group within Ingenix. After 2007, Ingenix hired
3 additional employees and increased the size of the Ingenix risk adjustment group,
4 including the size of the group in this District. The Ingenix risk adjustment group in this
5 District was responsible for, among other things, risk adjustment data/diagnosis codes
6 submissions, risk adjustment data remediation and the deletion of invalid diagnoses, risk
7 adjustment data analytics and finance (*e.g.*, tracking the results and financial impact of
8 the Chart Review and Claims Verification Programs), provider outreach and programs
9 relating to risk adjustment, and the Chart Review Program operations.

10 138. In January 2007, Dumcum made a presentation in which he stated that the
11 validation of provider-reported diagnosis codes had to improve. Dumcum knew that
12 providers were reporting unsupported diagnoses and that both fee-for-service and
13 capitated providers needed to improve their validation rates.

14 139. Prior to this, in 2006, Dumcum, Will, Holt and others had already participated in
15 discussions about conducting an Internal Data Validation (“IDV”) Program focused on
16 the validity of provider-reported diagnoses. The purpose of the IDV Program was to
17 determine whether the physicians’ medical records supported the diagnoses they
18 reported to the UHG Managing Defendants, who in turn submitted the diagnoses to
19 Medicare for risk adjustment payments.

20 140. In February 2007, Will, Holt, and Patricia Rasmussen, Manager of Encounter
21 Submissions at Ingenix, were informed of specific provider-reported codes that were
22 reported based on “faulty coding.” For example, Sharp Community Medical Group in
23 California submitted a diagnosis tracking to HCC 155 (Major Head Injury) but there was
24 “no documentation to support intracranial injury.” Likewise, Monarch/South Coast,
25 located in this District, submitted a diagnosis tracking to HCC 17 but there was “[n]o
26 documentation of diabetes or diabetic complication[.]” Will, Holt, and Rasmussen were
27 requested to remove, or delete, these codes before the final submission deadline but
28 Rasmussen replied that they did not have resources and could not do this.

1 141. In addition, UHG Managing Defendants knew that a significant percentage of
2 provider-reported diagnoses were invalid based on audits performed by CMS and similar
3 internal audits or reviews that they performed. For example, one such audit was
4 performed on diagnoses submitted for 2004 date of service medical encounters (*e.g.*
5 physician office visits) that mapped to 1,231 HCCs. The results were reported in a
6 September 2007 Risk Adjustment Programs presentation sent by Dumcum to Relator
7 Poehling. The presentation showed that no support was found in the beneficiaries'
8 medical records for 32 percent of the HCCs at issue. That is, the records did not confirm
9 the diagnoses mapping to 32 percent of the HCCs under review. The same presentation
10 showed the results of another audit of diagnoses submitted for 2005 date of service
11 medical encounters that mapped to 1,160 HCCs. It showed that, as of the date of the
12 presentation, 18 percent of the HCCs were "NOT supported" and another 8 percent were
13 most likely not supported.

14 142. In October 2007, Ingenix also emphasized the fact that more than 30 percent of
15 provider-reported diagnoses were unsupported by the beneficiaries' medical records as a
16 selling point for the risk adjustment services, including data validation services, that it
17 marketed to another MA Organization.

18 143. During the 2007 and 2008 time period, Ingenix implemented the IDV Program.
19 The program focused on physicians in California, Missouri, Texas, and Washington who
20 reported more than three times the number of diagnoses than the average. The program
21 was very small in scope, but the results confirmed that providers reported many invalid
22 diagnoses. In January 2008, the results for medical encounters in 2006 showed a 30
23 percent invalidation rate. That is, approximately 30 percent of provider-reported
24 diagnoses were invalid, which was consistent with what the PacifiCare employees had
25 known since at least 2005. In January 2008, these results were sent to Will, Holt, and
26 Rasmussen.

27 144. Accordingly, by at least 2005, the former PacifiCare employees Dumcum, Will,
28 Holt, and Leal knew that at least 30 percent of provider-reported diagnoses were not

1 supported by the beneficiaries' medical records; by at least 2007, Duncum had imparted
2 this knowledge to others at the UHG Managing Defendants; and, by at least 2008, the
3 UHG Managing Defendants' own medical record reviews had confirmed that fact.

4 145. Additional evidence demonstrates that, by at least the 2007 and 2008 time period,
5 the invalidity of provider-reported diagnoses was an ongoing concern. For example, in
6 September 2008, one of United's own actuarial consulting subsidiaries, Reden &
7 Anders, made a presentation that identified unsupported diagnosis codes as a "Potential
8 Compliance Risk Area" and warned that "[t]here is no such thing as minimally
9 compliant." Ovation's President Cynthia Polich possessed a copy of this presentation.

10 146. In addition, by at least 2008, the former PacifiCare employees, then at Ingenix,
11 had also imparted their knowledge that the UHG Managing Defendants were obligated
12 to identify and delete invalid provider-reported diagnoses. For example, a January 2008
13 training guide entitled "CMS-HCC Risk Adjustment Training Module," created by
14 Ingenix personnel for provider outreach, recognized that it is the accuracy of medical
15 record documentation and coding that supports entitlement to risk adjusted payments
16 from the Medicare Program. The presentation recognized that accurate medical record
17 documentation is key to accurate risk adjustment payments and necessary to validate
18 payments. In addition, in June 2008 emails, Patty Brennan, the Compliance Manager for
19 Ingenix, and Karen Wagor, a Senior Coder and National Trainer for Ingenix, both of
20 whom worked at Ingenix's Santa Ana office, recognized that Defendant MA
21 Organizations were not entitled to payment based on diagnoses that were not validated
22 by beneficiaries' medical records and that those entities risked losing revenue based on
23 invalid diagnoses: "We could be at risk of losing \$\$ if there isn't another piece in the
24 documentation before or after this date of service for the HCC if it can't be verified with
25 the most accurate validation. **The medical record must support all diagnoses coded
26 for the date of service and must be able to stand alone for an audit on those reported
27 diagnosis codes.**" (Emphasis in the original.)
28

1 147. Moreover, the UHG Managing Defendants knew they were required to effectively
2 address compliance issues. For example, a presentation from November 2009 entitled
3 “UnitedHealth Group – Audit Management Overview,” made at a Medicare Compliance
4 Oversight Committee meeting, expressly acknowledged the legal obligation to
5 implement an effective compliance program and stated that “[i]n order to have an
6 effective Compliance Program, an organization must have a robust internal monitoring
7 and auditing process in place.” In 2009, Jenny O’Brien, the Chief Medicare Compliance
8 Officer, was a Co-Chair of the Medicare Compliance Oversight Committee, a position
9 she held until approximately 2015. During this time period, O’Brien worked for
10 Ovations and then UnitedHealthcare Medicare & Retirement. Her Co-Chair was the
11 Chief Executive Officer or another officer of Ovations and then UnitedHealthcare
12 Medicare & Retirement. In the 2010-2011 time frame, the Co-Chair was Tom Paul.
13 And, as another example, in approximately May 2010, Larry Renfro, who was then the
14 Chief Executive Officer of both the Public & Senior Market Group (PSMG) and
15 Defendant Ovations, and David Orbuch, who was then the Executive Vice President and
16 Chief Compliance Officer of PSMG, met with CMS regarding their Medicare
17 compliance program and represented to CMS that they would “meet and exceed” CMS’
18 expectations.

19 148. Kimberly Halva, UnitedHealth Medicare & Retirement’s Finance Compliance
20 Officer from 2010 to 2013, also was keenly aware that the validity of provider-reported
21 diagnoses needed to be addressed. Halva understood that MA Organizations had an
22 obligation to identify and delete diagnoses that were not supported by its beneficiaries’
23 medical records. (Halva was also familiar with the Risk Adjustment Participants Guide.)
24 In November 2010, she sent a memorandum to Relator Poehling with recommendations
25 for compliance problems focused on identifying and deleting invalid provider-reported
26 diagnoses. In January 2011, she sent Relator Poehling “a few suggestions for risk
27 mitigation type programs UnitedHealthcare Medicare and Retirement could take to more
28 equally distribute resources between programs dedicated to improper coding or billing

1 and those focused on identifying additional reimbursement opportunities through
2 improved coding/documentation.” One of Halva’s suggestions was for
3 UnitedHealthcare to perform “General Coding Accuracy Audits,” which were essentially
4 “look both ways” medical record reviews that would identify both incomplete coding
5 (which she referred to as “under-coding”) and inaccurate coding (which she referred to
6 as “over-coding”). Another of her suggestions was for UnitedHealthcare Medicare &
7 Retirement to “Specifically Identify Traditionally Over-Coded or Incorrectly Coded
8 Conditions,” “such as stroke or COPD,” and conduct medical record reviews to
9 determine if those traditionally over-coded or incorrectly coded conditions could be
10 validated. Halva and Scott Theisen, the Chief Financial Officer for UnitedHealthcare
11 Medicare & Retirement from 2010 to 2013, were Co-Chairs of the UnitedHealthcare
12 Medicare & Retirement Finance Compliance Oversight Committee, which was
13 responsible for risk adjustment compliance issues. Halva also reported to Theisen as
14 well as Jennifer O’Brien.

15 149. In or around early 2009, Deloitte & Touche, which served as the public
16 accounting firm for UHG (which filed a consolidated financial statement for all of its
17 businesses), sent a memo to Ovations regarding an audit it performed to investigate the
18 appropriateness of an accounting treatment used by Ovations. In the audit, Deloitte &
19 Touche “looked both ways” when reviewing MA Program beneficiaries’ medical records
20 because, according to Auditor Bill Nepple, that was the only way to achieve a full and
21 complete picture of a beneficiary’s health status. The results of this “look both ways”
22 audit were communicated to Relator Poehling in February 2009 and he was aware that
23 both ADDS and DELETES resulted from the audit.

24 150. In addition, as part of their compliance efforts, the UHG Managing Defendants
25 had, since at least 2008, required financially-incentivized capitated provider groups to
26 submit attestations to them that certified that the diagnoses that they reported to the UHG
27 Managing Defendants were valid and met CMS’s requirements. For example, in or
28 around 2008, Ingenix sent notices to these providers describing these “**CMS DATA**

1 **ACCEPTANCE GUIDELINES,”** and stating that “[a]ll diagnoses must be
2 **documented at the time of the patient encounter or after receipt and confirmation**
3 **of the diagnosis (i.e. Lab or Radiology report) and must be documented in the**
4 **medical record,”** and “[o]nly report diagnosis codes that can be supported by the
5 **documentation in the medical record,”** and “[a]ll diagnosis codes should be valid . . .
6 .” (Emphasis in the original.)

7 151. In 2010, Holt and Leal were a part of an email chain discussing California
8 provider groups and risk adjustment data validation. Based on Holt’s involvement with
9 ICE’s RADAR team (and possibly other sources), Holt noted that California provider
10 groups are “acutely aware of the importance of data validation” and that risk adjustment
11 data validation was “a subject discussed frequently at the ICE meetings.” In the same
12 email chain, Holt also assured Relator Poehling that provider groups in California would
13 understand the importance of CMS’s RADV audits.

14 152. In November 2009, the results of an IDV audit for one of Ingenix’s commercial
15 clients, another company that owned and operated MA Plans, further confirmed what the
16 UHG Managing Defendants already knew, that is, that providers were reporting invalid
17 diagnoses at an alarming rate. The results of the audit showed a 45 percent invalidation
18 rate. Providers in that commercial client’s plans were providers for beneficiaries in one
19 or more of the Defendant MA Organizations’ Plans.

20 153. In mid-2010, the results of IDV reviews once again confirmed an ongoing
21 problem with the validity of provider-reported diagnoses. The results showed an
22 invalidation rate of approximately 40 percent for California provider groups which cared
23 for beneficiaries enrolled in one of more UHG MA Plans. Higher than the 30 percent
24 invalidation rate reported in 2005, these results confirmed that a significant percentage of
25 provider-reported diagnoses were invalid. In mid-2010, these results were shared with
26 Relator Poehling, Keith Dobbins (an attorney for one of the UHG Managing
27 Defendants), Stephanie Will, Patty Brennan, Ronnie Grower, among other individuals
28 working for the UHG Managing Defendants.

1 154. Also, in June 2010, an Ingenix Health Reform Implementation (HRI) Report
2 prepared for UHG's then Chief Executive Officer, Steve Hemsley, and other members of
3 the "UHG executive team" identified compliance as an important issue of immediate
4 concern to UHG, particularly compliance with the FCA. This report was sent to
5 Dumcum, Knutson, Valenta, Andy Slavitt, Timothy Wicks, and other individuals
6 working for the UHG Managing Defendants at the time.

7 155. Furthermore, in 2010, additional Government audits confirmed the problem with
8 invalid provider-reported diagnoses. In March 2010, the HHS Office of Inspector
9 General ("OIG") sent Jack Larsen, the Chief Financial Officer of Ovations, a draft report
10 of an audit of the risk adjustment data that one of UHG's Texas MA Organizations, then
11 called PacifiCare of Texas, submitted for payment year 2007. In July 2010, OIG sent
12 Thomas Paul, the Chief Executive Officer of Ovations, a draft report of an audit of the
13 risk adjustment data that UHG's California MA Organization, then called PacifiCare of
14 California, submitted for payment year 2007. In the draft reports, the OIG concluded
15 that the diagnoses for half the beneficiaries in the California audit and 44 percent of the
16 beneficiaries in the Texas audit were invalid, and that both plans' practices were not
17 effective for ensuring that the diagnoses they submitted to CMS complied with CMS
18 requirements. These draft OIG reports were described as a "top issue" in the third
19 quarter 2010 Public & Senior Markets Group Medicare Compliance Program Overview
20 for which Jennifer O'Brien was the Compliance Program Lead and Tom Paul was the
21 Business Lead. In May 2010, Paul sent OIG a response about its draft report relating to
22 PacifiCare of Texas and, in October 2010, Paul (whose job title had then been changed
23 to Chief Executive Officer of UnitedHealthcare Medicare & Retirement) sent OIG a
24 response about its draft report relating to PacifiCare of California. After consideration of
25 Paul's responses to the draft audit reports, the OIG issued final reports concluding that
26 the health risk scores for 45 percent of the beneficiaries in the California audit and 43
27 percent of the beneficiaries in the Texas audit were invalid because the diagnoses were
28 not supported by the beneficiaries' medical records or were uncertain or unconfirmed

1 diagnoses. In both the draft and final reports, the OIG provided examples of
2 unsupported diagnoses. The OIG also concluded that the MA Organizations should
3 refund the overpayments due to these invalid diagnoses. In addition to Larsen and Paul,
4 other individuals who were aware of the OIG audit reports during the 2010 and 2011
5 time period included Scott Theisen, Jenny O'Brien, Kimberly Halva, Joseph Keen, and
6 Jeffrey Dumcum.

7 156. The results of RADV audits were also of concern to UnitedHealthcare. The third
8 quarter 2010 Public & Senior Markets Group Medicare Compliance Program Overview
9 (for which Jennifer O'Brien was the Compliance Program Lead and Tom Paul was the
10 Business Lead) also stated that CMS was conducting RADV audits of three of the
11 Defendant MA Organizations. Then, when CMS announced in February 2011 that it
12 planned to extrapolate the sample audit results, Charles Hanson, the then Vice President
13 of Finance and Underwriting at UnitedHealthcare Medicare & Retirement, left a
14 voicemail message for Relator Poehling stating: "I haven't been close to this for . . .
15 three or four years now probably, but back that far I know the results of our RADV
16 audits were concerning, to say the least. That we had significant . . . errors or
17 undocumented RAFs [*i.e.*, undocumented diagnoses] in our claim submissions." He
18 asked Poehling: "I'm sure we're careful about how we communicate these findings, but
19 can you give me a sense of kind of more recent RADV audits, what impact could this
20 have? So just generally, are we still sort of, I'll say as bad as we were a few years ago? .
21 . . So, what's the potential impact on revenue of extrapolating these RADV audit
22 findings . . . ?"

23 157. Because of the problem with provider-reported diagnoses, in 2010, the UHG
24 Managing Defendants started the RACCR Program, as described more fully at
25 paragraphs 239-292 below, and Claims Verification Program, as described more fully at
26 paragraphs 196-234 below. Mary Hammond, one of the UnitedHealthcare Medicare &
27 Retirement employees who oversaw the RACCR Program, described it as "an important
28 part of Medicare & Retirement's efforts to meet CMS requirements to submit accurate

1 risk adjustment data.” The Claims Verification Program was also supposed to satisfy
2 this basic payment rule.

3 158. However, the major effect of the Claims Verification and RACCR Programs was
4 that they highlighted that a significant amount of the risk adjustment payments claimed
5 by the UHG Managing Defendants on behalf of the Defendant MA Organizations and
6 paid to the Defendant MA Organizations by the Medicare Program were unsupported
7 and invalidated by beneficiaries’ medical records. For instance, as explained in more
8 detail in paragraph 206 below, in December 2010, the results of the first pilot phase
9 (Phase I) of the CV Program showed that provider-reported diagnoses were unsupported
10 for over 50 percent of the medical records reviewed. Over a year later, as explained in
11 more detail in paragraph 208 below, Optum had completed the second pilot phase (Phase
12 II) of the CV Program on 17,398 charts and the results were even more striking. Phase II
13 identified 4,786 invalid diagnoses to be deleted, which was greater than the number of
14 additional diagnoses (ADDS) identified based reviews of the same medical records. In
15 February 2012, Dumcum, who was responsible for the Claims Verification Program, met
16 with Relator Poehling and Theisen, who was the Chief Financial Officer of
17 UnitedHealthcare Medicare & Retirement at that time, and reported: “I’m deleting as
18 much as I’m adding at the end of the day. And I don’t know if—you know, what I want
19 to do.” He also stated: “we’re getting more and more red here,” and that Claims
20 Verification “eats in very substantially” to the revenue from ADDS from chart reviews.

21 159. In addition, as explained in more detail below, by February 2012, there were
22 “5,519 bad codes” that were “identified and deleted” as the result of RACCR reviews of
23 the medical records for only 13,451 beneficiaries. On a beneficiary basis, the results
24 showed more than a 40 percent invalidation rate.

25 160. Over time, the UHG Managing Defendants also obtained more information about
26 incorrect diagnosis coding by providers, some of which information confirmed what had
27 been known for years. For example, by at least 2013, Tracey Bradberry, an Ingenix and
28 then Optum employee who was a certified coder, was aware of various reasons for

1 invalid provider-reported diagnoses, including, for example, the “[c]linical findings
2 and/or treatment does not support the diagnosis” and “[n]ot a current condition.” In
3 addition, in March of 2014, Melissa Ferron, a coding consultant, sent Optum employee
4 Christopher Webb a list identifying various HCC codes and diagnosis codes that were
5 unlikely to validate based on medical record reviews because providers frequently used
6 the codes incorrectly. These included HCCs 17 (diabetes with acute complications), 96
7 (specified heart arrhythmias), 104 (monoplegia, other paralytic syndromes), and 111
8 (chronic obstructive pulmonary disease).

9 161. More recently, other employees of the UHG Managing Defendants also have
10 recognized the obligation to ensure the validity of diagnoses submitted for risk
11 adjustment payments. They also understood that the obligation to correct invalid data
12 provided to Medicare for risk adjustment payments. For example, in an April 2013
13 email, Marybeth Meyer, the Vice President of Operations for UnitedHealthcare
14 Medicare & Retirement who succeeded Relator Poehling in managing the risk
15 adjustment team for that group, stated that “as a Medicare Advantage Plan, if we become
16 aware of a coding issue that impacted the revenue received from CMS for risk
17 adjustment, we are obligated to investigate and correct the submissions to CMS.” In
18 response to Meyer’s email, Halva, then Compliance Officer for UnitedHealthcare
19 Medicare & Retirement, agreed. She also stated that “[w]e have an obligation to go back
20 to CMS and correct submissions that impact the revenue received for risk adjustment
21 purposes.” Halva did not think that anything was wrong with the requirement that
22 UnitedHealthcare Medicare & Retirement delete unsupported diagnoses. Moreover, she
23 believed that “arguably” this obligation existed for ten years because of the ten-year
24 statute of limitation for the Government to pursue FCA claims against entities that
25 knowingly fail to delete unsupported diagnoses.

26 162. As another example, in February 2014, Melissa Sedor who worked in
27 UnitedHealthcare Medicare & Retirement’s controller’s office, sent an email stating that
28 “it is our responsibility to submit accurate records to CMS. Even if the provider submits

1 bad data to us, the responsibility is on us to be submitting the correct data.” Sedor
2 further explained that this was the reason United implemented compliance programs like
3 RACCR and Claims Verification. Sedor’s email was sent to others at UnitedHealthcare,
4 including Marybeth Meyer and William Hnath.

5 163. Finally, other employees in addition to Halva were aware of the potential FCA
6 liability for submitting invalid diagnoses to CMS for risk adjustment payments or for
7 failing to delete them. For example, in 2010, Carol Thompson, then National Manager
8 for Ingenix’s Risk Adjustment Programs who worked at the Ingenix office in this
9 District, provided the following reason as justification for funding for a coding vendor
10 who was assisting the UHG Managing Defendants with a CMS RADV audit: “Politics
11 and Congressional scrutiny put an exclamation point on our need to demonstrate that the
12 data submitted to CMS for risk adjustment payment is valid. Data that drives payment
13 from the government can be reviewed to determine if the claims are ‘valid.’ Improper
14 claims submission can fall under the False Claims Act.” Also, as alleged more fully
15 below, Dumcum informed Relator Poehling that the FCA was a consideration in
16 deciding whether the UHG Managing Defendants should implement the Claims
17 Verification Program and “look both ways” at the results of their Chart Review Program.

18 **II. Chart Reviews and Claims Verification**

19 **A. United’s “Look One Way” Chart Review Program**

20 164. Over the last decade, Defendants have obtained billions of dollars of risk
21 adjustment payments from Medicare from its national Chart Review Program because
22 they only looked one way at the results of their coders’ chart reviews. As part of this
23 program, the coders were instructed to perform “blind” reviews of the beneficiaries’
24 medical records. That is, the coders did not know which, if any, diagnoses had been
25 reported by the providers who treated the beneficiaries and created the medical records.
26 Thus, rather than confirming diagnoses already reported by the providers or identifying
27 only additional diagnoses supported by the records, the coders were instructed to look
28 for all medical conditions purportedly documented in the records, record all diagnosis

1 codes identifying those conditions, and give all of those codes to the UHG Managing
2 Defendants. But, the UHG Managing Defendants selectively utilized results of these
3 chart reviews – that is, the coders’ list of diagnosis codes – for the sole purpose of
4 identifying diagnosis codes that the providers had not reported and submitting ADDS for
5 additional risk adjustment payments. They did not utilize the coders’ lists of diagnosis
6 codes to determine if the providers had reported codes that were not supported by their
7 own medical records. If the UHG Managing Defendants had looked both ways and
8 deleted these unsupported and, thus, invalid provider-reported codes, their national Chart
9 Review Program would have been far less lucrative.

10 165. The UHG Managing Defendants’ national Chart Review Program was their largest
11 risk adjustment revenue-generating program. This program was started in 2005 as an
12 outgrowth of the chart review program that PacifiCare was already conducting.
13 Dumcum, Will, and other former PacifiCare employees became key participants in
14 designing, implementing, and managing the United Managing Defendants’ revenue-
15 generating national Chart Review Program. Will was the Program Manager for the
16 program.

17 166. During the first few years of the program, hundreds of thousands of charts were
18 reviewed each year in order to mine them for additional diagnosis codes. In 2008, The
19 Coding Source (“TCS”), a chart review/diagnosis coding vendor retained by Ingenix,
20 reported to Carol Thompson at Ingenix that “[s]ince 2005, TCS has partnered with
21 PacifiCare-United and Ingenix to support your HHC initiatives. TCS has successfully
22 completed 460,000 chart reviews for multiple United regions.”

23 167. In 2009, the UHG Managing Defendants significantly expanded the size of the
24 national Chart Review Program by providing Ingenix with the funds to acquire a coding
25 vendor called AIM Healthcare Services, Inc. and integrating Ingenix’s operations in
26 Santa Ana, California, and the AIM coding operations in Tennessee, and by providing
27 Ingenix with the funds to develop an in-house chart review computer database system
28 called ChartSync so that Ingenix’s in-house coders and third-party coding vendors could

1 electronically review medical records and electronically record the coding results of their
2 reviews. At or about the same time, the UHG Managing Defendants also expanded the
3 size of the Chart Review Program by providing Ingenix with the funds to open offices in
4 foreign countries (the Philippines and India) where it could hire foreign workers to
5 review beneficiaries' medical records in order to try to find additional diagnosis codes.

6 168. Due to the increased resources devoted to the Chart Review Program, the number
7 of medical records reviewed in the hunt for additional codes significantly increased over
8 time. For the first few years of the Chart Review Program, between 500,000 and
9 600,000 charts were reviewed each year. According to a presentation by Dumcum,
10 600,000 charts were reviewed in 2006 and, as of September 21, 2007, 400,000 charts had
11 been reviewed so far that year with 200,000 charts remaining for review during the
12 fourth quarter of 2007.

13 169. By 2010, the number of chart reviews had increased substantially to
14 approximately 850,000 charts for that year. For 2011 to 2014, approximately 1.5 million
15 charts were reviewed each year. The Government believes that, after 2014, the national
16 Chart Review Program was most likely similar in size.

17 170. As part of this national Chart Review Program, the UHG Managing Defendants
18 focused primarily on the review of charts from providers paid on a fee-for-service basis.
19 Ingenix and then Optum or their vendors obtained medical records from thousands of
20 these providers throughout the United States. They or their vendors sent these medical
21 records to coders that they employed in Tennessee, India, and the Philippines. They also
22 hired coding vendors to review these medical records. Those vendors were located in
23 various locations within and outside of the United States.

24 171. Physician groups owned by one or more of the UHG Managing Defendants also
25 had chart review programs. WellMed had a group called DataRaps that conducted
26 reviews of its physicians' medical records for patients in one or more Defendant MA
27 Organizations' MA plans. Southwest Medical Associates conducted some of its own
28

1 reviews though it also relied on Ingenix's/Optum's coding operations in Tennessee and
2 coding vendors for its chart reviews.

3 172. In 2006, the Defendant MA Organizations obtained approximately \$270 million in
4 additional risk adjustment payments from the ADDS that were submitted on their behalf
5 by the UHG Managing Defendants based on the national Chart Review Program. The
6 return on investment was substantial (approximately \$250 million) as it cost only
7 approximately \$18 million to review the charts in 2006.

8 173. Not unexpectedly, as the number of medical records reviewed significantly
9 increased over the years, so did risk adjustment payments from ADDS based on the
10 national Chart Review Program. Defendant MA Organizations received approximately
11 \$426 million in additional risk adjustment payments from ADDs the UHG Managing
12 Defendants submitted to Medicare based on the medical record reviews conducted as
13 part of the Chart Review Program for the 2011 payment year, approximately \$455
14 million for the 2012 payment year, approximately \$758 million for the 2013 payment
15 year, and approximately \$882 million for the 2014 payment year.

16 174. For payment years 2010 to 2015 combined, Defendant MA Organizations
17 obtained over \$3 billion in additional risk adjustment payments from Medicare due to the
18 ADDs the UHG Managing Defendants submitted on their behalf based on medical
19 record reviews conducted as part of the national Chart Review Program.

20 175. United's Chart Review Program was conducted according to an annual cycle. For
21 example, in the spring of 2012, Optum started its collection and review of medical
22 records relating to medical encounters in 2011 (*i.e.*, with 2011 dates of service). These
23 efforts then intensified through the remainder of the year until the final deadline for
24 submitting diagnosis codes to Medicare for payment year 2012, which was February 15,
25 2013.

26 176. Prior to the start of each annual cycle, the UHG Managing Defendants' senior
27 executives set a revenue target for the program. After chart reviews started, these senior
28 executives then closely monitored the progress of the program and, if the forecast did not

1 look like the program would achieve the revenue target, they made changes to the
2 diagnostic coding being performed by the coders. For instance, when UnitedHealthcare
3 Medicare & Retirement and Optum were not achieving the return on investment
4 expected from chart reviews for the 2012 payment year, they “liberalized” coding
5 policies and engaged in a “Recode Project” consisting of re-reviewing 900,000 charts
6 that had already been mined once for additional diagnoses. They liberalized the coding
7 policies to enable the coders to identify more diagnosis codes purportedly supported by
8 the beneficiaries’ medical records. In this second-round review, the coders did identify
9 more codes purportedly supported by the records based on the liberalized coding
10 policies, and UnitedHealthcare Medicare & Retirement and Optum submitted those
11 codes to Medicare for additional risk adjustment payments. Scott Theisen at
12 UnitedHealthcare Medicare & Retirement and Karen Erickson and Jon Bird at Optum
13 were involved in this “Recode Project.”

14 177. Despite their aggressive coding to submit as many ADDS as possible to meet their
15 annual revenue targets for their Chart Review Program, officers of UnitedHealthcare
16 Medicare & Retirement attested to the validity of *all* of these ADDS in the annual Risk
17 Adjustment Attestations submitted to Medicare and various senior management
18 employees of both UnitedHealthcare Medicare & Retirement and Optum attested to the
19 validity of *all* of these ADDS in approving the annual Risk Adjustment Attestations
20 submitted to Medicare. *See infra* at paragraphs 296-308 (describing this internal
21 approval process). If the results of these chart reviews were so reliable that they could
22 attest to the validity of all of the ADDS, then the results were of equal reliability for
23 them to have deleted all previously-submitted diagnoses invalidated by the reviews. To
24 the extent that Defendants call into question the results of their own chart reviews in *not*
25 finding support for and *not* validating hundreds of thousands of diagnoses, they also call
26 into question the overall reliability of the chart reviews and validity of the ADDS.
27 Under those circumstances, Defendants acted with reckless disregard for the truth by
28 submitting the ADDS and attesting to their validity, knowing they were not entitled to

1 payments by Medicare based on such unreliable data and the United States is entitled to
2 recover those payments in this action.

3 **B. United Knew It Was Obligated To Look Both Ways At The**
4 **Results Of Its Chart Reviews And Make DELETES As**
5 **Well As ADDS**

6 178. By 2008, Relator Poehling and others began to question the practice of ignoring
7 the negative results of blind chart reviews invalidating many provider-reported
8 diagnoses. In May 2008, Relator Poehling participated in a meeting in which he
9 discussed this issue with Will. She explained to Relator Poehling that, as part of the
10 Chart Review Program, Ovations and Ingenix did not look at whether provider-reported
11 diagnoses were not substantiated by the results of the coders' blind chart reviews.
12 Poehling and Will discussed the idea of changing this process, comparing the results of
13 the blind chart reviews to the provider-reported diagnoses that Ovations and Ingenix had
14 submitted to CMS, and deleting the unsupported diagnoses.

15 179. Thereafter, the need to address problems with the diagnoses reported by providers
16 continued to be an issue. In March 2009, the question of how to address problems with
17 diagnoses reported by fee-for-service providers arose during a discussion among Ingenix
18 employees about the Internal Data Validation Program that Ingenix conducted for
19 Ovations and the Defendant MA Organizations. During that discussion, Ronnie Grower,
20 Vice President of Market Consultation for Ingenix, noted that the Internal Data
21 Validation Program excluded fee-for-service providers and questioned whether the UHG
22 Managing Defendants would have another program to address diagnoses reported by fee-
23 for-service providers given that "there are common coding errors that get reported across
24 all providers." In fact, other than its short-lived Claims Verification Program, the UHG
25 Managing Defendants never had a medical record review program like the IDV or
26 RACCR Programs to address the validity (or lack thereof) of diagnoses reported to it by
27 its fee-for-service providers.
28

180. In 2009, these internal discussions continued. In early April 2009, Relator Poehling, Dumcum, Will, Kimberly Halva, Janice Redmond (the Senior Vice President of Market Outreach for Ingenix's Risk Adjustment Group, who worked in Santa Ana, California) and others participated in a discussion about compliance risks, including provider over-coding (*i.e.*, invalid coding). One of the items on the agenda that they discussed included "[a]uditing under & over coded conditions" as part of the chart review process, that is, "looking both ways." A few weeks later, Relator Poehling again met with Will and others to discuss what to do when provider-reported diagnosis codes were inconsistent with the results of the coders' blind chart reviews of the providers' medical records. At this second meeting in April 2009, the participants began to design a methodology for "looking both ways." This led to subsequent discussions about creating a Claims Verification Program in order to look both ways at the coders' blind chart review results and make DELETES as well as ADDS.

181. A few months later, in August 2009, in an internal presentation, Redmond noted that chart reviews only looked for additional revenue and suggested that the process should also include a certain amount of charts that are reviewed to determine the validity of providers' codes. Redmond was concerned that providers paid on a fee-for-service basis were not being audited to validate their diagnoses. Her presentation stated: "Known problematic codes are not audited across plans/providers raising the risk of error."

182. In early 2010, Will sent Dumcum a presentation proposing the Claims Verification Program. The stated goal of the program was to improve the accuracy of the diagnosis data that the UHG Managing Defendants submitted to CMS. Will believed that Claims Verification would achieve this goal.

183. In May 2010, Relator Poehling discussed the potential creation of the Claims Verification Program with Dumcum. Dumcum referenced the Department of Justice's enforcement of the FCA as a consideration.

1 184. According to Halva, while she was the UnitedHealthcare Medicare & Retirement
2 Compliance Officer from 2010 to 2013, the “general consensus from the
3 [UnitedHealthcare Medicare & Retirement] point of view was . . . that any time we
4 opened a chart we should be looking both ways.”

5 185. In the fall of 2010, after two years of discussions, senior executives such as
6 Thomas Paul, Cynthia Polich, and Lee Valenta acknowledged that the UHG Managing
7 Defendants should “look both ways” at the results of their blind chart reviews. By at
8 least that time, however, these Defendants should and could have compared the results of
9 *all* chart reviews to the provider-reported diagnoses and deleted all of the invalid
10 provider-reported diagnoses that they previously had submitted to the Medicare
11 Program. They also should and could have done this contemporaneously with
12 submitting ADDS based on the same chart reviews. Instead, they embarked on a very
13 slow, phased development of their Claims Verification Program. The senior executives
14 authorized only a pilot test program to look at the negative results (*i.e.*, the results
15 showing that provider-reported diagnoses were invalid) from only a very small sample of
16 chart reviews. Moreover, the Claims Verification process was designed to “save” – that
17 is, avoid deleting – the provider-reported diagnoses invalidated by the blind chart
18 reviews conducted as a part of the Chart Review Program. The UHG Managing
19 Defendants attempted to and sometimes did save some of these invalid codes by re-
20 reviewing the beneficiaries’ medical records, sometimes multiple times, to try to glean
21 any support, even doubtful or ambiguous support, for the provider-reported diagnoses at
22 issue.

23 186. In August 2011, Relator Poehling made clear to Scott Theisen, then Chief
24 Financial Officer of UnitedHealthcare Medicare & Retirement, that Poehling did not
25 believe it was appropriate to conduct chart reviews unless and until Claims Verification
26 was fully implemented and they were “looking both ways.” Theisen was one of the
27 senior managers charged with making decisions regarding the implementation and
28 design of the Claims Verification Program. At that time, in an email to Paul Bihm at

1 Optum, Poehling wrote: “You (and Scott [Theisen]) know where I stand on chart
2 reviews without full CV in place ... I wouldn’t do them. Scott, though, is the decision
3 maker” At that time, Bihm was an Optum Senior Vice President of Client
4 Management and had responsibilities relating to the Chart Review Program.

5 187. In September 2011, Mary Hammond, Associate Director of Strategy and Support
6 for UnitedHealthcare Medicare & Retirement’s risk adjustment team, attended an
7 industry conference in Washington, D.C. on risk adjustment. She reported that it was
8 “great to get a perspective on what the activity in DC may mean for risk adjustment.
9 More audit protection (*looking both ways compliance programs*), . . . and less reliance
10 on chart review are the recommendations.” (Emphasis added.)

11 188. In approximately November 2011, a “factual and unbiased” presentation was
12 created for UHG’s Chief Executive Officer Steve Hemsley, to provide him information
13 about Optum’s and its competitors’ risk adjustment programs and other risk adjustment
14 services. The presentation described “Compliance” as “the True Value of Claims
15 Verification.” The presentation further noted that the medical record is the “source of
16 truth” and that looking at this “source of truth” had a negative revenue impact because
17 comparing provider-reported diagnoses with the information in the providers’ medical
18 records resulted in having to delete some of their diagnoses. In December 2011, a copy
19 of this presentation was sent by Karen Petroff, the Senior Vice President of Business
20 Development at Optum, to Dumcum and Eric Murphy at Optum. Murphy was the
21 President of Payer Solutions at Optum at the time.

22 189. In December 2012, Mike Jacobson, Program Business Analyst/Project
23 Management at Optum, sent Patty Brennan an updated version of Optum’s Business
24 Vision Document for the marketing of the Claims Verification Program to commercial
25 clients (*i.e.*, third-party MA Organizations). Under the section titled “Business Segment
26 Strategies and Tactics,” the document stated that “Optum has an industry compliance
27 duty and responsibility to ensure that each HCC code is accurate and can be
28 substantiated within the medical charts.” Under the section titled “Competitive Analysis

1 – Market Research,” the document stated: “The marketplace will soon recognize the
2 need and importance of performing due diligence on HCCs added during the chart
3 review process but also verifying HCCs submitted to CMS can be substantiated within
4 the medical chart according to CMS guidelines. For HCCs that cannot be substantiated
5 within the medical chart, clients will need to perform the appropriate deletes in order to
6 remain compliant with CMS guidelines.” At this time, Optum had already begun
7 marketing Claims Verification or “looking both ways” chart reviews to commercial
8 clients.

9 190. In September 2012, the Chief Executive Officer of OptumInsight, William Miller,
10 informed the Government that the UHG Managing Defendants were developing a
11 Claims Verification Program to ensure the accuracy of the diagnosis data they submitted
12 to CMS and look both ways at the results of the chart reviews conducted as part of the
13 Chart Review Program. Miller further stated that unsupported diagnoses would be
14 deleted. The UHG Managing Defendants knew that this information was important to
15 the Government. They led the Government to believe that they were not deliberately
16 ignoring or recklessly disregarding the negative results of their Chart Review Program
17 showing that numerous provider-reported diagnoses that they had submitted for payment
18 were invalid.

19 191. Until 2012, UnitedHealthcare Medicare and Retirement and Optum allowed
20 coders to review medical records at providers’ offices if the providers did not want to
21 provide copies of their records. However, in 2012, in accordance with their
22 acknowledgement of their obligation to “look both ways,” these Defendants changed this
23 policy and restricted on-site reviews because they needed copies of the charts in order to
24 conduct Claims Verification. Mary Hammond, in an April 2012 email, explained this
25 decision: “M&R has made a decision on the chart reviews where providers are requiring
26 onsite coding. We will ask the [United] Provider Advocates to talk to the groups to try
27 to talk them out of it. If they won’t budge, then we will allow onsite coding if
28 OptumInsight has a solution for doing claims verification on those charts.”

1 192. Similarly, at around the same time, a decision was also made that Optum's
2 commercial clients were required to retain Optum to perform Claims Verification (*i.e.*, to
3 "look both ways") if Optum performed chart reviews for them and submitted risk
4 adjustment data, including diagnoses, to CMS on their behalf. According to Dumcum,
5 Optum decided "that if we did chart review and submissions, that we then must do the
6 two-way look. It became our policy of how we executed business at the time. So if they
7 bought both, then we required that piece [*i.e.*, Claims Verification] be implemented."

8 193. UnitedHealthcare has also consistently demanded that CMS and HHS OIG, when
9 performing their audits, credit the Defendant MA Organizations for any additional
10 medical conditions that UnitedHealthcare believed were supported by the medical
11 records but that had not been reported by the providers. UnitedHealthcare took the firm
12 position with the Government that, in order to accurately reflect a patients' true health
13 status, it was necessary to review patients' medical records for both the under-reporting
14 (not reporting diagnoses supported by the beneficiaries' medical records) and over-
15 reporting (the reporting of codes unsubstantiated by the beneficiaries' medical records)
16 of medical conditions by providers. In fact, CMS RADV audits have historically
17 credited MA Organizations, including UnitedHealthcare, for additional diagnoses found
18 during such audits.

19 194. For example, in a February 2011 letter from Thomas Paul, the then Chief
20 Executive Officer of UnitedHealthcare Medicare & Retirement, to CMS concerning the
21 parties' dispute about the preliminary results of CMS' pilot RADV audit of one of the
22 Defendant MA Organizations, UnitedHealthcare argued that the dispute process
23 "incorrectly exclude[d] consideration of additional CMS-HCCs" supported by the
24 beneficiaries' medical records. The letter stated that UnitedHealthcare identified
25 additional HCCs (*i.e.*, additional diagnoses mapping to additional HCCs) in the medical
26 records and, if CMS refused to give it credit for them, it would challenge CMS legally.
27 In September 2012, in a letter from Theisen, the then Chief Financial Officer of
28 UnitedHealthcare Medicare & Retirement, to CMS about the same RADV audit,

1 UnitedHealthcare continued to complain that the audit incorrectly excluded
2 consideration of additional HCCs and argued that the Defendant MA Organization
3 should receive credit for the additional HCCs. The letter stated: “If [the MA
4 Organization] is not credited for these incremental HCCs, then any adjustments made by
5 CMS do not accurately reflect an enrollee’s comprehensive medical conditions. The
6 goal of RADV audits should be to determine the full extent of enrollees’ medical
7 conditions, and **make overpayment and underpayment adjustments so that [MA
8 Organizations] are paid commensurate with enrollees’ health status.**” (Emphasis
9 added.) Similarly, in a September 2012 letter from Thomas Paul to HHS OIG,
10 UnitedHealthcare stated that “the OIG should correct the invalid HCCs and credit [the
11 MA Organization] with the incidental HCCs documented in the submitted medical
12 records.”

13 195. ICE, the industry group to which several of the Defendants belonged and which
14 they financially supported, also opined that “looking both ways” was a “Best Practice.”
15 It issued a Best Practices document encouraging the industry to conduct chart reviews
16 that “looked both ways.” It described the advantages of such chart reviews as
17 “[p]romoting validation functions for diagnostic codes previously submitted by
18 providers” and “[p]roviding the ability to submit code corrections forward (additions and
19 deletions) to health plans upon the completion of review.”

20 **C. United’s Short-lived “Look Both Ways” Claims**
21 **Verification Program**

22 196. In September 2010, Lee Valenta, then Ingenix’s Chief Operating Officer, sent
23 Thomas Paul, then Chief Executive Officer of Ovations, a memorandum “summariz[ing]
24 Ingenix’s plans for implementing a claims verification program for charts reviewed by
25 Ingenix on behalf of Ovations Medicare Advantage Plans.” Valenta explained that the
26 “overarching aim” of the Claims Verification Program was “improving the quality of
27 member-level diagnosis information submitted to CMS.” He also explained that the
28 program’s purpose was to identify the provider-reported diagnoses that were not

1 validated by the blind medical record reviews conducted as part of the Chart Review
2 Program and for another coder to conduct a second non-blind review to determine if the
3 provider-reported diagnoses had been missed by the first blind coder.

4 197. Valenta's memorandum also set forth a three-phased approach for the
5 development of the Claims Verification Program. The first phase, Phase I, was supposed
6 to focus on a random sample of 850 beneficiaries in Ovations MA Plans whose medical
7 records for encounters (*i.e.*, provider office visits) in 2009 were included in the Chart
8 Review Program in 2010 and had already been subject to a blind review as part of that
9 Program. Phase I was supposed to start in October 2010 and be completed by January
10 31, 2011. The second phase, Phase II, was supposed to focus on a larger sample of
11 beneficiaries and, thus, a larger number of medical records for encounters in 2010. This
12 group was supposed to include all beneficiaries who had medical encounters with only
13 one provider during 2010. Phase II was supposed to start by May 2011. The final phase,
14 Phase III, was supposed to focus on all beneficiaries in Ovations' MA Plans whose
15 medical records for medical encounters in 2011 were included in the national Chart
16 Review Program in 2012 and had already been subject to a blind review as part of that
17 Program. Phase III was supposed to be implemented in 2012.

18 198. In October 2010, Cindy Polich, then President of Ovations, which was in the
19 Public and Senior Markets Group ("PSMG") that managed the Defendant MA
20 Organizations at the time, responded to Valenta's memorandum. Polich agreed to his
21 proposal. Polich also acknowledged the need to improve PSMG's risk adjustment
22 programs. She stated that "[w]hile Ingenix is implementing Phase II [of Claims
23 Verification], PSMG will conduct a comprehensive review of its current risk adjustment
24 strategies, including our chart review strategy. The purpose of this review is to
25 determine the future programs and approaches to be used to improve the accuracy of our
26 risk scores."

27 199. A Claims Verification project management document, prepared by Optum,
28 Ingenix's successor, described Claims Verification as "[a] risk adjustment chart audit

1 service designed to ensure that qualified patient diagnoses and conditions are identified
2 and supported in the physician medical record documentation. This audit service
3 identifies any discrepant coding patterns contained within the medical record
4 documentation and the associated claims and encounters. This service includes the
5 submission and delete process to CMS, financial reporting, and training/education for
6 providers. Claims Verification will further supplement our efforts to assess coding
7 accuracy and our ability to drive prospective improvements by engaging and educating
8 providers.”

9 200. At a meeting in September 2012, Theisen explained to Jason Bainbridge and
10 Karin O’Hara, both of whom worked for UnitedHealthcare Community & State, that
11 UHG decided to “look both ways” and implement Claims Verification in order to defend
12 the Chart Review Program in light of increased scrutiny on risk adjustment. According
13 to Relator Poehling’s notes, the meeting focused on the financial impact of Claims
14 Verification, and Theisen “said historically when we audited we only added codes.
15 UHG has decided from a defensibility standpt, & the increased scrutiny on risk
16 adjustment, that we would begin deleting unsupported codes as well. Scott [Theisen]
17 explained that [Optum] did a CV pilot on ~ 5k charts. Scott said we anticipated ~
18 \$100M in give backs related to CV, but the pilot is showing ~ \$225M/yr (extrapolating
19 results).” Other attendees at this meeting included, but were not limited to, Relator
20 Poehling, Jon Bird, William Hnath, and Melissa Sedor.

21 201. At some point in 2012, UnitedHealthcare Medicare & Retirement also started to
22 impose a “look both ways” requirement on providers with which it was sharing the cost
23 of chart reviews. Many, if not all, of these providers were incentivized capitated
24 providers. UnitedHealthcare Medicare & Retirement sent letters to these providers about
25 this requirement. Some of the letters expressly stated that UnitedHealthcare Medicare &
26 Retirement was agreeing to share in the cost of the chart reviews based on its
27 understanding that the provider would use the information gathered from the chart
28 reviews to verify the diagnosis data that it previously reported to UnitedHealthcare

1 Medicare & Retirement. In other of the letters, UnitedHealthcare Medicare &
2 Retirement requested that the provider ensure that it uses the information gathered
3 during the chart reviews to verify the diagnoses that it previously reported to
4 UnitedHealthcare Medicare & Retirement. All of the letters further instructed the
5 providers on how to submit to UnitedHealthcare Medicare & Retirement (via Optum) a
6 data file of diagnosis codes that should be deleted (as well as those that should be added)
7 as a result of the chart reviews. In addition, UnitedHealthcare Medicare & Retirement
8 required all of the providers to complete and return a certification. Pursuant to the
9 certification, the provider had to attest that it had compared diagnoses previously
10 reported to UnitedHealthcare Medicare & Retirement with the charts that it reviewed,
11 and that it had submitted to UnitedHealthcare Medicare & Retirement and Optum a data
12 file of diagnoses that it had determined should be added or deleted. Pursuant to the
13 certification, the provider also had to certify that the information in the data file was
14 accurate and truthful. There was an attachment to the letters that specified the fields for
15 the data file that the providers were required to use. One of the fields was for the
16 providers to identify diagnoses that needed to be deleted because they were not validated
17 by the chart reviews.

18 202. UnitedHealthcare Medicare & Retirement and Optum, however, took over three
19 years to develop the Claims Verification Program. Furthermore, the manner in which
20 they developed and then implemented the Program shows that they were never
21 committed to honoring their obligation to undertake good faith efforts to ensure the
22 validity of the risk adjustment data that they submitted to the Medicare Program. They
23 did not automatically delete the provider-reported diagnoses that were not supported by
24 the medical record reviews conducted as part of the Chart Review Program. Rather, they
25 considered these invalid diagnoses as mere “potential deletes” and instructed the coders
26 to re-review the medical records to try to avoid deleting them. Optum also trained the
27 Claims Verification coders that the goal of Claims Verification, above all else, was to
28 “validate” or “save” the potential deletes through finding any support for the diagnosis in

1 the beneficiary's chart. Additionally, Optum instructed its coders to "save" these invalid
2 diagnoses even if the information in the medical records was ambiguous.

3 203. When performing Claims Verification, Optum also did not consult providers even
4 when medical records were ambiguous concerning whether the beneficiaries actually had
5 the medical conditions corresponding to the diagnosis codes.

6 204. Optum also saved "potential deletes" by simply accepting the diagnoses reported
7 by providers even when the medical conditions were not unambiguously documented in
8 the beneficiaries' medical records. Optum characterized this practice as deferring to the
9 judgment of the provider or the provider's administrative staff who assigned the
10 diagnosis codes. For example, if a chart was unclear, illegible, or missing, and even
11 though Optum could not identify any medical records documenting the medical
12 conditions identified by the provider-reported codes, it just accepted the codes and did
13 not delete them. Optum did this with either deliberate ignorance or reckless disregard
14 for the truth in light of the mountain of knowledge it possessed about the significant
15 percentage of invalid provider-reported diagnoses.

16 205. However, despite all its flaws, the Claims Verification Program confirmed what
17 UnitedHealthcare Medicare & Retirement and Optum already knew about the significant
18 error rate associated with provider-reported diagnoses that they submitted to the
19 Medicare Program for risk adjustment payments.

20 206. At the end of 2010, Ingenix, Optum's predecessor, had conducted the first pilot
21 phase, Phase I, of its development of the Claims Verification Program. As specified in
22 Valenta's memorandum, Phase I included a very small sample of medical records that
23 Ingenix had reviewed as part of the Chart Review Program for encounters (*e.g.*, office
24 visits) that beneficiaries had with providers in 2009. A "CV Dashboard" summary from
25 December 2010 shows that out of the many hundreds of thousands of medical records
26 included in the Chart Review Program for 2009 encounters, only 843 records were
27 included in Phase I of the Claims Verification Program. By December 2010, the review
28 for 728 of those medical records had been completed. The results showed that 224 of the

1 728 medical records re-reviewed as part of Claims Verification (*i.e.*, reviewed once as
2 part of the Chart Review Program and then again as part of Phase I of the Claims
3 Verification Program) had both at least one ADD (a diagnosis code that the provider had
4 not reported) and at least one DELETE (a diagnosis code that was reported by the
5 provider but not validated by the medical record) and 167 of the 728 medical records re-
6 reviewed as part of Claims Verification had at least one DELETE but no ADDS.
7 Furthermore, of the HCCs and the RxHCCs for which Ingenix looked for validation in
8 these 728 records that it had re-reviewed, 19 percent of the HCCs and 15 percent of the
9 RxHCCs did not validate. At the time that the summary was prepared, Ingenix was
10 conducting “follow-up” on 39 medical records. Of the HCCs and the RxHCCs for which
11 Ingenix looked for validation in these 39 medical records that it had re-reviewed, 47
12 percent of the HCCs and approximately 45 percent of the RxHCCs did not validate.
13 207. As part of Phase I, but only as part of Phase I, Ingenix sometimes contacted the
14 providers who gave it the medical records. It did this when the second non-blind review
15 of the records in Claims Verification failed to validate the diagnoses that the first blinded
16 review had failed to validate as part of the Chart Review Program. For some
17 beneficiaries, the providers responded that they should not have submitted their claims
18 (*i.e.*, the claims which included the diagnoses). Consequently, the diagnoses should not
19 have been submitted to CMS. For some other beneficiaries, the providers did not have
20 additional records or their additional records did not support the diagnoses in question.
21 208. In mid-2011, Ingenix/Optum began conducting the second pilot phase, Phase II, of
22 the Claims Verification Program. Phase II began in the summer of 2011 and was
23 completed in early 2012. Out of the many hundreds of thousands of medical records
24 included in the Chart Review Program for 2010 medical encounters, only approximately
25 17,000 charts were included in Phase II. Coders tried to save as many “potential deletes”
26 as possible when reviewing these medical records as part of Phase II. Nonetheless, the
27 results of their Claims Verification reviews confirmed more invalid diagnoses
28

(DELETES) than the number of additional codes (ADDS) gleaned from the same records.

209. In mid-2012, Optum began conducting a preliminary test or pilot for Phase III of the Claims Verification Program. This pilot included approximately 5,000 medical records relating to encounters (*e.g.*, office visits) that beneficiaries had with providers during calendar year 2011. In September 2012, Theisen explained to others including Relator Poehling, that UnitedHealthcare Medicare & Retirement, relying on the results of this sample review, had increased its estimate of the financial impact of Claims Verification deletes. In October 2012, Theisen sent Daniel Schumacher, the then Chief Financial Officer of Defendant UnitedHealthcare, and others a “CV III analysis – based on 2011-2012 Chart review activity for 2011 DOS.” The document showed validation rates based on the review of HCCs because the coders were instructed to find support for any diagnosis that mapped to the HCC under review even if it was not the same diagnosis reported by the provider that originally mapped to that HCC. The document showed that the validation rate “[b]ased on results of CV3 pilot (5,000 chart sample)” was 66.4 percent. In other words, only 66.4 percent of the HCCs reviewed were supported by the beneficiaries’ medical records. That meant that 33.6 percent of the HCCs were unsupported by the beneficiaries’ medical records even after UnitedHealthcare Medicare & Retirement and Optum had them reviewed twice, once as part of the Chart Review Program and again as part of the pilot Claims Verification Phase III process. Based on these results, UnitedHealthcare Medicare & Retirement estimated that the negative financial impact of Claims Verification in 2012 would be \$231 million based on the number of estimated “potential deletes” that it could not save and would have to be made. It estimated that diagnoses mapping to 120,147 HCCs would have to be deleted and that, on average, each delete would result in a \$1,924 negative financial impact.

210. In or about October 2012, UnitedHealthcare Medicare & Retirement recorded in its financial records a \$208 million accrual for potential revenue reductions due to

1 deletes that would need to be made as part of the Claims Verification Program
2 (hereinafter referred to as a “CV liability accrual”) for payment year 2012. Relator
3 Poehling and Kyle Anderson were aware of this CV liability accrual. In late 2012, other
4 individuals at UnitedHealthcare Medicare & Retirement and Optum, including Timothy
5 Noel, Scott Theisen, and Jon Bird, were also aware of the CV liability accrual and/or the
6 estimated negative financial impact of the Claims Verification Program.

7 211. UnitedHealthcare Medicare & Retirement and Optum did not complete their pilot
8 tests and start to implement their Claims Verification Program for charts relating to 2011
9 medical encounters (*i.e.*, with 2011 dates of service) until late 2012. Even after that,
10 they never fully implemented the program. They also continually changed the program
11 in order to limit its scope and created arbitrary rules to avoid looking at the negative
12 results of many of the blind chart reviews conducted as part of the Chart Review
13 Program. In addition, when they learned that their second review of the medical records
14 in Claims Verification was not saving a significant number of diagnoses from deletion,
15 they created another level of review. That is, it created a re-re-review or third review of
16 the beneficiaries’ medical records in order to keep trying to save the diagnoses from
17 deletion. They also limited the scope of Claims Verification by excluding certain
18 providers, including providers that they or their affiliates owned and operated. In 2014,
19 Defendants UHG and UnitedHealthcare then terminated CV without completing the
20 program for charts relating to 2012 medical encounters (with 2012 dates of service).

21 212. UnitedHealthcare Medicare & Retirement and Optum imposed several arbitrary
22 exclusionary rules to improperly disqualify many medical records reviewed as part of
23 their Chart Review Program from their Claims Verification Program. For medical
24 records for encounters in 2011 and 2012, they arbitrarily and improperly excluded
25 numerous medical records from Claims Verification. For example, they excluded
26 numerous charts from Claims Verification because the image of the chart was
27 purportedly “unavailable.” Yet, when making ADDS in the Chart Review Program, the
28 image of the chart or chart itself must have been available. But, instead of locating the

1 images or obtaining the charts for Claims Verification, they decided not to re-review the
2 charts to save those diagnoses invalidated by the results of their Chart Review Program.
3 They also did not delete those invalid diagnoses.

4 213. The re-reviews conducted as part of the Claims Verification Program did not save
5 as many deletes as UnitedHealthcare Medicare & Retirement would have liked and, in
6 2013, Theisen and others at UnitedHealthcare Medicare & Retirement became
7 increasingly concerned about the financial impact of the deletes. UnitedHealthcare
8 Medicare & Retirement decided that its coders were not saving enough “potential
9 deletes.” Accordingly, sometime in 2013, UnitedHealthcare Medicare & Retirement
10 decided that a third review or a re-re-review of the medical records had to be conducted
11 to try to save more deletes.

12 214. Thus, if Optum’s internal coders were unable, despite their best efforts, to “save” a
13 diagnosis code, Optum sent that code to a coding consultant for re-re-review. Optum
14 knew, however, that the consultant engaged in a pattern of “saving” diagnoses without
15 supporting medical records in several circumstances, including when the chart was
16 scanned illegibly, when pages were missing from a chart and the diagnosis could not be
17 validated, and when the reported date of service did not appear in the chart. By
18 accepting validation of these diagnoses without supporting medical records, Optum
19 knowingly and improperly avoided its and UnitedHealthcare Medicare and Retirement’s
20 obligation to return monies wrongfully obtained from the Medicare Program.

21 215. In November 2013, Donald James, then Director of Program Strategy for Optum
22 in Santa Ana, California, reported to senior management that the Claims Verification
23 Program had not yet started for charts reviewed as part of the 2013 Chart Review
24 Program. In December 2013, Patty Brennan, then also in the Optum Santa Ana office,
25 reported to Dumcum that “[h]alf of the CV volume for 2012 DOS has been completed
26 but deletes are on hold.” She also informed him that UnitedHealthcare Medicare &
27 Retirement “[r]equested all CV deletes be held until further noticed so Ops is not going
28 to complete the second half of the volume at this time.”

1 216. When Steve Nelson became the Chief Executive Officer of UnitedHealthcare
2 Medicare & Retirement in early 2014, he spoke with Steve Hemsley, then Chief
3 Executive Officer of UHG, about whether UnitedHealthcare Medicare & Retirement
4 should continue the Claims Verification Program. Hemsley encouraged Nelson to look
5 into whether or not it should do so, formulate an opinion, and report back to him.

6 217. In February 2014, Marc Beckmann, then in the Finance – Risk Adjustment
7 Analysis Group at UnitedHealthcare Medicare & Retirement, sent information about CV
8 liability accruals to Daniel Schumacher, the Chief Financial Officer of Defendant
9 UnitedHealthcare, and Brian Thompson, the Chief Financial Officer for
10 UnitedHealthcare Medicare & Retirement. He estimated that the effect of Claims
11 Verification on UnitedHealthcare Medicare & Retirement’s revenue would be \$208
12 million for payment year 2012, \$125 million for payment year 2013, and either \$125
13 million or \$175 million (depending on the number of charts reviewed) for payment year
14 2014. This information was also provided to other individuals at UnitedHealthcare
15 Medicare & Retirement including, but not limited to, Jay Matushak, Marybeth Meyer,
16 and Kyle Anderson.

17 218. On March 3, 2014, Jon Bird, the Optum Senior Vice President of Risk and Quality
18 Analytics, participated in a meeting with Brian Thompson about the CV liability accrual
19 for 2013. Thompson wanted to “move toward the more conservative range of the
20 confidence interval (from 50% to 80%) resulting in [a] \$29M higher CV estimate” for
21 the liability accrual. By March 3, 2014, UnitedHealthcare Medicare & Retirement’s
22 estimate of its CV liability accrual for 2013 already had been increased by over \$50
23 million dollars from \$125 million to \$180 million.

24 219. Also, in February or March 2014, the financial managers at UnitedHealthcare
25 Medicare & Retirement, including Brian Thompson, performed a comparison of their
26 then-expected revenues for 2014 with the revenue estimated in UnitedHealthcare
27 Medicare & Retirement’s annual budget for 2014. They determined that there was going
28

1 to be a shortfall in their financial performance relative to that budget and they started to
2 think about ways to eliminate the shortfall.

3 220. In March 2014, Thompson sent Nelson “a current brain dump of ‘shut off/stop
4 doing’ that is not yet valued/included in the road back to plan.” Part of the “brain dump”
5 was to “shut off” or reduce compliance efforts. Thompson asked others at
6 UnitedHealthcare Medicare & Retirement for other “shut offs.”

7 221. Subsequently in March 2014, Marybeth Meyer, who ran the risk adjustment team
8 at UnitedHealthcare Medicare & Retirement, reported to Thompson that the “CV
9 estimate of \$125M may be light (estimate for 2012 DOS/2013 payment year of
10 \$167M).”

11 222. In late March or early April 2014, Nelson met with other Chief Executive Officers
12 at Defendant UnitedHealthcare to discuss UnitedHealthcare Medicare & Retirement’s
13 financial performance. A very detailed slide deck was created for that meeting. The
14 slide deck was sent by Schumacher to senior executives at UnitedHealthcare, including
15 Gail Boudreaux (who reported to Hemsley), Nelson, Brian Thompson, and Paul
16 Balthazor. The slide deck highlighted that UnitedHealthcare Medicare & Retirement
17 was projecting that its actual revenues for 2014 were going to miss the target set forth in
18 the annual budget by half of a billion dollars. It stated: “Best estimate of \$500 million
19 budget miss.” It also stated that, because of that projected miss, UnitedHealthcare
20 Medicare & Retirement’s management was making a commitment to the senior
21 executives to “find \$250 million to cut miss in half.” UnitedHealthcare Medicare &
22 Retirement referred to this “Management Commitment” as a \$250M “good guy.”

23 223. Nelson and others, including Boudreaux (who reported to Hemsley), knew that, if
24 UnitedHealthcare Medicare & Retirement terminated the Claims Verification Program, it
25 could reduce the \$500 million budget miss by not deleting the provider-reported
26 diagnoses invalidated by its chart reviews and reversing the CV liability accruals. This
27 was their “good guy.” But, it appears that UHG, UnitedHealthcare, and Optum were
28 concerned about the consequences of terminating the program and reverting to ignoring

1 the negative results of their chart reviews. They decided to ask CMS about the
2 retroactivity of a proposed regulation requiring MA Organizations to design all medical
3 record reviews to validate diagnoses submitted to CMS.

4 224. Under Hemsley's direction, Larry Renfro, the Chief Executive Officer of Optum,
5 contacted senior government employees at CMS, including the Administrator of CMS,
6 to ask whether the Defendants had a legal obligation to perform Claims Verification
7 before the effective date of the proposed rule. These employees were not government
8 attorneys and could not render the requested legal advice. Renfro, moreover, knew
9 nothing about the UHG Managing Defendants' Chart Review and Claims Verification
10 Programs and could not impart any meaningful information about these programs to the
11 government employees. Accordingly, Renfro could not and did not provide the senior
12 government employees with any description of the Claims Verification Program or its
13 purpose. Hemsley and his attorneys, however, continued to push Renfro to make further
14 contacts with these government employees when UHG, UnitedHealthcare, and Optum
15 did not obtain from these government employees the legal opinion they wanted.

16 225. On or before April 8, 2014, Renfro asked Karen Erickson, an Optum executive
17 who worked directly for him, for speaking points for a call with the Administrator of
18 CMS. On April 8, 2014, Erickson sent Renfro's assistant, Juliet Domb, "aspirational"
19 talking points, that is, things that they wanted Renfro to get the CMS employees to say,
20 including "CV is not currently required" and that Defendants were "allowed to stop any
21 CV activities (including delete submission) currently underway." (Emphasis in the
22 original.) In her email, Erickson told Domb: "I sent this to Marianne [Short] and Matt
23 Shors for editing – they will send final directly, and they know it has to be today." The
24 same day, Renfro spoke to Hemsley and Short to obtain direction about what he should
25 say to the Administrator of CMS on the call that he had scheduled with the
26 Administrator. Renfro then purportedly spoke with the CMS Administrator and
27 purportedly dictated notes of the call to Domb, who wrote the notes by hand on Renfro's
28

1 notepad and sent them to Short. According to Renfro, he dictated these notes from
2 memory and he does not usually take notes, but was asked to do so by Short.

3 226. On April 26, 2014, Short asked Renfro to again contact the Administrator of CMS.
4 According to Brian Thompson (the Chief Financial Officer of UnitedHealthcare
5 Medicare & Retirement in 2014), Renfro had not obtained the “clarity” they wanted
6 from the Administrator about whether they were obligated to perform Claims
7 Verification. Accordingly, on April 27, 2014, Renfro sent an email to the Administrator
8 asking the same questions he had purportedly asked her on April 8 and to which she
9 purportedly had responded on April 8. He also asked for a meeting with other
10 employees at CMS who were responsible for operating the MA Program. On April 27,
11 2017, Renfro reported to Hemsley and Short that CMS was arranging for the UHG
12 Managing Defendants to meet with these employees. On April 29, 2014, Hemsley sent
13 UnitedHealthcare’s attorney, Thad Johnson, to Washington, D.C. to speak with those
14 CMS employees responsible for the MA Program, including Cheri Rice, the Director of
15 the Medicare Plan Payment Group at CMS. Nelson, Schumacher, and an Optum
16 executive, Karen Erickson, also attended the meeting. At the meeting, when the UHG
17 Managing Defendants informed CMS about the possibility of terminating their Claims
18 Verification Program, CMS told them that they had a statutory obligation to report and
19 repay the Medicare Program for erroneous risk adjustment payments and that there were
20 FCA implications if they failed to do so. CMS also told the UHG Managing Defendants
21 that they could not ignore information in their possession showing that diagnoses may be
22 invalid and that they were obligated to delete invalid diagnoses. According to Erickson,
23 CMS told the UHG Managing Defendants that “if there was reason to have knowledge
24 that something had been begun and we were [*i.e.*, Defendants were] far enough along
25 that there was knowledge that something might not be supported that we needed to
26 continue the investigation into those numbers, or those codes.” Erickson further recalled
27 CMS stating that, if they had “knowledge of things that might not be supported we [*i.e.*,
28 the Defendants] needed to continue the investigation.” According to Schumacher, CMS

1 also told them that CMS did not have sufficient information about the Claims
2 Verification Program to provide further guidance.

3 227. On April 30, 2014, Nelson sent an email to Cheri Rice at CMS about the meeting
4 between the UHG Managing Defendants and CMS on April 29, 2014. He stated: “[A]s
5 we discussed yesterday, CMS recently issued a proposed rule that would, if finalized,
6 require MA plans to design any medical record reviews to determine the accuracy of risk
7 adjustment diagnoses associated with those records. During our conversation yesterday
8 and other recent conversations, CMS confirmed to us that these requirements do not
9 apply until the effective date of the rule, and that MA plans are thus not currently
10 required to design their medical record reviews to determine the accuracy of risk
11 adjustment diagnoses. We currently have a process through which we review certain
12 medical records to determine the accuracy of risk adjustment diagnoses and submit
13 appropriate deletes. This process already has resulted in the identification of and, in
14 some instances, the submission of deletes for 2012 dates of service. But based on the
15 proposed rule, including the preamble, and recent conversations with CMS, we
16 suspended that process for 2012 dates of service while we consider whether to make
17 changes. Pursuant to our discussion, however, we will soon submit for deletion those
18 diagnosis codes that have undergone a complete review and that we have therefore
19 identified as appropriate deletes. In the near future, we will determine whether to
20 continue our review process for the diagnosis codes which were still under review at the
21 time we suspended our process. In the meantime we will not delete these codes.”

22 228. On May 2, 2014, Cheri Rice replied to Nelson’s email: “[R]egardless of the
23 effective date of the proposed requirement related to medical record reviews, there are
24 other laws that do impose standards, requirements and responsibilities on MA plans in
25 connection with the federal payments they receive from CMS. We cannot provide
26 advice to United about the scope of those other laws. Nor can we provide advice on
27 whether United’s plan[ned] course of action and/or purported limits on the scope of its
28 [Risk Adjustment Attestation, submitted April 30, 2014] are compliant with such other

1 laws. Your statement concerning the data submissions that have already been made and
2 United's plans for future action will be included in our records and we will proceed with
3 our evaluation and use of the risk adjustment data consistent with 42 CFR § 422.308, §
4 422.310, and other applicable law."

5 229. According to Schumacher and Nelson, Rice's May 2, 2014 email did not say
6 anything that was inconsistent with what CMS said in the meeting on April 29, 2014.
7 After Rice sent her May 2 email, the Department of Justice sent a letter to Defendants'
8 counsel emphasizing that the FCA is one of the "other laws" that imposes standards,
9 requirements, and responsibilities on MA Organizations and Related Entities in
10 connection with the federal payments received from the Medicare Program.

11 230. On May 5, 2014, Jay Matushak informed Jeffrey Putman, UHG's Controller who
12 reported to Hemsley, and others (including Schumacher and Brian Thompson) that
13 "M&R CV delete, good guy, is ~\$250M for the year (note this is just the M&R piece and
14 there is an incremental component at C&S)." On the same date, Brian Thompson also
15 informed Putnam and others (including Matushak and Schumacher) that
16 UnitedHealthcare Medicare & Retirement had "not made a final determination to our CV
17 policy," "[o]ur RAF counsel will make that determination," and that "determination will
18 not occur until later in May most likely." According to Schumacher, the \$250 million
19 was the estimated amount of the deletes from Claims Verification for 2014 and prior
20 years and, thus, the CV liability accruals that had been recorded for 2014 and prior years.
21 The "good guy" was the hoped-for release or reversal of those accruals.

22 UnitedHealthcare Medicare & Retirement knew the accruals were likely underestimated
23 and the financial impact likely greater if it did not terminate the Claims Verification
24 Program.

25 231. Despite CMS' warnings in the April 29 meeting and Cheri Rice's May 2 email,
26 Nelson, Schumacher, and Brian Thompson decided to go forward with the idea of
27 terminating the Claims Verification Program. This decision was reported to Hemsley
28

1 and, according to Nelson, Hemsley could have reversed this decision but instead he
2 supported it.

3 232. Despite the warnings, UnitedHealthcare Medicare & Retirement also decided not
4 to delete or otherwise report to CMS at least 100,000 invalid diagnoses about which it
5 had *actual* knowledge based on more than one review of the patients' medical records
6 for encounters in 2011 and 2012 (*i.e.*, encounters with 2011 and 2012 dates of service).
7 The single damages to the Medicare Program arising from its submission of and failure
8 to delete just these invalid diagnoses is approximately \$190 million under Part C alone.

9 233. After they terminated the Claims Verification Program, UnitedHealthcare
10 (including UnitedHealthcare Medicare & Retirement and UnitedHealthcare Community
11 & State) and Optum reverted to "looking one way" at the results of their chart reviews,
12 making only ADDS, and knowingly and improperly failing to delete invalid provider-
13 reported diagnoses and repay the Medicare Program for them.

14 234. At the time they decided to terminate the Claims Verification Program, Steve
15 Nelson, Dan Schumacher, and Brian Thompson knew that their decision would enable
16 UnitedHealthcare Medicare & Retirement to reverse its CV liability accruals by more
17 than \$250 million dollars. Hemsley also was aware that terminating Claims Verification
18 would enable UnitedHealthcare Medicare & Retirement to achieve this financial benefit.
19 This was important to all of them because they wanted to represent to investors that
20 UnitedHealthcare Medicare & Retirement's actual revenues were on target. An internal
21 document relating to their second quarter 2014 "earnings release" issued in July 2014
22 states: "Q2 was on track and we are building momentum that will take us through the
23 year and into 2015. Internal: Important to note that 2014 benefits from the one-time
24 claims verification policy change which investors are unaware of." (Emphasis in the
25 original.) On July 11, 2014, this internal document was sent to Nelson and Thompson,
26 among others.
27
28

**D. United Failed to Delete Diagnoses Invalidated By Its Own
Chart Review Program**

235. The results of the UHG Managing Defendants' national Chart Review Program provided them information about a significant number of invalid provider-reported diagnoses that should not have been, but were, submitted by them on behalf of the Defendant MA Organizations to the Medicare Program for risk adjustment payments. For example, for the 2011 payment year (involving payments based on diagnoses with 2010 dates of service), UnitedHealthcare Medicare & Retirement and Optum submitted at least 197,000 diagnoses that were invalidated by the medical record reviews conducted as part of their Chart Review Program. But, for that year, they deleted only a very few (only about 1,800) of these invalid diagnoses based on the results of Phase II of the Claims Verification Program. For the 2012 payment year (involving payments based on diagnoses with 2011 dates of service), UnitedHealthcare Medicare & Retirement and Optum submitted at least 222,329 diagnoses that were invalidated by the medical record reviews conducted as part of their national Chart Review Program. Based on the results of the Claims Verification Program for charts with 2011 dates of service, they deleted approximately 120,000 of these invalid diagnoses despite their arbitrary exclusionary rules and attempts to save these deletes. For the 2013 payment year (involving payments based on diagnoses with 2012 dates of service), UnitedHealthcare Medicare & Retirement and Optum submitted at least 285,122 diagnoses that were invalidated by the medical record reviews conducted as part of their national Chart Review Program. Based on the results of the Claims Verification Program for charts with 2012 dates of service, they deleted approximately 27,000 of these invalid diagnoses despite their arbitrary exclusionary rules, multiple attempts to save these deletes, and failure to complete the program. For the 2014 payment year (involving payments based on diagnoses with 2013 dates of service), UnitedHealthcare Medicare & Retirement and Optum submitted at least 199,039 diagnoses that were invalidated by the medical record reviews conducted as part of their Chart Review Program. Because UHG,

1 UnitedHealthcare, and Optum terminated the Claims Verification Program, they did not
2 delete any of these invalid diagnoses. These numbers apply to invalid diagnoses relating
3 to risk adjustment payments under Part C only and not also Part D.

4 236. Accordingly, the UHG Managing Defendants knowingly and improperly failed to
5 delete or otherwise repay Medicare for most of the diagnoses invalidated by their
6 national Chart Review Program over the last decade.

7 237. For example: for the 2011 payment year, they failed to repay the Medicare
8 Program at least \$377,734,792 by failing to look both ways and delete diagnoses
9 invalidated by the Chart Review Program; for the 2012 payment year, they failed to
10 repay the Medicare Program at least \$213,978,134 by failing to look both ways and
11 delete diagnoses invalidated by the Chart Review Program; for the 2013 payment year,
12 they failed to repay the Medicare Program at least \$317,329,602 by failing to look both
13 ways and delete diagnoses invalidated by the Chart Review Program; and for the 2014
14 payment year, they failed to repay the Medicare Program at least \$234,159,775 by
15 failing to look both ways and delete diagnoses invalidated by the Chart Review Program.
16 These numbers apply to the failure to make repayments relating to risk adjustment
17 payments under Part C only and not also Part D.

18 238. Examples of beneficiaries with invalid diagnoses about which Defendants knew
19 but failed to delete based on its Chart Review Programs for payment years 2011 through
20 2014 are set forth in Exhibit 13 to this Complaint.

21 **III. The RACCR Program**

22 239. The UHG Managing Defendants (which, in this section, refers to Ingenix or
23 Optum, depending on the time period, and Ovations or UnitedHealthcare Medicare &
24 Retirement, depending on the time period) negotiated agreements with some of the
25 largest healthcare provider groups that tied the provider groups' compensation to their
26 beneficiaries' risk scores. The UHG Managing Defendants knew that this compensation
27 structure created a financial incentive for the provider groups to increase the number and
28 severity of diagnoses they reported and to report invalid diagnoses. Nonetheless, while

1 the UHG Managing Defendants were scouring millions of medical records through the
2 Chart Review Program to identify additional diagnoses and increase their revenue, their
3 effort to identify the invalid codes submitted by these incentivized providers was limited
4 to the RACCR Program. Moreover, the UHG Managing Defendants designed and
5 implemented the RACCR Program to limit its scope and to minimize the number of
6 invalid diagnoses for which the UHG Managing Defendants would have to return
7 overpayments to CMS. They failed to delete invalid diagnosis codes identified through
8 the RACCR Program, and eventually restructured the RACCR program to become just
9 another program to identify additional diagnoses and to increase revenue, rather than a
10 program to remedy the known problem of invalid coding by incentivized providers.

11 **A. Defendants Knew That Their Financially-Incentivized**
12 **Providers Were Reporting Invalid Codes**

13 240. As discussed above, the UHG Managing Defendants entered into financial
14 arrangements with capitated and gainsharing providers that were tied to the risk
15 adjustment payments that the Defendant MA Organizations received from the Medicare
16 Program. As a result, these providers benefited financially from any increase in risk
17 adjustment payments resulting from the diagnoses they reported to the UHG Managing
18 Defendants for beneficiaries enrolled in the Defendant MA Organizations' Plans.

19 241. The UHG Managing Defendants knew that these compensation arrangements
20 created a strong financial incentive for these providers to increase the number and
21 severity of diagnoses they reported for each beneficiary, and in some cases to report
22 invalid diagnosis codes.

23 242. Early on, Ingenix implemented the Internal Data Validation ("IDV") reviews
24 discussed earlier in this Amended Complaint. In or about 2010, Ovations (or its
25 successor, UnitedHealthcare Medicare & Retirement) and Ingenix expanded and
26 changed the name of that program to RACCR. Ingenix was responsible for conducting
27 the RACCR Program until Optum succeeded it in 2011, after which Optum was
28 responsible for conducting the program. Likewise, Ovations was responsible for

1 managing the RACCR Program until UnitedHealthcare Medicare & Retirement
2 succeeded it and assumed responsibility for the program in 2010.

3 243. Although the IDV and RACCR Programs were extremely limited in scope and
4 utility, they confirmed what the UHG Managing Defendants already knew: that there
5 were serious problems with the diagnoses being reported by a number of the financially-
6 incentivized providers, including WellMed (which UHG acquired in 2011).

7 **B. UnitedHealthcare Structured The RACCR Program To**
8 **Limit The Number Of Invalid Diagnosis Codes It Identified**

9 244. The UHG Managing Defendants knew they had an obligation to review diagnoses
10 reported by incentivized providers to determine their validity. In an April 23, 2012
11 email to many United Healthcare executives and managers (including Scott Theisen,
12 Keith Dobbins, Michael McCarthy, and Kimberly Halva), Mary Hammond, one of the
13 UnitedHealthcare employees who oversaw the RACCR program, described RACCR as
14 “an important part of Medicare & Retirement’s efforts to meet CMS requirements to
15 submit accurate risk adjustment data.” Later, in a June 22, 2012 agenda for a meeting
16 attended by Keith Dobbins, Kim Halva, Benjamin Poehling, and others, Mary Hammond
17 stated that the answer to “Why RACCRs?” was that “We have an obligation to submit
18 accurate Dx data to CMS.”

19 245. Despite the UHG Managing Defendants’ understanding that the RACCR Program
20 was part of UHG’s effort to comply with CMS’s accuracy requirements, they structured
21 the RACCR Program to limit its utility in identifying invalid diagnosis codes. There
22 were various fundamental limitations on the RACCR Program.

23 246. First, the UHG Managing Defendants excluded from their RACCR Program any
24 incentivized providers who cared for fewer than 500 beneficiaries in a Plan. This
25 resulted in the exclusion of approximately 40 percent of the financially-incentivized
26 providers from the RACCR Program for medical encounters in 2008, 2009, and 2010
27 (*i.e.*, with dates of service in those years).

247. Second, for the incentivized provider groups with 500 beneficiaries or more, the UHG Managing Defendants did not review the medical documentation for any diagnoses unless the provider group was an extreme outlier in reporting diagnoses that mapped to one or more HCCs. For medical encounters in 2008, 2009, and 2010 (*i.e.*, with dates of service in those years), the UHG Managing Defendants defined an outlier as a provider that reported diagnoses mapping to a particular HCC more than three times as often as the average national prevalence rate for that HCC for all beneficiaries in the Defendant MA Organizations' MA Plans. For example, if 15 percent of the beneficiaries in these MA Plans nationwide were reported by providers to have a diagnosis that mapped to HCC 52 (Drug/Alcohol Dependence), the UHG Managing Defendants did not consider the incentivized provider an outlier unless it reported diagnoses mapping to HCC 52 for more than 45 percent of its patients enrolled in a Defendant MA Organization's Plan. Combined with the exclusion of providers with less than 500 beneficiaries, this resulted in a total exclusion of over 80 percent of the financially-incentivized providers for medical encounters in 2008, 2009, and 2010.

248. For medical encounters in 2011 and 2012, the UHG Managing Defendants further limited which providers would qualify as outliers in order to reduce the number of providers and HCCs subject to review. Instead of using a national average prevalence rate for each HCC based on diagnoses reported by *all* of the providers in the Defendant MA Organizations' MA Plans, the UHG Managing Defendants used the average rate at which only financially-incentivized providers reported diagnoses mapping to each HCC. Thus, an incentivized provider was considered an outlier only if it reported diagnoses mapping to an HCC greater than two standard deviations above the rate that the HCC was coded by other incentivized providers, that is, providers who *also* had a financial incentive to invalidly code.

249. A large percentage of the outliers were located in the Central District of California. They are listed in Exhibit 14 to this Complaint.

250. Third, after limiting the program to only extreme outliers, the UHG Managing Defendants conducted an initial review of just a small sample of beneficiaries for whom the provider had reported diagnoses mapping to the outlier HCC or HCCs (as used herein, an “outlier HCC” is one that meets the criteria identified in Paragraphs 246 and 247 above for a particular provider and a particular encounter year). For medical encounters in 2008, 2009, and 2010, the initial sample size for even the largest provider groups was never more than 30 beneficiaries per outlier HCC, and was often as few as 10 beneficiaries per outlier HCC. The UHG Managing Defendants purposefully kept the sample size small to ensure the samples were not statistically significant, in the hope of preserving the ability to argue later that they were unable to extrapolate the results of their sample reviews to all of the diagnoses reported by the provider that mapped to the outlier HCC. For 2011 and 2012 medical encounters, the UHG Managing Defendants increased the initial sample size to 50 beneficiaries per provider for each outlier HCC.

251. Fourth, after reviewing the medical records for the beneficiaries in the sample to determine if the diagnoses were valid, the UHG Managing Defendants gave a provider a “passing” grade if anything less than 20 percent of the diagnoses were determined to be invalid. Accordingly, even if 19 percent of the diagnoses in the sample were invalid, the provider passed and no further review was conducted.

252. Fifth, if a provider failed the initial review for a particular outlier HCC, the UHG Managing Defendants often added only a few additional beneficiaries to the sample (*i.e.*, additional beneficiaries for whom the provider had reported diagnoses mapping to the outlier HCC). The UHG Managing Defendants called this slightly larger sample an “incremental sample.” If they were successful in decreasing the invalidation rate to below 20 percent based on increasing the sample size, the UHG Managing Defendants considered the provider group to have a passing grade for that HCC. Accordingly, if 19 percent of the diagnoses in the “incremental sample” were invalid, the provider passed and no further review was conducted.

253. Sixth, when the UHG Managing Defendants determined that a provider failed the incremental sample review for an outlier HCC, their RACCR policy specified that, with limited exceptions, *all* diagnoses reported by that provider mapping to the outlier HCC should be reviewed. In other words, once it was established that a provider reported diagnoses mapping to a particular HCC three times or more than the national average *and* that 20 percent or more of the diagnoses in a sample review were not supported by the beneficiaries' medical records *and* that increasing the sample size did not reduce the percentage of unsupported codes, even the UHG Managing Defendants recognized that, with limited exceptions, a complete review of the medical records for all beneficiaries for whom the provider had reported diagnoses mapping to the outlier HCC was essential. But in most cases, the UHG Managing Defendants did not conduct these 100 percent reviews themselves. Instead, as part of the RACCR Program, the UHG Managing Defendants purported to require the financially incentivized providers – the very providers who had over-reported the diagnoses at issue – to conduct these 100 percent reviews.

**C. Despite Its Limited Scope, The RACCR Program
Confirmed That Financially Incentivized Providers Were
Submitting Invalid Diagnosis Codes**

254. Despite the many flaws of the RACCR Program, the UHG Managing Defendants knew from the results of their small sample reviews and the 100 percent reviews that were actually conducted that significant problems existed with diagnoses reported by financially-incentivized providers.

255. By the end of March 2011, the UHG Managing Defendants were analyzing final results of RACCR sample analyses for encounters in 2008 and 2009, and had determined that a majority of the outlier HCCs analyzed in those years had validation rates below 80 percent, according to a March 29, 2011 email and spreadsheet that Benjamin Poehling sent to Paul Bihm.

1 256. By mid-February 2012, the UHG Managing Defendants reviewed samples for
2 encounters in 2010 and, again, found a substantial number of outlier HCCs that had
3 validation rates below 80 percent, according to a February 13, 2012 email and supporting
4 materials that Mary Hammond sent to Benjamin Poehling.

5 257. Overall, for the sample reviews for 2008, 2009, and 2010 encounters, nearly half
6 (49.61 percent) of the outlier HCCs reviewed failed the 80 percent validation test. Over
7 a third (37.01 percent) of all sampled diagnoses were not supported by the beneficiaries'
8 medical records. On April 23, 2012, Mary Hammond reported to numerous of the
9 employees of the UHG Managing Defendants (including Scott Theisen, Michael
10 McCarthy, Kimberly Halva, Keith Dobbins, and others) that Optum had calculated the
11 final results for samples from encounters in 2008, 2009, and 2010, and had identified the
12 providers who had failed the 80% validation test.

13 258. For the sample reviews for 2011 encounters, more than half (57.34 percent) of the
14 outlier HCCs reviewed failed the 80 percent validation test, and over 30 percent of all
15 sampled diagnoses reviewed for that year were not supported by the beneficiaries'
16 medical records, according to an August 8, 2013 email and supporting documentation
17 from Optum's Tracey Bradberry to Scott Hughes at Optum and Melissa Ferron, the
18 President of iCodify, a diagnosis coding consultant.

19 259. For the sample reviews for 2012 encounters, more than half of the outlier HCCs
20 failed the 80 percent validation test, and more than a third (38 percent) of all sampled
21 diagnoses were invalid, according to a July 2, 2014 presentation by Marybeth Meyer.

22 260. The problems with incentivized providers' invalid diagnoses were not isolated
23 incidents, but in many circumstances reflected a clear pattern of miscoding by provider
24 groups. Although the UHG Managing Defendants purposefully reviewed only a small
25 sample of medical records each year, they knew that certain provider groups were
26 consistently identified as extreme outliers on certain HCCs and failed the 80 percent
27 sample validation test year after year. For example:

1 • Every year from 2008 through 2011, Edinger Medical Group was an
2 extreme outlier for Spinal Cord Disorders/Injuries (HCC 69). Over those four years,
3 Optum (or its predecessor, Ingenix) reviewed medical records for a total of 126
4 beneficiaries that Edinger diagnosed with Spinal Cord Disorders/Injuries and determined
5 that the medical records of only *two* of those beneficiaries actually supported those
6 diagnoses. (Under the RACCR Program, Edinger or the UHG Managing Defendants
7 should have conducted 100 percent reviews of its diagnoses that mapped to this HCC for
8 the years 2008 through 2011, but they did not do so.)

9 • Every year from 2008 through 2012, HealthCarePartners was an extreme
10 outlier for Drug/Alcohol Psychosis (HCC 51). During those five years,
11 HealthCarePartners's highest sample validation rate for this HCC was 57.14 percent.
12 HealthCarePartners conducted 100 percent reviews for 2008, 2009, and 2011, and even
13 HealthCarePartners recognized that over a third of the diagnoses it reported were not
14 supported by its medical records. (Under the RACCR Program, HealthCarePartners or
15 the UHG Managing Defendants should have conducted 100 percent reviews for 2010
16 and 2012, but they did not do so.)

17 • Every year from 2008 through 2012, a provider named CAIPA was an
18 extreme outlier for Chronic Hepatitis (HCC 27). During those five years, CAIPA's
19 highest sample validation rate for this HCC was 76.92 percent. CAIPA conducted 100
20 percent reviews for 2008 and 2009 encounters, and its highest self-audit validation rate
21 was 56.73 percent. (Under the RACCR Program, CAIPA or the UHG Managing
22 Defendants should have conducted a 100 percent reviews for 2010 through 2012, but
23 they did not do so.)

24 • Every year from 2008 through 2012, Hemet Community Medical Group
25 was an extreme outlier for Spinal Cord Disorders/Injuries (HCC 69). During those five
26 years, Hemet's highest sample validation rate for this HCC was 50 percent. Hemet
27 conducted 100 percent reviews for 2008 through 2011, and its highest self-audit
28 validation rate also was 50 percent. (Under the RACCR Program, Hemet or the UHG

1 Managing Defendants should have conducted a 100 percent review for 2012, but they
2 did not do so.)

3 • Every year from 2008 through 2012, WellMed was an extreme outlier for
4 Disorders of Immunity (HCC 45). During those five years, WellMed's highest sample
5 validation rate for this HCC was 56.00 percent. WellMed conducted 100 percent
6 reviews for 2008, 2009 and 2011, and its highest self-audit validation rate was 63.64
7 percent. (Under the RACCR Program, WellMed or the UHG Managing Defendants
8 should have conducted a 100 percent review for 2010 and 2012 encounters, but they did
9 not do so.)

10 261. In those cases in which providers performed 100 percent reviews, the results
11 confirmed that the providers had initially submitted numerous invalid codes. Marybeth
12 Meyer and Scott Hughes's RACCR tracking spreadsheet indicated that more than 65
13 percent of the HCCs that providers reviewed in conducting 100 percent reviews had
14 validation rates below 80 percent. The RACCR "master tracking" documents that
15 Hughes updated regularly for Marybeth Meyer from 2013 through 2015 showed that
16 validation rates for problematic HCCs did not improve over time.

17 262. The UHG Managing Defendants' executives were routinely informed of RACCR
18 results. Beginning in 2011 and until at least 2014, the UHG Managing Defendants held
19 frequent meetings – usually weekly – concerning the status of the RACCR Program and
20 its results, with regular attendance by those responsible for the RACCR Program
21 (including, at various times, Kim Halva, Keith Dobbins, Marybeth Meyer, Benjamin
22 Poehling, Patty Brennan, Mary Hammond, Scott Hughes, and Pam Thomsen). During
23 these meetings, participants discussed the status and results of RACCR reviews, coding
24 results for individual practice groups, provider meetings to discuss results and 100
25 percent reviews, how 100 percent reviews would be handled in cases of provider
26 resistance, the financial impact of RACCR reviews, and changes to the RACCR
27 Program.

263. At least as early as February 14, 2012, Scott Theisen, Mary Hammond, and Benjamin Poehling met to discuss the deletion of codes resulting from the IDV and RACCR Programs for encounters in 2008, 2009, and 2010, and whether those deletions had been submitted. In March 2012, Theisen asked Hammond, Dumcum, Poehling, and Paul Bihm to pull together summary data concerning RACCR sample results for discussions with the incentivized providers. Theisen continued to be actively involved with some of the large incentivized providers that month, reviewing HealthCarePartners' results with Hammond and asking Hammond to identify the volume of codes that might be reviewed if WellMed were asked to do a 100 percent review so that he could provide a "worst case" scenario to John Way. In April 2012, Poehling updated Way regarding the status of WellMed's RACCR review, and Kimberly Fadden wrote to a number of employees of the UHG Managing Defendants, including Jeff Dumcum, Stephanie Will, and Jon Bird, noting that, among other things, there were then 40 to 42 provider groups in the 100 percent review process. The UHG Managing Defendants continued to provide periodic overviews or status updates concerning the RACCR Program to their executives and responsible employees. For example, in October 2013, Hammond sent Karen Erickson, Jon Bird, Scott Theisen, Jeff Dumcum, Patty Brennan, Marybeth Meyer, and others a "two-page detailed document that outlines the status, by provider group and year, of the 2008-2012 RACCR program."

264. The UHG Managing Defendants also kept their financial teams apprised of the status of the RACCR Program so that they could monitor, report, and account for its financial impact. For example, at some time before April 4, 2012, Jon Bird and Scott Theisen began discussing a rough estimate of the financial impact of the deletion of diagnosis codes as a result of RACCR. Theisen, Jon Bird, Bill Hnath, Melissa Sedor, and others also attended a December 3, 2012 meeting discussing, among other things, the financial effect of the IDV (*i.e.*, RACCR) Program, including the deletion of thousands of diagnosis codes as a result of that program. As set forth in more detail below, the UHG Managing Defendants' financial teams, including, at various times,

1 Theisen, Brian Thompson, Sedor and Hnath, also calculated liability accruals that
2 UnitedHealthcare Medicare & Retirement took in 2012 and 2013 to account for the
3 financial effect of the diagnosis codes that would have to be deleted as a result of the
4 RACCR Program.

5 **D. UnitedHealthcare Knew It Was Obligated To Delete**
6 **Invalid Diagnosis Codes Identified Through The RACCR**
7 **Reviews**

8 265. The Managing Defendants knew that they were required to submit accurate
9 diagnosis data to the Medicare Program. First, as described above, many of those
10 executives understood that RACCR was an important part of UnitedHealthcare Medicare
11 & Retirement's efforts to meet CMS's requirements regarding the submission of
12 accurate risk adjustment data, which necessarily implied the correction of inaccurate data
13 identified through the program.

14 266. Second, the UHG Managing Defendants' conduct demonstrated their knowledge
15 that they were required to delete invalid diagnosis codes identified through the RACCR
16 Program. From 2012 through 2015, the Managing Defendants deleted – albeit belatedly
17 – many invalid diagnosis codes submitted to CMS for encounters from 2008 through
18 2013, after determining, through the RACCR Program, that those codes were invalid.

19 267. Third, UnitedHealthcare Medicare & Retirement's practice of booking contra-
20 revenue accruals for the value of the deletions it had to submit as a result of the RACCR
21 Program demonstrated that the UHG Managing Defendants knew of their obligation to
22 return overpayments discovered through that program to the Government. Pursuant to
23 Statement of Financial Accounting Standards No. 5, *Accounting for Contingencies*, an
24 estimated loss from a loss contingency shall be accrued by a charge to income if both:
25 (a) a liability or impairment of an asset is "probable"; and (b) the amount of the loss can
26 be reasonably estimated. Thus, the accrual of loss contingencies relating to RACCR
27 reflected an acknowledgement that the return of an overpayment to the Government was
28

1 “probable,” and that UnitedHealthcare could reasonably estimate the amount of the
2 overpayment to be returned.

3 268. Beginning in 2012, UnitedHealthcare began taking liability accruals to account for
4 changes in its revenue that it expected to incur as a result of deletion of invalid codes
5 identified through the RACCR Program. By end of year 2012, it calculated that it would
6 have to reduce its revenue by \$79 million to account for its deletion of invalid codes
7 resulting from RACCR reviews (including expected 100 percent reviews) of medical
8 encounters in 2008, 2009, and 2010. That \$79 million was less than the total amount of
9 overpayment that it estimated it owed the United States, since it included both a
10 reduction in revenue resulting from the expected return of the overpayment and an offset
11 for the amount of money that it expected to recover from the incentivized providers,
12 which would have to share a portion of the burden of overpayment.

13 269. Accordingly, UnitedHealthcare took a liability accrual of \$79 million. It shared
14 this calculation with Deloitte and Touche in connection with that firm’s audit of UHG’s
15 financial statements, as part of UnitedHealthcare’s quarterly RAF Accounting Treatment
16 for Q4 2012 and Risk Adjustment Factor Revenue and Receivable Accounting for 2012.
17 Bill Hnath and Melissa Sedor told UHG’s Deloitte auditors that the \$79 million liability
18 accrual was “related to overpayments by CMS” that were identified through the RACCR
19 Program.

20 270. Scott Theisen was aware of the existence of a RACCR liability, and the
21 expectation that UnitedHealthcare would take an accrual for it, at least as early as
22 October 9, 2012, when Melissa Sedor sent him and Bill Hnath an August 2012 RAF
23 Financial Summary showing a \$97.5 million exposure (*i.e.*, amount of overpayment to
24 be returned) relating to the RACCR Program for encounters in 2008, 2009, and 2010.

25 271. In December 2013, Anne Reis, UnitedHealthcare Medicare & Retirement’s
26 Associate Director of Revenue, shared risk adjustment accruals with UnitedHealthcare
27 executives, including Scott Theisen, Brian Thompson, Bill Hnath, and Marybeth Meyer.
28 Those accruals included an additional liability accrual of \$34.5 million for RACCR

1 overpayments for the 2012 date of service year (2013 payment year), increasing the total
2 liability accrual for the RACCR Program to \$90.7 million for the 2008-2012 date of
3 service years (2009-2013 payment years). In taking a liability accrual for the 2012 date
4 of service year, UnitedHealthcare determined that it was probable that RACCR reviews
5 for the 2012 date of service year would result in the identification of deletes of diagnoses
6 reported by incentivized providers for medical encounters in 2012, as these reviews had
7 done in previous years.

8 272. The accuracy of the risk adjustment data that UnitedHealthcare and others
9 submitted to CMS on behalf of the Defendant MA Organizations was material to the
10 government's decision to pay and to the amount of risk adjustment payments. The
11 submission of inaccurate diagnosis data from incentivized providers directly resulted in
12 increases in risk adjustment payments that the Government made to the Defendant MA
13 Organizations.

14 273. Similarly, when the UHG Management Defendants deleted inaccurate diagnoses –
15 as they did when inaccurate diagnoses were identified in sample RACCR reviews or 100
16 percent reviews under the RACCR Program – the Government was able to offset its
17 subsequent payments to the Defendant MA Organizations by the value of those
18 deletions. UnitedHealthcare Medicare & Retirement's and Optum's failure to delete
19 unsupported codes because of their failure to conduct or complete 100 percent reviews
20 when their sample reviews identified Provider/HCC combinations with unacceptably
21 high error rates was material because if they had conducted the 100 percent reviews and
22 submitted deletes for the inaccurate diagnosis codes found in those reviews, those
23 deletions would have resulted in further offsets and, thus, reductions of payments to the
24 Defendant MA Organizations.

25 **E. Defendants Failed To Follow Their Own RACCR Protocol**
26 **Requiring 100 Percent Reviews**

27 274. As set forth above, the RACCR Program provided that if the sample review of an
28 outlier HCC showed that less than 80 percent of the diagnoses were supported by the

1 medical record, the provider would be required to perform a 100 percent review of all
2 instances of that outlier HCC coded by that provider for the date-of-service year at issue.
3 This requirement reflects a recognition by the UHG Managing Defendants that if a
4 provider codes a diagnosis three times as often as the national average rate *and* a sample
5 review shows that more than 1 in 5 diagnoses are not supported by the medical record,
6 then the provider's other uses of the same diagnosis code are highly likely to include
7 invalid diagnoses and must be reviewed for accuracy. Nonetheless, despite this
8 requirement of the RACCR Program, the UHG Managing Defendants frequently did not
9 require providers to perform 100 percent reviews of problematic HCCs for which sample
10 results showed unacceptably high error rates.

11 275. Not surprisingly, many providers were very resistant to performing 100 percent
12 reviews. Sometimes, the providers reviewed the records for only some, but not all,
13 additional beneficiaries for whom they had reported diagnoses mapping to the outlier
14 HCC. Sometimes, they did nothing.

15 276. For medical encounters in 2008 to 2010, at least 58 provider groups should have
16 performed 100 percent reviews because they failed the sample validation test for at least
17 one outlier HCC. Combined, these providers should have conducted 100 percent
18 reviews relating to 192 problematic HCCs. However, the providers only conducted
19 reviews of 143 of the 192 HCCs. Thus, a quarter of all outlier HCCs that failed the
20 sample validation test were not further reviewed by either the provider groups or
21 UnitedHealthcare. Similarly, for 2011 encounters, 100 percent reviews were conducted
22 for only 69 of 82 HCCs that failed Optum's sample validation test. Because the UHG
23 Managing Defendants did not require provider to perform 100 percent reviews of these
24 high-frequency but low-validating codes, they were able to avoid deleting the invalid
25 codes among them.

26 277. For example, for 2010 encounters, Edinger Medical Group coded Drug/Alcohol
27 Dependence (HCC 52) at a rate greater than three times the national rate. Optum (or its
28 predecessor, Ingenix) determined that only 70 percent of the diagnoses in its sample

1 were supported by medical record documentation. Because 30 percent of the sampled
2 diagnoses were invalid, the UHG Managing Defendants should have required Edinger to
3 review the additional 66 Edinger beneficiaries with a diagnosis mapping to HCC 52 that
4 were not included in the sample (or the UHG Managing Defendants should have
5 performed that review themselves). Nonetheless, the UHG Managing Defendants did
6 not require Edinger to do this review and they did nothing further to examine Edinger's
7 additional diagnoses mapping to HCC 52 that were not included in the sample.

8 278. Additional examples of provider groups that failed to conduct 100 percent reviews
9 for particular HCCs are shown in the chart attached as Exhibit 15 to this Complaint. The
10 UHG Managing Defendants also did not conduct the 100 percent reviews of these
11 problematic HCCs.

12 279. Moreover, even when a financially incentivized provider group conducted a 100
13 percent review, the UHG Managing Defendants knew they could not rely on the
14 accuracy of that review. For example, in a draft "WellMed RACCR Audit Status
15 Summary as of 2-9-12" that Mary Hammond circulated to Benjamin Poehling for
16 discussion with John Way in February 2012, Hammond reported that WellMed did a
17 self-audit for eight HCCs, but that the UHG Managing Defendants determined that "70%
18 of the codes [WellMed] indicated were properly documented actually were not supported
19 in the medical record." Hammond's summary also stated that, based on sample reviews
20 for medical encounters in 2008, 2009, and 2010, "WellMed failed to achieve an
21 acceptable validation rate for multiple HCCs ..., as defined by the RACCR audit
22 program policy and procedure."

23 **F. Even After Identifying Miscoding By Providers,**
24 **Defendants Failed To Delete Invalid Codes**

25 280. Even when the UHG Managing Defendants determined that diagnoses in a sample
26 review or 100 percent review were not supported by the medical records,
27 UnitedHealthcare Medicare & Retirement did not always delete them. For example:
28

1 • For 2008 medical encounters, the UHG Managing Defendants conducted a
2 sample review for Edinger Medical Group of diagnoses mapping to Drug/Alcohol
3 Dependence (HCC 52) and Major Complications of Medical Care & Trauma
4 (HCC 164). Optum's (or Ingenix's) coders determined that "[t]here was no
5 clinical documentation to support the diagnoses" mapping to HCC 52 for six
6 beneficiaries and that the diagnosis mapping to HCC 164 was the "wrong code"
7 for one beneficiary. (For all examples, further information to identify or aid in
8 identifying the beneficiaries will be separately provided to the Defendants.) On
9 January 23, 2013, Mary Hammond recommended to Keith Dobbins and Marybeth
10 Meyer that these results be put "on hold." The UHG Managing Defendants never
11 deleted these codes.

12 • For 2008 medical encounters, Optum (or its predecessor, Ingenix)
13 conducted a sample review for Family Practice Medical Group's diagnoses
14 mapping to Drug/Alcohol Dependence (HCC 52). For two beneficiaries, Optum's
15 (or Ingenix's) coder concluded there was "no clinical documentation to support
16 the diagnoses." In the Corrective Action Plan for the sample review, the reviewer
17 gave the provider "the benefit of the doubt" for the two diagnoses, despite noting
18 that "if these were submitted for a CMS or OIG audit, they may have been
19 rejected."

20 • In a sample review for Sharp-Rees Sealy for Vascular Disease (HCC 105)
21 for 2011, the UHG Managing Defendants failed to delete a diagnosis for
22 Beneficiary AA even though Optum's (or Ingenix's) coder, iCodify, determined it
23 was the "wrong code."

24 • In a sample review for HealthCarePartners for Protein-Calorie Malnutrition
25 (HCC 21) for 2011, the UHG Managing Defendants failed to delete a diagnosis for
26 Beneficiary BB even though Optum's (or Ingenix's) coder, iCodify, determined it
27 was the "wrong code."
28

1 • In a sample review for Mercy Physicians Medical Group for Protein-Calorie
2 Malnutrition (HCC 21) for 2011, the UHG Managing Defendants failed to delete a
3 diagnosis for Beneficiary CC even though Optum's (or Ingenix's) coders, under
4 the supervision of Tracey Bradberry, an Optum Operations Manager, determined
5 that it was the "wrong code."

6 • In a sample review for WellMed for Major Complications of Medical Care
7 and Trauma (HCC 164) for 2011, the UHG Managing Defendants did not delete a
8 diagnosis for Beneficiary DD even though Optum's (or Ingenix's) coder noted the
9 "dx [was] not documented" in the record.

10 • In a sample review for HealthCarePartners for Pneumococcal Pneumonia,
11 Emphysema, Lung Abscess (HCC 112) for 2012, the UHG Managing Defendants
12 did not delete a diagnosis code for Beneficiary EE even though Optum's (or
13 Ingenix's) coder determined the "dx [was] not documented."

14 • In a sample review for WellMed for Disorders of Immunity (HCC 45) for
15 2011, the UHG Managing Defendants did not delete a diagnosis code for
16 Beneficiary FF even though Optum's (or Ingenix's) coder determined the
17 diagnosis in the record was "not a current condition."

18 281. For some providers, the UHG Managing Defendants simply agreed not to delete
19 invalid codes. In January 2013, Keith Dobbins was informed that the UHG Managing
20 Defendants had not yet submitted deletes reflecting invalid codes found in RACCR
21 sample reviews of Edinger and WellMed diagnoses for encounters in 2008, 2009, and
22 2010. Optum kept those deletes "on hold," meaning that the UHG Managing Defendants
23 did not submit them, despite knowledge that the underlying codes had led to improper
24 payments from CMS.

**G. UnitedHealthcare Medicare & Retirement Discontinued
100 Percent Reviews And Converted The RACCR
Program Into A Revenue Generating Program**

282. By early 2014, UnitedHealthcare Medicare & Retirement knew, based on its observation of the results of the RACCR Program (as set forth above), that many of its large incentivized providers had reported unacceptably high rates of invalid diagnoses for numerous conditions. However, rather than redoubling its efforts to address invalid coding by incentivized providers, UnitedHealthcare Medicare & Retirement had Optum restructure the RACCR Program to turn it into just another chart review program focused on making ADDS. By July 2014, Optum made changes to the RACCR Program that effectively terminated the program as a tool for remedying the known problem of invalid coding by incentivized providers and refunding Medicare for risk adjustment payments based on those providers' invalid diagnoses.

283. First, UnitedHealthcare Medicare & Retirement stopped requiring any 100 percent reviews when the sample reviews failed the 80 percent sample validation test. At the time it made this decision, it was conducting RACCR sample reviews for 2012 DOS medical encounters. Accordingly, no 100 percent reviews were conducted for any outlier HCCs associated with 2012 medical encounters.

284. For 2012 DOS, there were 21 provider groups that had failed the 80 percent sample validation test for at least one outlier HCC. Optum had determined that the average invalidation rate was 34.73 percent for these 21 providers based on the sample reviews of their outlier HCCs. The UHG Managing Defendants knew from prior years that 100 percent reviews would result in the identification of more deletes. Nonetheless, they failed to require 100 percent reviews of the outlier HCCs or perform reviews themselves.

285. Second, for dates of service years after 2012, the UHG Managing Defendants stopped selecting sample beneficiaries for reviews based on whether the providers had submitted diagnoses for them mapping to outlier HCCs. Instead, they began selecting

1 beneficiaries and medical records based on what they believed would yield additional
2 codes and result in increased risk adjustment payments.

3 286. Third, starting with 2013 DOS medical encounters, UnitedHealthcare Medicare &
4 Retirement and Optum reviewed even fewer medical records than in previous years (less
5 than 100 total) for each incentivized provider group. Thus, they reviewed only several
6 thousand medical records as part of this new program.

7 287. By making these changes, the UHG Managing Defendants and Optum effectively
8 terminated the RACCR Program as an effort to correct the submission of invalid
9 diagnosis codes. Instead, they deliberately avoided identifying (and, thus, deleting)
10 invalid diagnoses reported by their financially-incentivized providers and repaying
11 Medicare for risk adjustment payments based on them.

12 288. Executives at Optum and UnitedHealthcare, including Scott Theisen, Jeff
13 Dumcum, Karen Erickson, Brian Thompson, and Keith Dobbins, were aware that the
14 changes to the RACCR Program for 2013 DOS and future years created a program that
15 no longer targeted outlier HCCs by provider, but instead selected beneficiaries and
16 medical records based on methods that Optum believed would yield additional codes and
17 result in increased risk adjustment payments. They knew that there was no replacement
18 program put into place to target the outlier HCCs and providers that had previously been
19 identified by the RACCR program. They knew that by stopping its program to look for
20 inaccurate codes, outlier providers who had failed the 80 percent validation tests would
21 continue to submit inaccurate codes to UnitedHealthcare, causing the submission of
22 inaccurate codes to CMS.

23 **H. RACCR-Related Falsehoods In UnitedHealthcare's And**
24 **Optum's Attestations**

25 289. As discussed in more detail below, Defendant UnitedHealthcare, on behalf of the
26 Defendant MA Organizations, submitted a Risk Adjustment Attestation to the Medicare
27 Program each year after the final risk adjustment submission deadline. *See infra*
28

1 paragraphs 309 to 327. Defendant Optum approved these Attestations in order for
2 UnitedHealthcare to submit them. *Id.*

3 290. In March 2012, Scott Theisen signed an Attestation on behalf of United's
4 Medicare & Retirement health plans certifying to the accuracy of UnitedHealthcare's
5 data for the 2010 date of service year (2011 payment year). By that date, the members of
6 UHG Management Defendants' RACCR team (including Michael McCarthy, Keith
7 Dobbins, Kim Halva, Benjamin Poehling, and Mary Hammond) knew that the RACCR
8 Program had identified thousands of invalid codes mapping to outlier HCCs from
9 encounters in 2010, that those codes had not yet been deleted, and that efforts were
10 underway to identify the providers that would be required to conduct 100 percent
11 reviews for encounters in 2010 because some of their diagnosis codes did not pass the 80
12 percent sample validation test.

13 291. In April 2013, Scott Theisen signed an Attestation on behalf of
14 UnitedHealthcare's Medicare & Retirement health plans certifying to the accuracy of
15 UnitedHealthcare's data for the 2011 date of service year (2012 payment year). By that
16 date, Theisen, along with the members of UHG Management Defendants' RACCR team
17 (including Marybeth Meyer, Keith Dobbins, Kim Halva, Patty Brennan, Benjamin
18 Poehling, and Scott Hughes) knew that the RACCR Program had identified thousands of
19 invalid codes mapping to HCCs from encounters in 2011, that those codes had not yet
20 been deleted, and that efforts were underway to identify the providers that would be
21 required to conduct 100 percent reviews for encounters in 2011 because some of their
22 diagnosis codes did not pass the 80 percent sample validation test.

23 292. In April 2014, Brian Thompson signed an Attestation on behalf of
24 UnitedHealthcare's Medicare & Retirement health plans certifying to the accuracy of
25 UnitedHealthcare's data for the 2012 date of service year (2013 payment year). By that
26 date, the members of UHG Management Defendants' RACCR team (including Marybeth
27 Meyer, Keith Dobbins, Kim Halva, Scott Theisen, Scott Hughes, and Tracey Bradberry)
28 knew that the RACCR Program had identified thousands of invalid codes mapping to

1 HCCs from encounters in 2012 through sample reviews, and that those codes had not yet
2 been deleted. Additionally, Thompson was aware that there was a contra-revenue
3 accrual in the amount of \$34.5 million for anticipated RACCR deletes for the 2012 date
4 of service year alone.

5 **IV. Defendants' False Risk Adjustment Attestations**

6 293. The UHG Managing Defendants submitted or caused the submission, on behalf of
7 the Defendant MA Organizations, of the annual Risk Adjustment Attestations to the
8 Medicare Program after the final submission deadline but before the final reconciliation
9 payment each year. Officers of Defendants Ovations and UnitedHealthcare reviewed
10 and signed these Attestations. Defendant Optum and its predecessor Ingenix reviewed
11 and approved these Attestations. These Defendants knew that the Defendant MA
12 Organizations were required to submit truthful Risk Adjustment Attestations to the
13 Medicare Program. Their officers and employees (*e.g.*, Jeffrey Dumcum, Stephanie
14 Will, Jon Bird, Patty Brennan, Rebecca Martin, Scott Theisen, Relator Poehling, Mary
15 Hammond) were aware of the obligations for deleting invalid diagnoses from RAPs or
16 otherwise reporting and repaying risk adjustment overpayments by other means. Their
17 officers and employees (*e.g.*, Jeffrey Dumcum, Stephanie Will, Jon Bird, Patty Brennan,
18 Rebecca Martin, Scott Theisen, Relator Poehling, Mary Hammond) also knew that, if
19 they deleted or withdrew invalid diagnoses from RAPS prior to the submission of an
20 Attestation, Medicare would not pay for them or would recover any erroneous payments
21 associated with them. However, Defendants failed to do this and knowingly submitted
22 or caused the submission of false Attestations. They did this with actual knowledge that
23 the Attestations were false or acted in deliberate ignorance or reckless disregard of the
24 falsity of the Attestations.

25 294. Starting with the Attestation for payment year 2008 (if not for earlier Attestations)
26 and continuing forward, attorneys for one or more of the UHG Managing Defendants
27 added a footnote to the Attestations which stated that the Attestations were "based on
28 facts reasonably available or made available to" the Defendant MA Organizations as of

1 the date of the Attestations. Optum and its predecessor Ingenix knew about this footnote
2 because its senior management, including Karen Erickson, Jeff Dumcum and Scott
3 Theisen, reviewed the Attestations and approved them prior to their submission to the
4 Medicare Program. The officers of Ovations and UnitedHealthcare who signed the
5 Attestations also knew about this footnote. Even without this footnote, the Attestations
6 themselves state that they must be made based on information available to the MA
7 Organizations: “Based on best knowledge, *information*, and belief as of the date
8 indicated below, all information submitted to CMS in such report [*i.e.*, the risk
9 adjustment data reported for the payment year at issue] and not subsequently deleted
10 prior to the date hereof is accurate, complete, and truthful.” (Emphasis added).

11 295. Information and facts reasonably available or made available to the Defendant
12 MA Organizations and the groups and entities that managed them at the time the
13 Attestations were submitted included the results of the medical record reviews conducted
14 as part of the Chart Review, Claims Verification, and RACCR Programs. In particular,
15 the results of the Chart Review Program were available before the final submission
16 deadline each year as the Chart Review Program ended when additional diagnoses could
17 no longer be submitted. Thus, the results of the Chart Review Program were
18 “information” and “facts reasonably available” before Ingenix and Optum approved the
19 Attestations and before Ovations and UnitedHealthcare executed and submitted the
20 Attestations to CMS on behalf of the Defendant MA Organizations. However, these
21 Defendants knowingly failed to delete numerous diagnoses that they had previously-
22 submitted that were unsupported and invalidated by their own chart reviews.

23 **A. Defendants’ Internal Attestation Approval Process**

24 296. Generally, the Chief Financial Officers of the groups with responsibility for
25 managing the Defendant MA Organizations owned by UHG were the officers designated
26 to sign and execute the annual Risk Adjustment Attestations on behalf of the Defendant
27 MA Organizations. Over the relevant time period, these groups included, but were not
28 limited to, Secure Horizons, the Public & Seniors Markets Group, Ovations,

1 UnitedHealthcare Medicare & Retirement, and UnitedHealthcare Community & States.
2 They were “responsible for establishing and maintaining adequate internal controls over
3 completion of attestations” submitted to the Medicare Program. They used a form to
4 “confirm that the appropriate legal, regulatory, and business owners” reviewed and
5 approved the attestations. *Id.* These legal, regulatory, and business owners were
6 required to sign Internal Approval Forms in order for the designated officials to sign the
7 Risk Adjustment Attestations.

8 297. Part C regulation, 42 C.F.R. § 422.504(1), and the agreements between the MA
9 Organizations and CMS required that this internal approval process include any related
10 entity, contractor or subcontractor of the Defendant MA Organizations that generated or
11 submitted risk adjustment data on their behalf. Furthermore, if a related entity generated
12 data relating to an MA Organization’s claims for payments from the Medicare Program,
13 the related entity (as well as the MA Organization) must certify the accuracy and
14 truthfulness of the data. *Id.* at § 422.504(l)(3). The contracts stated: “If such risk
15 adjustment data are generated by a related entity, contractor, or subcontractor of an MA
16 Organization, such entity, contractor, or subcontractor must also attest to (*based on best*
17 *knowledge, information, and belief, as of the date specified on the attestation form*) the
18 accuracy, completeness, and truthfulness of the data.” See Exhibits 1-7, attached hereto
19 (Article IV, Section D.2). Optum (and its predecessor, Ingenix), Ovations, and
20 UnitedHealthcare Medicare & Retirement understood this requirement as shown by the
21 previously-described MOU that obligated Optum to attest to the validity of the risk
22 adjustment data that it submitted to the Medicare Program on behalf of the Defendant
23 MA Organizations. See *supra* paragraphs 83-86.

24 298. During the time period relevant to this Complaint, the “business owners” that
25 signed off on the Internal Approval Forms were executives of Optum and Ingenix. One
26 of these business owners was Jeffrey Dumcum, who ran the Risk Adjustment Group at
27 Ingenix and then Optum. Dumcum’s internal attestations stated that he had reviewed the
28 content of the Risk Adjustment Attestations to be submitted by the managing entity (e.g.,

1 Oventions or UnitedHealthcare) to the Medicare Program and confirmed that the
2 Attestations were factually accurate. For example, on March 26, 2010, Dumcum sent an
3 email to Emily Vue, a Senior Regulatory Affairs Analyst for “Oventions – PSMG,
4 UnitedHealth Group, Inc.,” stating that he approved the Risk Adjustment Attestation for
5 John Larsen, the Chief Financial Officer of the Ovation Public & Senior Markets Group,
6 to submit to Medicare for payment year 2009. On March 24, 2011, Dumcum sent an
7 email to Barbara Carlson, a Senior Regulatory Affairs Analyst for UnitedHealthcare
8 Medicare & Retirement, stating that he approved the Risk Adjustment Attestation for
9 Scott Theisen, the Chief Financial Officer of UnitedHealthcare Medicare & Retirement,
10 to submit to Medicare for payment year 2010. On March 8, 2012, Dumcum sent an
11 email to Sandy Rick, a Senior Regulatory Affairs Analyst for UnitedHealthcare
12 Medicare & Retirement, stating that he approved the Risk Adjustment Attestation for
13 Mr. Theisen to submit to Medicare for payment year 2011.

14 299. Mr. Dumcum approved the Larsen and Theisen Risk Adjustment Attestations after
15 reviewing them and the footnotes added by the attorneys to them, including the footnote
16 stating that the Attestations were based on information available to the Defendant MA
17 Organizations about the accuracy and truthfulness of the diagnosis data that was
18 submitted on their behalf to the Medicare Program for risk adjustment payments.
19 However, Dumcum deliberately ignored or recklessly disregarded information available
20 to the Defendant MA Organizations and the entities that managed them (including
21 Oventions, UnitedHealthcare, Ingenix, and Optum, depending on the time period) about
22 invalid diagnoses, that is, he deliberately ignored and recklessly disregarded the negative
23 results of the medical record reviews conducted as part of the Chart Review, Claims
24 Verification, and RACCR Programs. Accordingly, Dumcum, as a senior executive of
25 Defendant Optum (and its predecessor, Ingenix), caused false Risk Adjustment
26 Attestations to be submitted to the Medicare Program.

27 300. For example, in March 2010, when Dumcum approved the Larsen Attestation for
28 payment year 2009, his Risk Adjustment Group at Ingenix possessed information about

1 the negative results of the Chart Review Program focused on the review of medical
2 records for medical encounters in date of service year 2008. Also, in March 2010,
3 Dumcum knew (or deliberately ignored or recklessly disregarded) that the managing
4 entities were not deleting or withdrawing the diagnoses unsubstantiated and invalidated
5 by those chart reviews. At that time, Dumcum also knew (or deliberately ignored or
6 recklessly disregarded) that these managing entities and the MA Organizations had an
7 obligation to delete or withdraw those invalid diagnoses. In fact, in 2009 prior to
8 Dumcum's approval of the Larsen Attestation, Dumcum knew that his Risk Adjustment
9 Group had already started discussing "looking both ways" at the results of chart reviews
10 and the methodology to do so in order to make DELETES as well as ADDS. *See supra*
11 paragraphs 180-182. Nonetheless, Dumcum signed the Internal Approval Form and
12 caused Larsen to submit a false Attestation to the Medicare Program.

13 301. As another example, in March 2011, when Dumcum approved the Theisen
14 Attestation for payment year 2010, his Risk Adjustment Group at Optum possessed
15 information about the negative results of the Chart Review Program focused on the
16 review of medical records for medical encounters in date of service year 2009. Also, in
17 March 2011, Dumcum knew (or deliberately ignored or recklessly disregarded) that
18 neither Optum nor UnitedHealthcare were deleting or withdrawing the diagnoses
19 invalidated by those chart reviews because they were not supported by the beneficiaries'
20 medical records. At that time, Dumcum also knew (or deliberately ignored or recklessly
21 disregarded) that both UnitedHealthcare and Optum had an obligation to delete or
22 withdraw those invalid diagnoses. In fact, in the fall of 2010 prior to Dumcum's
23 approval of the Theisen Attestation, Dumcum knew that senior executives of Ingenix and
24 Ovations had already acknowledged that they should be "looking both ways" at the
25 results of the chart reviews to make DELETES as well as ADDS. *See supra* paragraphs
26 185 and 196-198. In December 2010, the results of the first pilot phase (Phase I) of the
27 Claims Verification Program, which showed that provider-reported diagnoses were
28 unsupported for over 50 percent of the medical records reviewed, were also known by or

1 available to Dumcum. *See supra* paragraph 206. Nonetheless, Dumcum signed the
2 Internal Approval Form and caused Theisen to submit a false Attestation to the Medicare
3 Program.

4 302. In addition, in March 2012, when Dumcum approved the Theisen Attestation for
5 payment year 2011, his risk adjustment group at Optum possessed information about the
6 negative results of the Chart Review Program focused on the review of medical records
7 for medical encounters in date of service year 2010. Also, in March 2012, Dumcum
8 knew (or deliberately ignored or recklessly disregarded) that neither Optum nor
9 UnitedHealthcare were deleting or withdrawing the diagnoses invalidated by those chart
10 reviews, *i.e.*, those diagnoses not supported by the beneficiaries' medical records. At
11 that time, Dumcum also knew (or deliberately ignored or recklessly disregarded) that
12 both UnitedHealthcare and Optum had an obligation to delete or withdraw those invalid
13 diagnoses but were not doing so. In fact, by the time that Dumcum approved Theisen's
14 Attestation in March 2012, Optum had completed the second pilot phase (Phase II) of the
15 Claims Verification Program on 17,398 charts and the results were striking. Optum
16 identified 4,786 invalid diagnoses to be deleted, which was greater than the number of
17 additional diagnoses (ADDs) identified by the coders based on their review of the same
18 medical records. And, as previously stated, in February 2012, Dumcum, who was
19 responsible for the Claims Verification Program, met with Relator Poehling and Theisen
20 and reported: "I'm deleting as much as I'm adding at the end of the day. And I don't
21 know if—you know, what I want to do." He also stated: "we're getting more and more
22 red here," and that Claims Verification "eats in very substantially" to the revenue from
23 ADDs from chart reviews. Nonetheless, Dumcum signed the Internal Approval Form
24 and caused Theisen to submit a false Attestation.

25 303. Another "business owner" who executed the Internal Approval Form was Karen
26 Erickson, an Executive Vice President of Optum. On April 3, 2013, Erickson approved
27 Risk Adjustment Attestations for Scott Theisen, the Chief Financial Officer of
28 UnitedHealthcare Medicare & Retirement, and Paul Balthazor, the Chief Financial

1 Officer of UnitedHealthcare Community & State, to submit to Medicare for payment
2 year 2012. Erickson's internal attestation stated that she had reviewed the content of the
3 Theisen and Balthazor Risk Adjustment Attestations and confirmed that the Attestations
4 were factually accurate. Because she reviewed these Risk Adjustment Attestations she
5 knew about the footnotes that UnitedHealthcare included in the Attestations, stating that
6 the Attestations were based on information available to the Defendant MA
7 Organizations. In April 2013, Erickson knew (or deliberately ignored or recklessly
8 disregarded) that this information included the negative results of the Chart Reviews
9 focused on the review of medical records for medical encounters in date of service year
10 2011. Also, in April 2013, Erickson knew (or deliberately ignored or recklessly
11 disregarded) that neither Optum nor UnitedHealthcare were deleting or withdrawing all
12 of the diagnoses invalidated by those chart reviews because they were not supported by
13 the beneficiaries' medical records. At that time, Erickson also knew (or deliberately
14 ignored or recklessly disregarded) that both UnitedHealthcare and Optum had an
15 obligation to delete or withdraw all invalid diagnoses. In addition, prior to approving the
16 Attestations in 2013, Erickson, who was part of the team that developed the operational
17 plan for Claims Verification, knew and was concerned about the error rates based on
18 chart reviews conducted as part of the Claims Verification Program. Nonetheless,
19 Erickson signed the Internal Approval Forms and caused Theisen and Balthazor to
20 submit false Attestations.

21 304. In addition, on April 17 and 21, 2014, Erickson approved Risk Adjustment
22 Attestations for Brian Thompson, the Chief Financial Officer of UnitedHealthcare
23 Medicare & Retirement, and for Paul Balthazor, the Chief Financial Officer of
24 UnitedHealthcare Community & State, to submit to Medicare for payment year 2013.
25 Erickson's internal attestation stated that she reviewed the content of the Thompson and
26 Balthazor Risk Adjustment Attestations and confirmed that the Attestations were
27 factually accurate. Because she reviewed these Risk Adjustment Attestations she knew
28 about the footnotes that UnitedHealthcare included in the Attestations, stating that the

1 Attestations were based on information available to the Defendant MA Organizations.
2 In April 2014, Erickson knew (or deliberately ignored or recklessly disregarded) that this
3 information included the negative results of the Chart Reviews focused on the review of
4 medical records for medical encounters in date of service year 2012. Also, in April
5 2014, Erickson knew (or deliberately ignored or recklessly disregarded) that neither
6 Optum nor UnitedHealthcare were deleting or withdrawing all of the diagnoses
7 invalidated by those chart reviews because they were not supported by the beneficiaries'
8 medical records. At that time, Erickson also knew (or deliberately ignored or recklessly
9 disregarded) that both UnitedHealthcare and Optum had an obligation to delete or
10 withdraw all invalid diagnoses. Nonetheless, Erickson signed the Internal Approval
11 Forms and caused Thompson and Balthazor to submit false Attestations.

12 305. During the time period relevant to this Complaint, one of the "regulatory owners"
13 that executed the Internal Approval Form was David Walsh, the Senior Director of
14 Regulatory Affairs for UnitedHealthcare. He attested that he had reviewed the content
15 of the Risk Adjustment Attestation "to confirm that it complies with applicable
16 *regulatory* requirements and determined that it is appropriate for the designated
17 executive to proceed with signature." However, Walsh deliberately ignored or recklessly
18 disregarded the negative results of the Chart Review Program. He also ignored and
19 disregarded that Defendants had failed to comply with the requirements that diagnoses
20 must be supported by patients' medical records and those diagnoses that are not
21 supported by the patients' medical records must be deleted from RAPS or otherwise
22 reported to CMS and corrected to repay or avoid any overpayment.

23 306. During the time period relevant to this Complaint, one of the "legal owners" that
24 executed the Internal Approval Form was UnitedHealthcare's Senior General Counsel
25 Keith Dobbins. For example, on March 26, 2010, Dobbins approved the Risk
26 Adjustment Attestation for John Larsen to submit to the Medicare Program for payment
27 year 2009. Dobbins attested that he had reviewed the content of the Risk Adjustment
28 Attestation to confirm that it complied with "applicable *legal* requirements" and was

1 “appropriate” for Larsen to sign. (emphasis in the original). As another example, on
2 March 25, 2011, Dobbins approved the Risk Adjustment Attestation for Scott Theisen,
3 the Chief Financial Officer of UnitedHealthcare Medicare & Retirement, to submit to the
4 Medicare Program for payment year 2010. Again, Dobbins attested that he reviewed the
5 content of the Attestation to confirm that it complied with “applicable legal
6 requirements” and was “appropriate” for Theisen to submit to the Medicare Program for
7 payment year 2011. In addition, on March 9, 2012, Dobbins approved the Risk
8 Adjustment Attestation for Scott Theisen, the Chief Financial Officer of
9 UnitedHealthcare Medicare & Retirement, to submit to the Medicare Program for
10 payment year 2011. Again, Dobbins attested that he reviewed the content of the
11 Attestation to confirm that it complied with “applicable legal requirements” and was
12 “appropriate” for Theisen to submit to the Medicare Program for payment year 2011.
13 On April 30, 2014, Dobbins also approved the Risk Adjustment Attestation for Brian
14 Thompson, the Chief Financial Officer of UnitedHealthcare Medicare & Retirement, to
15 submit to Medicare for payment year 2013. Again, Dobbins attested that he reviewed
16 the content of the Attestation to confirm that it complied with “applicable legal
17 requirements” and was “appropriate” for Theisen to submit to the Medicare Program for
18 payment year 2011. On information and belief, Dobbins approved other Risk
19 Adjustment Attestations for other payment years and attested to their accuracy.
20 307. Each time Dobbins approved the Attestations, he knew (or deliberately ignored or
21 recklessly disregarded) that information available to the Defendant MA Organizations
22 included the negative results of the chart reviews for the date of service years at issue.
23 Also, he knew (or deliberately ignored or recklessly disregarded) that neither
24 Ingenix/Optum nor Ovations/UnitedHealthcare (depending on the time period) were
25 deleting or withdrawing all of the diagnoses invalidated by those chart reviews because
26 they were not supported by the beneficiaries’ medical records. At that time, he also
27 knew (or deliberately ignored or recklessly disregarded) that both Ingenix/Optum and
28 Ovations/UnitedHealthcare had an obligation to delete or withdraw all invalid diagnoses.

308. During the years relevant to his approvals, Dobbins was a member of UnitedHealthcare's Risk Adjustment Compliance Oversight Committee and Optum's Clinical Programs and Compliance Oversight Committee. During those years, Dobbins also attended various meetings involving the work that Ingenix and then Optum performed for Ovations and then UnitedHealthcare. As a member of these committees and a participant in these meetings, Dobbins was included in numerous discussions about the validity of the risk adjustment data submitted to the Medicare Program, the Chart Review Program, the development and results of the Claims Verification Program, and the RACCR Program. Dobbins was also one of the individuals who was responsible for reviewing quarterly compliance scorecards that included detailed information about the Chart Review, Claims Verification, and RACCR Programs. Despite these compliance responsibilities and this knowledge, Dobbins ignored and disregarded that Ovations, UnitedHealthcare, Optum, and Ingenix had failed to comply with the requirements that diagnoses must be supported by patients' medical records and that diagnoses unsupported by patients' medical records must be deleted from RAPS or otherwise reported to CMS and corrected to repay or avoid any overpayments.

B. The False Attestations Submitted To The Government

309. On March 19, 2009, John Way executed and submitted or caused to be submitted to the Medicare Program an "Attestation of Risk Adjustment Data Information Relating to CMS Payment to a Medicare Advantage Organization." He submitted this Attestation "[o]n behalf of the UnitedHealth Group entities listed in Attachment 1." This Attestation related to risk adjustment data, that is, diagnoses, which Ovations and/or UnitedHealthcare and Ingenix submitted on behalf of many of the Defendant MA Organizations for risk adjustment payments for payment year 2008. See Exhibit 16, attached hereto. The Risk Adjustment data, that is, the diagnoses, were related to medical encounters that occurred in date of service year 2007. Way signed the Attestation as "Chief Financial Officer, SecureHorizons." At this time, March 2009, SecureHorizons was an internal group within Ovations or UnitedHealthcare. Way added

1 a footnote to the Attestation which stated that the Attestation was “based on facts
2 reasonably available or made available to the MA Organization as of the date of” the
3 Attestation. The Attestation itself said it was made based on information available to the
4 MA Organizations. In March 2009, information and facts reasonably available to the
5 Defendant MA Organizations, Ovations and/or UnitedHealthcare, and Ingenix included
6 the negative results of the Chart Review Program for 2007 date of service medical
7 encounters.

8 310. In March 2009, when Way signed the Attestation, he deliberately ignored or
9 recklessly disregarded the negative results of the Chart Review Program relating to
10 medical encounters with 2007 dates of service. Way also ignored and disregarded that
11 Defendants had failed to comply with the requirements that diagnoses must be supported
12 by patients’ medical records and those diagnoses that are not supported by patients’
13 medical records are invalid and must be deleted from RAPS or otherwise reported to
14 CMS and corrected to repay or avoid any overpayment. In addition, at this time, Relator
15 Poehling was a direct report to Way, Relator Poehling and Way had numerous
16 conversations about risk adjustment programs, and Relator Poehling voiced his concerns
17 to Way about Ovations failure to “look both ways” at the results of medical record
18 reviews conducted as part of the Chart Review Program.

19 311. On March 18, 2009, Kara Rios executed and submitted or caused to be submitted
20 to the Medicare Program an “Attestation of Risk Adjustment Data Information Relating
21 to CMS Payment to a Medicare Advantage Organization.” She submitted this
22 Attestation “[o]n behalf of the UnitedHealth Group entities listed in Attachment 1.” This
23 Attestation related to Risk Adjustment data, that is, diagnoses, that Ovations (or the
24 group known as AmeriChoice, which, on information and belief, was located within
25 Ovations at this time) and Ingenix submitted on behalf of certain Defendant MA
26 Organizations for Risk Adjustment payments for payment year 2008. The Risk
27 Adjustment data, that is, the diagnoses, were related to medical encounters that occurred
28 in date of service year 2007. Rios signed the Attestation as “Chief Financial Officer,

1 AmeriChoice.” Rios added a footnote to the Attestation which stated that the Attestation
2 was “based on facts reasonably available or made available to the MA Organization as of
3 the date of” the Attestation. The Attestation itself said it was made based on information
4 available to the MA Organizations. In March 2009, information and facts reasonably
5 available to all Defendants included the negative results of the Chart Review Program.

6 312. On March 2, 2009, Jonathan Bunker executed and submitted or caused to be
7 submitted to the Medicare Program an “Attestation of Risk Adjustment Data Information
8 Relating to CMS Payment to a Medicare Advantage Organization.” He submitted this
9 Attestation “[o]n behalf of Sierra Health and Life Insurance Company, Inc.,” a
10 Defendant MA Organization. This Attestation was for payment year 2008. The Risk
11 Adjustment data, that is, the diagnoses, were related to medical encounters that occurred
12 in date of service year 2007. Bunker signed the Attestation as President of Sierra Health
13 and Life Insurance Company, Inc. At this time, March 2009, Sierra Health and Life
14 Insurance Company, Inc. was an MA Organization owned by UHG and managed by
15 UnitedHealthcare. The Attestation was submitted to the Medicare Program by Shelly
16 Cranley, the Director of Regulatory Affairs for UnitedHealthcare.

17 313. On March 2, 2009, Jonathan Bunker executed and submitted or caused to be
18 submitted to the Medicare Program another “Attestation of Risk Adjustment Data
19 Information Relating to CMS Payment to a Medicare Advantage Organization.” He
20 submitted this Attestation “[o]n behalf of Health Plan of Nevada, Inc.,” a Defendant MA
21 Organization, and its MA Plans. This Attestation was for payment year 2008. The Risk
22 Adjustment data, that is, the diagnoses, were related to medical encounters that occurred
23 in date of service year 2007. Bunker signed the Attestation as President of Health Plan
24 of Nevada, Inc. At this time, March 2009, Health Plan of Nevada, Inc. was an MA
25 Organization owned by UHG and managed by UnitedHealthcare. The Attestation was
26 submitted to the Medicare Program by Shelly Cranley, the Director of Regulatory
27 Affairs for UnitedHealthcare.

1 314. On March 19, 2009, Justin Roth executed and submitted or caused to be submitted
2 to the Medicare Program another “Attestation of Risk Adjustment Data Information
3 Relating to CMS Payment to a Medicare Advantage Organization.” This Attestation was
4 for payment year 2008. The Risk Adjustment data, that is, the diagnoses, were related to
5 medical encounters that occurred in date of service year 2007. Roth signed the
6 Attestation as “Chief Financial Officer of Evercare” and stated that the Attestation was
7 signed “[o]n behalf of the UnitedHealth Group entities listed in Attachment 1,” which
8 included various Defendant MA Organizations, including many United Healthcare
9 Insurance Company MA Organizations, Oxford Health Plans of New Jersey, Inc., and
10 Evercare of Texas. At this time, March 2009, these MA Organizations were owned by
11 UHG and managed by UnitedHealthcare. The Attestation stated that it was based on
12 information and facts reasonably available or made available to the MA Organizations
13 listed in Attachment 1 at the time the Attestation was submitted.

14 315. On March 26, 2010, John Larsen executed and submitted or caused to be
15 submitted to CMS an “Attestation of Risk Adjustment Data Information Relating to
16 CMS Payment to a Medicare Advantage Organization.” He submitted this Attestation
17 “[o]n behalf of the UnitedHealth Group entities listed in Attachment 1.” These entities
18 included numerous Defendant MA Organizations. This Attestation related to Risk
19 Adjustment data, that is, diagnoses, that Optum (or its predecessors Ingenix) and
20 Ovations and/or UnitedHealthcare submitted on behalf of these MA Organizations to
21 Medicare for Risk Adjustment payments for payment year 2009. See Exhibit 17,
22 attached hereto. The Risk Adjustment data, that is, the diagnoses, were related to
23 medical encounters that occurred in date of service year 2008. Larsen signed the
24 Attestation as “Chief Financial Officer, Public & Senior Markets Group.” At this time,
25 the Public & Senior Markets Group included Ovations. Larsen added a footnote to his
26 Risk Adjustment Attestation which stated that the Attestation was “based on facts
27 reasonably available or made available to the MA Organization as of the date of” the
28 Attestation. The Attestation itself stated that it was based on information available to the

1 MA Organizations. In March 2010, information and facts reasonably available to the
2 Defendant MA Organizations included the negative results of the Chart Review Program
3 relating to medical encounters that occurred in 2008.

4 316. When Larsen signed the Attestation, he deliberately ignored or recklessly
5 disregarded the negative results of the Chart Review Program. Larsen also ignored or
6 disregarded that Defendants had failed to comply with the requirements that diagnoses
7 must be supported by patients' medical records and that diagnoses that are not supported
8 by patients' medical records are invalid and must be deleted from RAPS or otherwise
9 reported to CMS and corrected to repay or avoid any overpayment. During the relevant
10 time period, Larsen was involved in meetings concerning the Chart Review Program and
11 knew that the Public & Senior Markets Group could have "looked both ways" at the
12 results of the chart reviews but was not doing so and, thus, that the Public & Senior
13 Markets Group was not reporting to CMS those provider-reported codes that were not
14 supported by the beneficiaries' medical records.

15 317. On March 25, 2011, Scott Theisen executed and submitted or caused to be
16 submitted to CMS an "Attestation of Risk Adjustment Data Information Relating to
17 CMS Payment to a Medicare Advantage Organization." He submitted this Attestation
18 "[o]n behalf of the UnitedHealth Group entities listed in Attachment 1." This Attestation
19 related to Risk Adjustment data, that is, diagnoses, that UnitedHealthcare and Optum (or
20 its predecessor Ingenix) submitted on behalf of numerous Defendant MA Organizations
21 to Medicare for risk adjustment payments for payment year 2010. See Exhibit 18,
22 attached hereto. The risk adjustment data, that is, the diagnoses, were related to medical
23 encounters that occurred in date of service year 2009. Theisen signed the Attestation as
24 "Chief Financial Officer, UnitedHealthcare Medicare & Retirement." Theisen added a
25 footnote to his Risk Adjustment Attestation which stated that the Attestation was "based
26 on facts reasonably available or made available to the MA Organization as of the date
27 of" the Attestation. The Attestation itself stated that it was made based on information
28 available to the Defendant MA Organizations. In March 2011, information and facts

1 reasonably available to the Defendant MA Organizations, UnitedHealthcare, and Optum
2 (or its predecessor, Ingenix) included the negative results of the Chart Review Program
3 relating to medical encounters in 2009.

4 318. On March 9, 2012, Scott Theisen executed and submitted or caused to be
5 submitted to CMS an “Attestation of Risk Adjustment Data Information Relating to
6 CMS Payment to a Medicare Advantage Organization.” He submitted this Attestation
7 “[o]n behalf of the UnitedHealth Group entities listed in Attachment 1.” This Attestation
8 related to Risk Adjustment data, that is, diagnoses, that UnitedHealth and Optum
9 submitted to on behalf of numerous MA Organizations to Medicare for risk adjustment
10 payments for payment year 2011. See Exhibit 19, attached hereto. The risk adjustment
11 data, that is, the diagnoses, were related to medical encounters that occurred in date of
12 service year 2010. Theisen signed the Attestation as “Chief Financial Officer,
13 UnitedHealthcare Medicare & Retirement. The Attestation stated that it was based on
14 information available to the MA Organizations. It also included a footnote that stated
15 the Attestation was “based on facts reasonably available or made available to the MA
16 Organization as of the date” of the Attestation. In March 2012, information and facts
17 reasonably available to all Defendants included the negative results of the medical record
18 reviews conducted as part of the Chart Review Program for payment year 2011 (date of
19 service year 2010).

20 319. On April 9, 2013, Scott Theisen executed and submitted or caused to be submitted
21 to CMS an “Attestation of Risk Adjustment Data Information Relating to CMS Payment
22 to a Medicare Advantage Organization.” He submitted this Attestation “[o]n behalf of
23 the UnitedHealth Group entities listed in Attachment A.” This Attestation related to
24 Risk Adjustment data, that is, diagnoses, that UnitedHealthcare and Optum submitted on
25 behalf of numerous MA Organizations to Medicare for risk adjustment payments for
26 payment year 2012. See Exhibit 20, attached hereto. The risk adjustment data, that is,
27 the diagnoses, were related to medical encounters that occurred in date of service year
28 2011. Theisen signed the Attestation as “Chief Financial Officer, UnitedHealthcare

1 Medicare & Retirement.” The Attestation stated that it was based on information
2 available to the MA Organizations and also included a footnote stating that the
3 Attestation was “based on facts reasonably available or made available to the MA
4 Organization as of the date of” the Attestation. In March 2013, information and facts
5 reasonably available to the MA Organizations, UnitedHealthcare, and Optum included
6 the negative results of the medical record reviews conducted as part of the Chart Review
7 Program for payment year 2012 (date of service year 2011).

8 320. Each time Theisen signed the Attestations, he deliberately ignored or recklessly
9 disregarded the negative results of the Chart Review Program for the 2010, 2011, and
10 2012 payment years and 2009, 2010, and 2011 date of service years at issue. Theisen
11 also ignored or disregarded that the Defendant MA Organizations, UnitedHealthcare,
12 and Optum (or its predecessor, Ingenix) had failed to comply with the requirements that
13 diagnoses must be supported by patients’ medical records and that those diagnoses that
14 are not supported by patients’ medical records are invalid and must be deleted from
15 RAPS or otherwise reported to CMS and corrected to repay or avoid any overpayments.

16 321. During the years in which he was Chief Financial Officer of UnitedHealthcare
17 Medicare & Retirement and approved the Attestations, Theisen was co-chair and
18 business lead of UnitedHealthcare Medicare & Retirement’s Financial Compliance
19 Oversight Committee. He also attended quarterly meetings with UnitedHealthcare
20 Medicare & Retirement’s Compliance Committee, comprised of UnitedHealthcare
21 Medicare & Retirement’s executive leadership team; Executive Steering Committee
22 meetings; and meetings to identify and evaluate corporate risks. As a member of these
23 committees, a participant in these meetings, and in fulfilling his duties as
24 UnitedHealthcare Medicare & Retirement’s Chief Financial Officer, Theisen was
25 involved in discussions about the Chart Review Program, the implementation and results
26 of the Claims Verification Program, and the RACCR Program. During this time period,
27 Theisen had authority to make decisions on behalf of UnitedHealthcare, including how
28 much to spend on the Chart Review Program, how many charts to include in the Chart

1 Review Program, and whether to submit DELETES based on information available to
2 UnitedHealthcare. He also had authority to make similar decisions about the RACCR
3 Program.

4 322. In addition, Theisen was aware of the significant number of invalid provider-
5 reported diagnoses based on the results of the Chart Review and Claims Verification
6 Programs. For example, when Theisen executed the Risk Adjustment Attestation in
7 March 2011, the results of the first pilot phase (Phase I) of the Claims Verification
8 Program were available. As previously explained, those results showed that provider-
9 reported diagnoses were unsupported for over 50 percent of the medical records
10 reviewed. *See supra* paragraph 206. As another example, in February 2012 prior to his
11 signing the March 2012 Attestation, Theisen (as well as Dumcum and Relator Poehling)
12 had actual knowledge of the strikingly negative results of the Claims Verification Phase
13 II pilot program showing that there were more DELETES than ADDS. *See supra*
14 paragraph 158. In addition, on April 3, 2013, when Theisen executed and submitted the
15 Risk Adjustment Attestations for payment year 2012, the information available to the
16 Defendants MA Organizations, UnitedHealthcare Medicare & Retirement (including
17 Theisen), and Optum included the results of the chart reviews for 2011 dates of service,
18 which showed that they had submitted at least 100,000 diagnoses that were invalid, but
19 had not been deleted (and never were deleted). *See supra* paragraph 235. Yet, Theisen
20 attested that these invalid diagnoses were accurate and truthful.

21 323. On March 25, 2011, Brian Thompson, the Chief Financial Officer of
22 UnitedHealthcare Community & State, executed and submitted or caused to be
23 submitted an “Attestation of Risk Adjustment Data Information Relating to CMS
24 Payment to a Medicare Advantage Organization.” He submitted this Attestation on
25 behalf of “the UnitedHealth Group entities listed in Attachment 1.” This Attestation
26 related to risk adjustment data, that is, diagnoses, that UnitedHealthcare and Optum (or
27 its predecessor, Ingenix) submitted on behalf of certain of the Defendant MA
28 Organizations to Medicare for payment year 2010. The data related to the 2009 date of

1 service year. The Attestation as based on information and facts reasonably available to
2 the MA Organizations, including the negative results of the Chart Review Program based
3 on medical record reviews for date of service year 2009. Information and facts available
4 to the MA Organizations, UnitedHealthcare, and Optum (or its predecessor, Ingenix)
5 included the results of the medical record reviews conducted as part of the Chart Review
6 Program for medical encounters during the 2009 date of service year. However,
7 Thompson and these Defendants deliberately ignored or recklessly disregarded the
8 negative results of these chart reviews. They also ignored or disregarded that the
9 Defendant MA Organizations, UnitedHealthcare, and Optum (or its predecessor,
10 Ingenix) had failed to comply with the requirements that diagnoses must be supported by
11 patients' medical records and that those diagnoses that are not supported by patients'
12 medical records are invalid and must be deleted from RAPS or otherwise reported to
13 CMS and corrected to repay or avoid any overpayments.

14 324. On March 29, 2012, Paul Balthazor, the Chief Financial Officer of
15 UnitedHealthcare Community & State, executed and submitted or caused to be
16 submitted an "Attestation of Risk Adjustment Data Information Relating to CMS
17 Payment to a Medicare Advantage Organization." He submitted this Attestation on
18 behalf of "the UnitedHealth Group entities listed in Attachment 1." This Attestation
19 related to risk adjustment data, that is, diagnoses, that UnitedHealthcare and Optum (or
20 its predecessor, Ingenix) submitted on behalf of certain of the Defendant MA
21 Organizations to Medicare for payment year 2011. The data related to 2010 date of
22 service year. The Attestation was based on information and facts reasonably available to
23 the MA Organizations, UnitedHealthcare, and Optum including the negative results of
24 the medical record reviews conducted as part of the Chart Review Program for the 2010
25 date of service year. However, Balthazor and these Defendants deliberately ignored or
26 recklessly disregarded the negative results of these chart reviews. They also ignored or
27 disregarded that the Defendant MA Organizations, UnitedHealthcare, and Optum had
28 failed to comply with the requirements that diagnoses must be supported by patients'

1 medical records and that those diagnoses that are not supported by patients' medical
2 records are invalid and must be deleted from RAPS or otherwise reported to CMS and
3 corrected to repay or avoid any overpayments. In April 2013, Balthazor also executed
4 the Risk Adjustment Attestation for the MA Organizations managed by
5 UnitedHealthcare Community & State for payment year 2012 (date of service year
6 2011). For this year too, Balthazor and the Defendant MA Organizations,
7 UnitedHealthcare, and Optum ignored the results of the chart reviews and their
8 obligations to delete invalid diagnoses.

9 325. On April 30, 2014, Brian Thompson executed and submitted or caused to be
10 submitted Risk Adjustment Attestations on behalf of all of the Defendant MA
11 Organizations managed by UnitedHealthcare Medicare & Retirement at that time. (On
12 the same date, Paul Balthazor executed and submitted or caused to be submitted Risk
13 Adjustment Attestations on behalf of all Defendant MA Organizations managed by
14 UnitedHealthcare Community & State at the time.) An example of one of Thompson's
15 Attestations includes the Attestation he submitted "[o]n behalf of the UnitedHealth of
16 California." See Exhibit 21, attached hereto. This Attestation related to risk adjustment
17 data, that is, diagnoses, which UnitedHealthcare and Optum submitted on behalf of
18 UnitedHealthcare of California to the Government for risk adjustment payments for
19 payment year 2013. The risk adjustment data, that is, the diagnoses, were related to
20 medical encounters that occurred in date of service year 2012. At the time Thompson
21 signed this Attestation he was the Chief Financial Officer of UnitedHealthcare Medicare
22 & Retirement. The Attestation was based on information available to the MA
23 Organizations. UnitedHealthcare could not add a footnote to the Attestation because it
24 was submitted electronically. However, Steve Nelson, the Chief Executive Officer of
25 UnitedHealthcare Medicare & Retirement, sent CMS an email on April 30, 2014, stating
26 that the Attestation was "based on facts reasonably available or made available to us as
27 of the date of" the Attestation. (Emphasis added). In April 2014, facts reasonably
28 available to all the Defendant MA Organizations, UnitedHealthcare, and Optum included

1 the negative results of the Chart Review and Claims Verification Programs relating to
2 medical encounters in 2012. Other information and facts that were available included,
3 for instance, millions of dollars of invalid diagnoses about which United had *actual*
4 knowledge but never deleted. *See supra* paragraph 232.

5 326. In April 2014, when Thompson signed the Attestation, he deliberately ignored or
6 recklessly disregarded the negative results of the Chart Review Program. Thompson
7 also ignored that Defendants had failed to comply with the requirements that diagnoses
8 must be supported by patients' medical records and that those diagnoses that are not
9 supported by patients' medical records must be deleted from RAPS or otherwise
10 reported to CMS and corrected to repay or avoid any overpayment. At the time that
11 Thompson submitted the Attestation on April 30, 2014, he knew about the actual or
12 estimated adverse financial impact of DELTES from the Chart Review and Claims
13 Verification Programs for payment year 2013 (date of service year 2012) and he knew
14 about CV liability accruals. *See supra* paragraphs 217-221. Furthermore, on April 30,
15 2014, the date the Attestations were submitted for the 2013 payment year, the
16 information available to the Defendant MA Organizations, UnitedHealthcare Medicare
17 & Retirement (including Thompson), and Optum included the results of the chart
18 reviews for the date of service year 2012, which showed that at least 250,000 diagnoses
19 were invalid. *See supra* paragraph 235. Yet, Thompson certified that this invalid data
20 was accurate and truthful even though the invalid diagnoses had not been deleted (and
21 never have been).

22 327. On June 26, 2015 and June 7, 2016, Thompson executed and submitted or caused
23 to be submitted Risk Adjustment Attestations on behalf of all of the Defendant MA
24 Organizations managed by UnitedHealthcare Medicare & Retirement on those dates.
25 (On the same dates, UnitedHealthcare Community & State also submitted Risk
26 Adjustment Attestations for the Defendant MA Organizations that it managed.) These
27 Attestations related to risk adjustment data, that is, diagnoses, which UnitedHealthcare
28 and Optum submitted on behalf of these MA Organizations to the Government for risk

1 adjustment payments for payment years 2014 and 2015. The risk adjustment data, that
2 is, the diagnoses, were related to medical encounters that occurred in date of service
3 years 2013 and 2014. At the time Thompson signed these Attestations he was the Chief
4 Financial Officer of UnitedHealthcare Medicare & Retirement. The Attestations were
5 the same as those for prior years (except that they did not have footnotes.) The
6 Attestations were based on information available to the MA Organizations, including
7 information about diagnoses unsupported and, thus, invalidated by the chart reviews for
8 the dates of service years at issue. On June 26, 2015, the date the Attestations were
9 submitted for the 2014 payment year, the information available to the Defendant MA
10 Organizations, UnitedHealthcare Medicare & Retirement (including Thompson), and
11 Optum were the results of the chart reviews for date of service year 2013, which showed
12 that at least 199, 039 diagnoses were invalid. *See supra* paragraph 235. Yet, Thompson
13 certified that this invalid data was accurate and truthful even though the invalid codes
14 had not been deleted (and never have been).

15 **V. Diagnoses Solely Determine Risk Adjustment Payments Based**
16 **On Health Status**

17 328. The diagnostic data submitted by an MA Organizations are not merely ancillary to
18 its claims for risk adjustment payments. Rather, the diagnoses are the sole determinant
19 in the calculation of any risk adjustment payment based on a beneficiary's health status.
20 The submissions of diagnoses are themselves claims for risk adjustment payments and
21 are inexorably material to any payment based on the beneficiary's health status. The
22 diagnoses are the *raison d'être* of RAPS submissions, *i.e.*, risk adjustment claims.

23 329. As emphasized throughout this Amended Complaint, the Government has never
24 agreed to make risk adjustment payments based on invalid diagnoses, and MA
25 Organizations are required by their contracts with CMS, federal regulations, and CMS
26 instructions (*e.g.*, the Managed Care Manual and Participant Guide) to delete invalid
27 diagnoses. Moreover, no statute or regulation entitles an MA Organization to risk
28 adjustment payments based on invalid diagnoses, including payments based on

1 diagnoses that are unsubstantiated by the beneficiaries' medical records. *See Swoben*,
2 848 F.3d at 1179 (rejecting arguments that MA Organizations are allowed to ignore
3 information about invalid diagnoses based on their own chart reviews and that they are
4 not obligated to delete such invalid diagnoses submitted by them for risk adjustment
5 payments).

6 330. When MA Organizations provide CMS with information identifying specific
7 invalid diagnoses that were submitted for payment (such as by deleting the invalid
8 diagnoses in the RAPS system) and, thus, CMS has *actual knowledge* about the specific
9 invalid diagnoses that were submitted for payment (such as because they were deleted in
10 the RAPS system), Medicare recovers the associated overpayments. *See United States*
11 *ex rel. Campie v. Gilead Sciences, Inc.*, 862 F.3d 890, 906 (9th Cir. 2017) (holding that,
12 in assessing materiality, the court must examine what the agency does when it has *actual*
13 *knowledge* of the regulatory violation). There is no way that CMS can obtain this actual
14 knowledge about invalid diagnoses by looking at an Attestation. The falsity of the
15 Attestation is not apparent on the face of the document. Someone must inform CMS that
16 the MA Organization has information showing that its diagnoses are invalid and that it
17 failed to delete those invalid diagnoses.

18 331. The UHG Managing Defendants and the Defendant MA Organizations knew that
19 they were required to delete invalid diagnoses that they had submitted for payment and,
20 in fact, they did this by making deletes in the RAPS system. For example, as previously
21 explained, based on their short-lived Claims Verification Program, UnitedHealthcare
22 Medicare & Retirement and Optum deleted diagnoses from the RAPS system. They also
23 deleted some invalid diagnoses from the RAPS system based on their RACCR reviews.

24 332. In addition, in the past, when UnitedHealthcare has informed CMS that it is in
25 possession of information about invalid diagnoses that it had submitted and requested
26 some direction with respect to deleting the invalid diagnoses, CMS has worked with it to
27 recover the overpayments. In 2010 and 2011, CMS did this when Joseph Keen, the
28 Chief Compliance Audit Officer at UnitedHealthcare, informed it about risk adjustment

1 data that UnitedHealthcare had submitted that included invalid diagnoses. Importantly,
2 CMS also asked Keen a series of questions to obtain information about the invalid
3 diagnoses, an explanation why the deletes were being made after the final submission
4 deadline for the payment year (because, if made prior to the deadline, CMS would have
5 been able to offset the overpayment as a part of the final reconciliation payment
6 process), and for an explanation of the steps that UnitedHealthcare was taking to ensure
7 that deletes were made in a timely manner. Keen responded that UnitedHealthcare was
8 “continuing to conduct targeted chart validation reviews to determine if the member-
9 diagnoses reviewed are supported by a medical record. These reviews continue and we
10 may need to delete certain risk adjustment data in the future. We will promptly notify
11 CMS of any risk adjustment data determined through these reviews to have been
12 incorrectly submitted.”

13 333. If Defendants had complied with their obligation to delete invalid diagnoses from
14 RAPS, Medicare’s Risk Adjustment System (“RAS”) would have processed the
15 corrected data and recalculated the risk score for the beneficiaries for whom an invalid
16 diagnosis had been deleted. The degree of the change in the payment amount for that
17 beneficiary would have depended on the HCC to which the invalid diagnosis was
18 grouped. The risk adjustment reconciliation payment system would have made these
19 adjustments automatically if the DELETES were made in RAPS. The system would
20 have done this as part of the final reconciliation payment process or future
21 reconciliations conducted by CMS for the payment year at issue.

22 334. If an MA Organization does not comply with its express obligation to delete the
23 invalid diagnoses from RAPS prior to the final submission deadline, Medicare pays for
24 the invalid diagnoses as part of its final reconciliation payment to the MA Organization
25 or, if it already paid for the invalid diagnosis, does not recover the overpayment as part
26 of the final reconciliation payment process. If the MA Organization never deletes the
27 invalid diagnoses from RAPS, Medicare does not recover the overpayment when future
28 payment reconciliations are done for the payment year at issue. Accordingly, the

1 diagnostic information submitted by an MA Organization is not merely ancillary to its
2 claim for risk adjustment payments, it is the sole determinant in the calculation of the
3 amount (if any) of the risk adjustment payments made by Medicare based on the health
4 status of a beneficiary and, therefore, inexorably material to the amount (if any) paid.

5 335. A false Risk Adjustment Attestation, by its very nature, is also material as it
6 relates directly to the data element – diagnoses – that is the sole determinant of risk
7 adjustment payments based on health status. Submission of invalid diagnoses and
8 failing to delete them are not minor or insubstantial infractions of the MA Organization’s
9 obligations to Medicare with which they pledge to comply. Keen, the UnitedHealthcare
10 Chief Compliance Audit Officer, and others at UnitedHealthcare and Optum were aware
11 of these obligations.

12 336. The purpose of the Risk Adjustment Attestation is, first, to remind MA
13 Organizations that they may not ignore or disregard information about invalid diagnoses,
14 such as (but not limited to) the negative results of chart reviews showing that diagnoses
15 previously submitted for payment are unsupported by the charts; and, second, to enforce
16 the fundamental program requirement that MA Organizations delete invalid diagnoses.
17 *See* 65 Fed. Reg. 40,170, 40,268 (June 29, 2000) (noting that “certifications would help
18 ensure accurate data submissions”). When MA Organizations do not comply with these
19 payment data integrity requirements of the MA Program (which are reiterated and
20 enforced by the Attestations), the result is the submission of and/or failure to delete false
21 diagnostic data and, thus, the submission of false Attestations that the data is accurate
22 and truthful. When MA Organizations do this by deliberately ignoring or recklessly
23 disregarding information about invalid diagnoses and, thus fail to delete invalid
24 diagnoses, as Defendants here have done, they are unable to represent that their data is
25 accurate, complete, and truthful, as the Attestations require. Moreover, in that situation,
26 their Attestations are “knowingly” false, as the term knowingly is defined in the FCA.

27 337. The Risk Adjustment Attestation itself includes language warning about the
28 serious legal implications of making false representations about diagnoses. It states that

1 “[t]he MA Organization acknowledges . . . that misrepresentations to CMS about the
2 accuracy of such [risk adjustment] information may result in Federal civil action and/or
3 criminal prosecution.” See Exhibits 15-21. Risk adjustment Attestations thus are
4 intended to serve as a powerful deterrent against an MA Organization’s “knowingly”
5 submitting false claims for payment. *United States ex rel. Swoben v. UnitedHealthcare*
6 *Insurance Co. et al.*, 848 F.3d 1161, 1168 (9th Cir. 2016) (characterizing certifications
7 “[a]s a further bulwark against fraud”).

8 338. Defendants’ knowledge of the importance of the Attestations is demonstrated by
9 the footnotes that UnitedHealthcare and other UHG Managing Defendants added to the
10 Attestations they submitted on behalf of the Defendant MA Organizations, such as the
11 footnotes that stated the Attestations should not be construed as representations that the
12 data may not require subsequent modification should additional information become
13 available. See Exhibits 15-20. According to Dumcum, UnitedHealthcare’s counsel
14 added these footnotes.

15 339. Defendants’ knowledge of the importance of the Attestations is also demonstrated
16 by the meeting they requested with CMS in April 2014. As previously explained, on
17 April 29, 2014, Steve Hemsley, Defendant UHG’s Chief Executive Officer, sent
18 UnitedHealthcare’s attorney Thad Johnson, UnitedHealthcare Medicare & Retirement’s
19 Chief Executive Officer Steve Nelson, UnitedHealthcare’s Chief Financial Officer
20 Daniel Schumacher, and Optum executive Karen Erickson, to meet with CMS
21 employees responsible for the MA Program, including Cheri Rice, the Director of the
22 Medicare Plan Payment Group at CMS. Defendant UHG and its subsidiaries,
23 UnitedHealthcare and Optum, asked for this meeting on very short (just a few days)
24 notice because the Chief Financial Officer of UnitedHealthcare Medicare & Retirement,
25 Brian Thompson, had to execute and submit the Risk Adjustment Attestations for the
26 Defendant MA Organizations on April 30, 2014. Defendants UHG, UnitedHealthcare
27 and Optum wanted to disclose to CMS, before the Attestations were submitted, that they
28 were in possession of information *from chart reviews* (the nature and mechanics of

1 which they did not describe in any detail) about invalid diagnoses (which were not
2 specifically identified to CMS) that they had submitted to the Government but had not
3 deleted. They apparently believed that this sort of very vague disclosure would
4 somehow render the Attestations truthful even if they did not delete the invalid diagnoses
5 from RAPS.

6 340. In addition, for many years, Jeffrey Dumcum, the senior executive overseeing all
7 risk adjustment programs and activities at Ingenix and then Optum, was also aware of
8 the FCA implications of ignoring information about invalid diagnoses. He told Poehling
9 that the Department of Justice's enforcement of the FCA was a consideration in deciding
10 to delete diagnoses when the results of blind chart reviews showed that they were
11 unsupported by the patients' medical records. In fact, Optum even decided that all of its
12 clients (its commercial clients as well as its internal client, UnitedHealthcare) had to look
13 both ways at the results of blind chart reviews and delete diagnosis codes invalidated by
14 the chart reviews if Optum was responsible for submitting risk adjustment data to CMS
15 on their behalf. This requirement was most likely imposed by Optum (at least for some
16 period of time) because Optum had to execute the internal attestations certifying the
17 accuracy and truthfulness of the diagnoses it submitted to Medicare on behalf of its
18 clients and, perhaps, it was also concerned about violating the FCA by causing its MA
19 Organization clients to submit false Attestations. Accordingly, like UHG and
20 UnitedHealthcare, Optum was aware that the Attestations required it to make deletes
21 based on information available to it about the negative results of chart reviews.

22 **FIRST CLAIM FOR RELIEF**

23 **False Claims Act: Reverse False Claims**

24 **31 U.S.C. § 3729(a)(1)(G) (formerly 31 U.S.C. § 3729(a)(7))**

25 341. The United States repeats and re-alleges the allegations contained in Paragraphs 1
26 to 340 above as though they are fully set forth herein.

27 342. Defendants violated the second part of 31 U.S.C. § 3729(a)(1)(G) as follows:
28 Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) concealed

1 or knowingly and improperly avoided or decreased an obligation to pay or transmit
2 money or property to the Government. Specifically, Defendants knowingly concealed or
3 knowingly and improperly avoided or decreased an obligation to repay risk adjustment
4 payments to which they were not entitled from the Medicare Program. In particular,
5 Defendants knowingly and improperly failed to delete in the RAPS system the invalid
6 diagnoses that had been submitted to the Medicare Program for risk adjustment
7 payments which were made by the Medicare Program to them or knowingly and
8 improperly failed to otherwise return to the Medicare Program the overpayments based
9 on the invalid diagnoses.

10 343. By virtue of the said acts of concealment and/or improper avoidance, the United
11 States incurred damages and therefore is entitled to multiple damages under the False
12 Claims Act, plus a civil penalty for each violation of the Act.

13 **SECOND CLAIM FOR RELIEF**

14 **False Claims Act: Presentation of False or Fraudulent Claims**

15 **31 U.S.C. § 3729(a)(1)(A) (formerly 31 U.S.C. § 3729(a)(1))**

16 344. The United States repeats and re-alleges the allegations contained in Paragraphs 1
17 to 340 above as though they are fully set forth herein.

18 345. Defendants violated 31 U.S.C. § 3729(a)(1)(A) as follows: Defendants knowingly
19 (as “knowingly” is defined by 31 U.S.C. § 3729(b)(1)) presented or caused to be
20 presented a false or fraudulent claim for payment or approval. Specifically, Defendants
21 knowingly presented or caused to be presented to the Medicare Program a false or
22 fraudulent Risk Adjustment Attestation claiming risk adjustment payments from the
23 Medicare Program.

24 346. Defendants violated former 31 U.S.C. § 3729(a)(1) as follows: Defendants
25 knowingly presented, or caused to be presented, to the Government a false or fraudulent
26 claim for payment or approval. Specifically, Defendants knowingly presented or caused
27 to be presented to the Medicare Program a false or fraudulent Risk Adjustment
28 Attestation claiming risk adjustment payments from the Medicare Program.

347. By virtue of the said false or fraudulent claim, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

THIRD CLAIM FOR RELIEF

False Claims Act: Making or Using False Records or Statements

31 U.S.C. § 3729(a)(1)(B) (formerly 31 U.S.C. § 3729(a)(2))

348. The United States repeats and re-alleges the allegations contained in Paragraphs 1 to 340 above as though they are fully set forth herein.

349. Defendants violated 31 U.S.C. § 3729(a)(1)(B) as follows: Defendants knowingly (as “knowingly” is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation material to a false or fraudulent claim for risk adjustment payments from the Medicare Program.

350. Defendants violated former 31 U.S.C. § 3729(a)(2) as follows: Defendants knowingly made, used, or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation to get a false or fraudulent claim for risk adjustment payments paid or approved by the Medicare Program.

351. By virtue of the said false record or statement, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

FOURTH CLAIM FOR RELIEF

False Claims Act: Reverse False Claims

31 U.S.C. § 3729(a)(1)(G) (formerly 31 U.S.C. § 3729(a)(7))

352. The United States repeats and re-alleges the allegations contained in Paragraphs 1 to 340 above as though they are fully set forth herein.

353. Defendants violated the first part of 31 U.S.C. § 3729(a)(1)(G) as follows: Defendants knowingly (as “knowingly” is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation material to an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program.

354. Defendants also violated former 31 U.S.C. § 3729(a)(7) as follows: Defendants knowingly (as “knowingly” is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Government. Specifically, Defendants knowingly made, used, or caused to be made or used, a false Risk Adjustment Attestation to conceal, avoid or decrease an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program.

355. By virtue of the said false record, statement, and other acts of concealment and improper avoidance, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

FIFTH CLAIM FOR RELIEF

Unjust Enrichment

356. The United States repeats and re-alleges the allegations contained in Paragraphs 1 to 340 above as though they are fully set forth herein.

357. Defendants have received money from the United States to which Defendants were not entitled, which unjustly enriched Defendants, and for which Defendants must make restitution. Defendants received such money by claiming and retaining Medicare risk adjustment payments based on invalid risk adjustment data. In equity and good conscience, such money belongs to the United States and to the Medicare Program.

1 358. The United States is entitled to recover such money from Defendants in an amount
2 to be determined at trial.

3 **SIXTH CLAIM FOR RELIEF**

4 **Payment by Mistake**

5 359. The United States repeats and re-alleges the allegations contained in Paragraphs 1
6 to 340 above as though they are fully set forth herein.

7 360. The United States paid money to Defendants as a result of a mistaken
8 understanding. Specifically, the United States paid Defendants claims for risk
9 adjustment payments under the mistaken understanding that such claims were based on
10 valid risk adjustment data. Had the United States known the truth, it would not have
11 paid such claims. Payment was therefore by mistake.

12 361. As a result of such mistaken payments, the United States has sustained damages
13 for which Defendants are liable in the amount to be determined at trial.

14 **PRAYER**

15 **WHEREFORE**, the United States requests that judgment be entered in its favor
16 and against Defendants as follows:

17 362. On Claims I, II, III, and IV (False Claims Act), against all Defendants jointly and
18 severally, for the amount of the United States' damages, trebled as required by law,
19 together with the maximum civil penalties allowed by law, costs, post-judgment interest,
20 and such other and further relief as the Court may deem appropriate;

21 363. On Claim V (Unjust Enrichment), against all Defendants jointly and severally, for
22 an amount equal to the monies that Defendants obtained from the United States without
23 right and by which Defendants have been unjustly enriched, plus costs, pre- and post-
24 judgment interest, and such other and further relief as the Court may deem appropriate;
25 and

26 364. On Claim VI (Payment By Mistake), against Defendants for an amount equal to
27 the United States' damages, plus costs, pre- and post-judgment interest, and such other
28 and further relief as the Court may deem appropriate.

DEMAND FOR JURY TRIAL

The United States of America hereby demands a trial by jury.

Dated: November 17, 2017

Respectfully submitted,

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EXHIBIT 1

Contract with Eligible Medicare Advantage (MA) Organization Pursuant to
Sections 1851 through 1859 of the Social Security Act for the Operation
of a Medicare Advantage Coordinated Care Plan(s)

CONTRACT (# H0251)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR 422.503, agree to the following for the purposes of sections 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

You must check off AND initial each required Addendum type to reflect the coverage offered under the H (or R) number associated with this contract

<u>Addendum Type</u>	<u>Initials</u>
☒ Part D Addendum	_____
_____ EGWP ("800 Series") MA-PD Addendum	_____
_____ EGWP ("800 Series") MA-Only Addendum	_____
_____ Variances/Waivers (Provided directly to Demonstration Organizations by CMS)	_____
_____ Regional Preferred Provider Organization Addendum (Provided directly to RPPOs by CMS)	_____

Final: August 21, 2009

Article I

Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2010, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR 422.505(c) and as discussed in Paragraph A in Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D also must execute an Addendum to the Medicare Managed Care Contract Pursuant to Sections 1860D-1 through 1860D-42 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II

Coordinated Care Plan

A. The Medicare Advantage Organization agrees to operate one or more coordinated care plans as defined in 42 CFR 422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

E. The MA organization must comply with all applicable requirements as described in CMS regulations and guidance implementing the Medicare Improvements for Patients and Providers Act of 2008.

Article III

Final: August 21, 2009

Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under §422.101 and, to the extent applicable, supplemental benefits under §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a skilled nursing home facility according to the requirements of section 1852(l) of the Act and §422.133. A skilled nursing home facility is a facility in which an MA enrollee resided at the time of admission to the hospital, a facility that provides services through a continuing care retirement community, a facility in which the spouse of the enrollee is residing at the time of the enrollee's discharge from the hospital, or hospital, or wherever the enrollee resides immediately before admission for extended care services.

[422.133; 422.504(a)(3)]

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of part 422.

2. The MA Organization shall comply with the provisions of §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with §§422.2, 422.4(a)(1)(iv) and 422.52.

[422.504(a)(2)]

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in subpart M of part 422, governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must--

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

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(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this section (C), other than the provider contract requirements specified in paragraph (C)(3)(a) of this Article, the MA Organization may use--

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this section, CMS may provide--

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with Section 1852(e) of the Social Security Act and 42 CFR 422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees' participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan's MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review

The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and §422.118, the anti-discrimination requirements of §1852(b) of the Act and §422.110, the access to services requirements of §1852(d) of the Act and §422.112, and the advance directives requirements of §1852(i) of the Act and §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart F, and the applicable requirements described in §423.165, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.
2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR 422.80(b) and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed

with and not disapproved by CMS in accordance with §422.80. The file and use process set out at §422.80(a)(2) must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR 422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation Section 1851(h) of the Act and 42 CFR §§422.80, 422.111 and 423.50. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV

CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. Methodology. CMS agrees to pay the MA Organization under this contract in accordance with the provisions of section 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. Attestation of payment data (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization

shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis. (NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions are made available.)

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must *attest to (based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also attest to (based on best knowledge, information, and belief, as of the date specified on the attestation form) the accuracy, completeness, and truthfulness of the data. **[422.504(l)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(l)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that--

(1) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

(2) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final

date of the contract period or from the date of completion of any audit, whichever is later.
[422.504(i)(2)]

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

- (1) Enrollee protection provisions that provide--
 - (a) Consistent with Article III(C), arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and
 - (b) Consistent with Article III(C), provision for the continuation of benefits.
- (2) Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this article.
- (3) A provision requiring that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a contract or written agreement between the related entity, contractor, or subcontractor and the MA Organization will be consistent and comply with the MA Organization's contractual obligations to CMS.

[422.504(i)(3)]

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

- (1) Written arrangements must specify delegated activities and reporting responsibilities.
- (2) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.
- (3) Written arrangements must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.
- (4) Written arrangements must specify that either--
 - (a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or
 - (b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.
- (5) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions.

[422.504(i)(4)]

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's written arrangements with that organization must state that the MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

- (1) Agrees that any physician incentive plan it operates meets the requirements of §422.208, and
- (2) Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with §422.208(f). **[422.208]**

Article VI

Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that--

- (a) Are sufficient to do the following:
 - (i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.
 - (ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.
 - (iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.
 - (iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.
 - (v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.
 - (vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and
 - (b) Include at least records of the following:
 - (i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.
 - (ii) Financial statements for the current contract period and six prior periods.
 - (iii) Federal income tax or informational returns for the current contract period and six prior periods.
 - (iv) Asset acquisition, lease, sale, or other action.
 - (v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.
 - (vi) Franchise, marketing, and management agreements.
 - (vii) Schedules of charges for the MA Organization's fee-for-service patients.
 - (viii) Matters pertaining to costs of operations.
 - (ix) Amounts of income received, by source and payment.
 - (x) Cash flow statements.
 - (xi) Any financial reports filed with other Federal programs or State authorities.
- [422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means--

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in section (A) of this article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless--

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information as described in the remainder of this section (B). **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in paragraph (2)(a)(v) of

this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty-five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty-five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by paragraph (2)(a)(iv) must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in paragraph (2)(a)(v) with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities.

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)(1)(ii)]**

(c) Patterns of utilization of the MA Organization's services.

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including --

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

- (vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;
 - (e) Information about beneficiary appeals and their disposition;
 - (f) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;
 - (g) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**
4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under §422.64 and, upon an enrollee's request, the financial disclosure information required under §422.516. **[422.504(f)(3)]**
5. Reporting and disclosure under ERISA.
- (a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).
 - (b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**
6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**
7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

Article VII

Renewal of the MA Contract

- A. Renewal of contract: In accordance with §422.505, following the initial contract period, this contract is renewable annually only if-
- (1) The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**
 - (2) CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**
 - (3) CMS informs the MA Organization that it authorizes a renewal.
- B. Nonrenewal of contract
- (1) Nonrenewal by the Organization.
 - (a) In accordance with §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in subparagraphs (b) and (c) of this paragraph.
 - (b) If the MA Organization does not intend to renew its contract, it must notify--
 - (i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to §422.506

(ii) Each Medicare enrollee, at least 90 days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(iii) The general public, at least 90 days before the end of the current calendar year, by publishing a CMS-approved notice in one or more newspapers of general circulation in each community located in the MA Organization's service area.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if --

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) and (1)(b)(iii) of this section; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under subparagraph (1), CMS will not enter into a contract with the Organization for 2 years from the date of contract separation unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

(2) CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) The MA Organization's level of enrollment, growth in enrollment, or insufficient number of contracted providers is determined by CMS to threaten the viability of the organization under the MA program and or be an indicator of beneficiary dissatisfaction with the MA plan(s) offered by the organization.

(ii) For any of the reasons listed in §422.510(a) [Article VIII, section (B)(1)(a) of this contract], which would also permit CMS to terminate the contract.

(iii) The MA Organization has committed any of the acts in §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iv) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by May 1 of the contract year, except in the event of (2)(a)(iv) above, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(iii) To the general public at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with § 422.644. **[422.506(b)]**

Article VIII

Modification or Termination of the Contract

A. Modification or Termination of Contract by Mutual Consent

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in section (A)(2) of this Article, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in section B(2)(b)(ii) and B(2)(b)(iii) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in section B of this article.

[422.508(b)]

B. Termination of the Contract by CMS or the MA Organization

1. Termination by CMS.

(a) CMS may terminate a contract for any of the following reasons:

(i) The MA Organization has failed substantially to carry out the terms of its contract with CMS.

(ii) The MA Organization is carrying out its contract with CMS in a manner that is inconsistent with the effective and efficient implementation of 42 CFR Part 422.

(iii) CMS determines that the MA Organization no longer meets the requirements of 42 CFR Part 422 for being a contracting organization.

(iv) There is credible evidence that the MA Organization committed or participated in false, fraudulent or abusive activities affecting the Medicare program, including submission of false or fraudulent data.

(v) The MA Organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) The MA Organization substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) The MA Organization fails to provide CMS with valid risk adjustment data as required under §422.310 and 423.329(b)(3).

(viii) The MA Organization fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) The MA Organization substantially fails to comply with the prompt payment requirements in §422.520.

(x) The MA Organization substantially fails to comply with the service access requirements in §422.112.

(xi) The MA Organization fails to comply with the requirements of §422.208 regarding physician incentive plans.

(xii) The MA Organization substantially fails to comply with the marketing requirements in 422.80.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in section (B)(1)(a) above, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Immediate termination of contract by CMS.

(i) For terminations based on violations prescribed in paragraph (B)(1)(a)(v) of this article, CMS will notify the MA Organization in writing that its contract has been terminated effective the date of the termination decision by CMS. If termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before terminating a contract for reasons other than the grounds specified in section (B)(1)(a)(v) of this article, CMS will provide the MA Organization with reasonable opportunity, not to exceed time frames specified at 42 CFR Part 422 Subpart N, to develop and receive CMS approval of a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exception. If a contract is terminated under section (B)(1)(a)(v) of this article, the MA Organization will not have the opportunity to submit a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX

Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with--

(1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC 3729 et seq.), and the anti-kickback statute (section 1128B(b) of the Act); and

(2) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. **[422.504(h)]**

B. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

C. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X

Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI

Miscellaneous

A. Definitions. Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. Alteration to Original Contract Terms. The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. Approval to Begin Marketing and Enrollment. The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. Incorporation of Applicable Addenda. All addenda checked off and initialed on the cover sheet of this contract by the MA Organization are hereby incorporated by reference.

In witness whereof, the parties hereby execute this contract.

FOR THE MA ORGANIZATION

Printed Name

Title

Signature

Date

Organization

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

Teresa DeCaro, R.N., MS
Acting Director
Medicare Drug and Health Plan Contract
Administration Group
Center for Drug and Health Plan Choice

Date

ATTACHMENT A

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (H0251), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

(INDICATE TITLE [CEO, CFO, or delegate])

on behalf of

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.
(INDICATE MA ORGANIZATION)

DATE

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ATTACHMENT B

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (H0251), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

(INDICATE TITLE [CEO, CFO, or delegate])

on behalf of

UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

(INDICATE MA ORGANIZATION)

DATE

**[SAMPLE - DO NOT USE - THIS DOCUMENT WILL BE SENT DIRECTLY TO THE MAO THROUGH HPMS]
ATTACHMENT C – Medicare Advantage Plan Attestation of Benefit Plan and Price**

<Legal Entity Name>
<Contract # >

Date: <XX/XX/XXXX>

I attest that the following plan numbers as established in the final Plan Benefit Package (PBP) will be operated by the above-stated organization and made available to eligible Medicare beneficiaries in the approved service area during program year 2010

Plan ID	Segment ID	Version	Plan Name	Plan Type	Transaction Type	MA Premium	Part D Premium	CMS Approval Date	Effective Date
<xxx>	<x>	<x>	<Plan Name>	<Plan Type>	<Transaction Type>	\$<Plan Premium>	\$<Part D Premium>	<xx/xx/xx>	<xx/xx/xx>
<xxx>	<x>	<x>	<Plan Name>	<Plan Type>	<Transaction Type>	\$<Plan Premium>	\$<Part D Premium>	<xx/xx/xx>	<xx/xx/xx>
<xxx>	<x>	<x>	<Plan Name>	<Plan Type>	<Transaction Type>	\$<Plan Premium>	\$<Part D Premium>	<xx/xx/xx>	<xx/xx/xx>

CEO

CFO

CEO	Date	CFO	Date
<Name of CEO>		<Name of CFO>	
<Title>		<Title>	
<Address 1>		<Address 1>	
<Address 2>		<Address 2>	
<City, State Zip>		<City, State Zip>	
<Phone #>		<Phone #>	

EXHIBIT 2

**CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)**

CONTRACT (H0543)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

UNITEDHEALTHCARE OF CALIFORNIA
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR 422.503, agree to the following for the purposes of sections 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS authorized representative through December 31, 2011, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR 422.505(c) and as discussed in Paragraph A in Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D also must execute an Addendum to the Medicare Managed Care Contract Pursuant to Sections 1860D-1 through 1860D-42 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The Medicare Advantage Organization agrees to operate one or more coordinated care plans as defined in 42 CFR 422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

E. The MA organization must comply with all applicable requirements as described in CMS regulations and guidance implementing the Medicare Improvements for Patients and Providers Act of 2008.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under §422.101 and, to the extent applicable, supplemental benefits under §422.102 and as established in the MA Organizations final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a skilled nursing home facility according to the requirements of section 1852(l) of the Act and §422.133. A skilled nursing home facility is a facility in which an MA enrollee resided at the time of admission to the hospital, a facility that provides services through a continuing care retirement community, a facility in which the spouse of the enrollee is residing at the time of the enrollees discharge from the hospital, or hospital, or wherever the enrollee resides immediately before admission for extended care services. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of part 422.

2. The MA Organization shall comply with the provisions of §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in subpart M of part 422, governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must--

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organizations insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this section (C), other than the provider contract requirements specified in paragraph (C)(3)(a) of this Article, the MA Organization may use--

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this section, CMS may provide-

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with Section 1852(e) of the Social Security Act and 42 CFR 422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plans MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review

The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organizations medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

A. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and §422.118, the anti-discrimination requirements of §1852(b) of the Act and §422.110, the access to services requirements of §1852(d) of the Act and §422.112, and the advance directives requirements of §1852(i) of the Act and §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in §423.165, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

B. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organizations firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

C. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR 422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with §422.80. The file and use process set out at §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR 422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation Section 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. Methodology. CMS agrees to pay the MA Organization under this contract in accordance with the provisions of section 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. The MA Organization agrees to abide by the requirements in 42 CFR 495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment may be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. Attestation of payment data (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis. (NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions are made available.)

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also attest to *(based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(I)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(I)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that

1. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

2. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide

(a) Consistent with Article III(C), arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III(C), provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this article.

3. A provision requiring that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a contract or written agreement between the related entity, contractor, or subcontractor and the MA Organization will be consistent and comply with the MA Organization's contractual obligations to CMS. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

1. Written arrangements must specify delegated activities and reporting responsibilities.

2. Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Written arrangements must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Written arrangements must specify that either-

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's written arrangements with that organization must state that the MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of §422.208, and

2. Has assured that all physicians and physician groups that the MA Organizations physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with §422.208(f). **[422.208]**

Article VI Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

- (i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.
- (ii) Financial statements for the current contract period and six prior periods.
- (iii) Federal income tax or informational returns for the current contract period and six prior periods.
- (iv) Asset acquisition, lease, sale, or other action.
- (v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.
- (vi) Franchise, marketing, and management agreements.
- (vii) Schedules of charges for the MA Organization's fee-for-service patients.
- (viii) Matters pertaining to costs of operations.
- (ix) Amounts of income received, by source and payment.
- (x) Cash flow statements.
- (xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means--

- (i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;
- (ii) The facilities of the MA Organization; and
- (iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in section (A) of this article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless--

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this section (B). **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in paragraph (2)(a)(v) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) thirty-five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) thirty-five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by paragraph (2)(a)(iv) must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in paragraph (2)(a)(v) with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

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3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

- (i) The benefits covered under the MA plan;
- (ii) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.
- (iii) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;
- (iv) Plan quality and performance indicators for the benefits under the plan including --
 - (i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;
 - (ii) Information on Medicare enrollee satisfaction;
 - (iii) The patterns of utilization of plan services;
 - (iv) The availability, accessibility, and acceptability of the plan's services;
 - (v) Information on health outcomes and other performance measures required by CMS;
 - (vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and
 - (vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;
- (v) Information about beneficiary appeals and their disposition;
- (vi) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;
- (vii) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under §422.64 and, upon an enrollee's, request, the financial disclosure information required under §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA.

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

Article VII
Renewal of the MA Contract

A. Renewal of contract: In accordance with §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

3. CMS informs the MA Organization that it authorizes a renewal.

B. Nonrenewal of contract

1. Nonrenewal by the Organization.

(a) In accordance with §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in subparagraphs (b) and (c) of this paragraph.

(b) If the MA Organization does not intend to renew its contract, it must notify--

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to §422.506

(ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this section; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under subparagraph (1), CMS will not enter into a contract with the Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

2. CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) For any of the reasons listed in §422.510(a) [Article VIII, section (B)(1)(a) of this contract], which would also permit CMS to terminate the contract.

(ii) The MA Organization has committed any of the acts in §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by August 1 of the contract year, except in the event of (2)(a)(iv) above, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with § 422.644. **[422.506(b)]**

Article VIII

Modification or Termination of the Contract

A. Modification or Termination of Contract by Mutual Consent

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in section (A)(2) of this Article, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in section B(2)(b)(ii) and B(2)(b)(iii) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in section B of this article. **[422.508(b)]**

B. Termination of the Contract by CMS or the MA Organization

1. Termination by CMS.

(a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(i) has failed substantially to carry out the terms of its contract with CMS.

(ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(iv) based on credible evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(v) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) fails to provide CMS with valid risk adjustment data as required under §422.310 and 423.329(b)(3).

(viii) fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(x) substantially fails to comply with the service access requirements in §422.112.

(xi) fails to comply with the requirements of §422.208 regarding physician incentive plans.

(xii) substantially fails to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in section (B)(1)(a) above, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Expedited termination of contract by CMS.

(i) For terminations based on violations prescribed in paragraph (B)(1)(a)(iv) or (B)(1)(a)(v) of this article, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in section (B)(1)(a)(iv) or (B)(1)(a)(v) of this article, CMS will provide the MA Organization with notice specifying the MA Organizations deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under section (B)(1)(a)(iv) or (B)(1)(a)(v) of this article, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination. #2307

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with--

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC 3729 et seq.) , and the anti-kickback statute (section 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. **[422.504(h)]**

B. Pursuant to section 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under section 3004 of the Public Health Service Act, as amended by section 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI Miscellaneous

A. Definitions. Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

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B. Alteration to Original Contract Terms. The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. Approval to Begin Marketing and Enrollment. The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organizations Sponsors behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.
#2312

This document has been electronically signed by:

FOR THE MA ORGANIZATION

THOMAS PAUL

Contracting Official Name

9/7/2010 2:24:51 PM

Date

UNITEDHEALTHCARE OF CALIFORNIA

5995 PLAZA DRIVE
CYPRESS, CA 90630

Organization

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES



10/4/2010 3:03:20 PM

Danielle R. Moon, J.D., M.P.A
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

Date

EXHIBIT 3

**CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)**

CONTRACT (H0543)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

UNITEDHEALTHCARE OF CALIFORNIA
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

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Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS authorized representative through December 31, 2012, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2011 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2011 contract, the parties execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2011 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

F. The MA organization must comply with all applicable requirements as described in CMS regulations and guidance implementing the Medicare Improvements for Patients and Providers Act of 2008.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organizations final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

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2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422.133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, and process both voluntary and involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR O Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must--

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits--

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organizations insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA Organization may use--

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plans MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

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(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organizations medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization as required in 42 CFR §422.504(a)(15) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plans main Web page.

F. EFFECTIVE COMPLIANCE PROGRAM

The MA Organization agrees to implement an effective compliance program in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organizations firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY.

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A and B).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also attest to *(based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(I)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(I)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that--

1. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

2. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide--

(a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a contract or written agreement between the related entity, contractor, or subcontractor and the MA Organization will be consistent and comply with the MA Organization's contractual obligations to CMS. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

1. Written arrangements must specify delegated activities and reporting responsibilities.

2. Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Written arrangements must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Written arrangements must specify that either-

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's written arrangements with that organization must state that the MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organizations physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and ten prior periods.

(iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means--

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(W) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(i) The benefits covered under the MA plan;

(ii) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(iii) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(iv) Plan quality and performance indicators for the benefits under the plan including --

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(viii) Information about beneficiary appeals and their disposition;

(ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's, request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA --

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part C and Part D Payments for the contract year as provided in 42 CFR §422.504(n) and, for Part D plan sponsors, 42 CFR §423.505(o).

Article VII Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**
2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**
3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. Nonrenewal by the Organization.

(a) In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

(b) If the MA Organization does not intend to renew its contract, it must notify--

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this paragraph; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under this subparagraph, CMS will not enter into a contract with the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(5), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

2. CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) For any of the reasons listed in 42 CFR §422.510(a) § which would also permit CMS to terminate the contract.

(ii) The MA Organization has committed any of the acts in 42 CFR §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by August 1 of the contract year, except in the event described in subparagraph (2)(a)(iii) of this paragraph, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with 42 CFR §422.644. **[422.506(b)]**

Article VIII Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article. **[422.508(b)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(i) has failed substantially to carry out the terms of its contract with CMS.

(ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(iv) based on credible evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(v) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) fails to provide CMS with valid risk adjustment data as required under 42 CFR §§422.310 and 423.329(b)(3).

(viii) fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) substantially fails to comply with the prompt payment requirements in 42 CFR §422.520.

(x) substantially fails to comply with the service access requirements in 42 CFR §422.112.

(xi) fails to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(xii) substantially fails to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in subparagraph 1 (a) of this paragraph, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Expedited termination of contract by CMS.

(i) For terminations based on violations prescribed in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organizations deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under subparagraph 1(a)(iv) or (v) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N.

[422.510(d)]

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with--

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. APPROVAL TO BEGIN MARKETING AND ENROLLMENT

The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organizations Sponsors behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.
#2333

This document has been electronically signed by:

FOR THE MA ORGANIZATION

SCOTT THEISEN

Contracting Official Name

9/2/2011 10:21:45 AM

Date

UNITEDHEALTHCARE OF CALIFORNIA

5995 PLAZA DRIVE
CYPRESS, CA 90630

Organization

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES



9/16/2011 2:35:02 PM

Danielle R. Moon, J.D., M.P.A
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

Date

EXHIBIT 4

**CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)**

CONTRACT (H0543)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

UHC OF CALIFORNIA, INC.
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

#2336

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2013, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2012 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2012 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2012 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

F. The MA organization must comply with all applicable requirements as described in CMS regulations and guidance implementing the Medicare Improvements for Patients and Providers Act of 2008.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

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2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR O Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA Organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees' participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan's MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

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(b) For MA regional preferred provider organizations (RPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization as required in 42 CFR §422.504(a)(15) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also attest to *(based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(I)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(I)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

1. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

2. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide—

(a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract will be consistent and comply with the MA Organization's contractual obligations. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any first tier, downstream, or related entity:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal. #2343

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and ten prior periods.

(iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless—

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including —

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(viii) Information about beneficiary appeals and their disposition;

(ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part C and Part D Payments for the contract year as provided in 42 CFR §422.504(n) and, for Part D plan sponsors, 42 CFR §423.505(o).

Article VII Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. Nonrenewal by the Organization.

(a) In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this paragraph; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under this subparagraph, CMS will not enter into a contract with the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(5), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

2. CMS decision not to renew.

(i) For any of the reasons listed in 42 CFR §422.510(a) which would also permit CMS to terminate the contract.

(ii) The MA Organization has committed any of the acts in 42 CFR §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by August 1 of the contract year, except in the event described in subparagraph (2)(a)(iii) of this paragraph, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with 42 CFR §422.644. **[422.506(b)]**

Article VIII Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article. **[422.508(b)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(i) has failed substantially to carry out the terms of its contract with CMS.

(ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(iv) based on credible evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(v) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) fails to provide CMS with valid risk adjustment data as required under 42 CFR §§422.310 and 423.329(b)(3).

(viii) fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) substantially fails to comply with the prompt payment requirements in 42 CFR §422.520.

(x) substantially fails to comply with the service access requirements in 42 CFR §422.112.

(xi) fails to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(xii) substantially fails to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in subparagraph 1 (a) of this paragraph, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Expedited termination of contract by CMS.

(i) For terminations based on violations prescribed in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under subparagraph 1(a)(iv) or (v) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan. #2349

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

Article X Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. APPROVAL TO BEGIN MARKETING AND ENROLLMENT

The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

E. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(17).

F. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars as required by 42 CFR §422.504(a)(18).

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.
#2354

This document has been electronically signed by:

FOR THE MA ORGANIZATION

SCOTT THEISEN

Contracting Official Name

8/29/2012 5:02:01 PM

Date

UHC OF CALIFORNIA, INC.

5995 PLAZA DRIVE
CYPRESS, CA 90630

Organization

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES



9/14/2012 12:31:10 PM

Danielle R. Moon, J.D., M.P.A
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

Date

EXHIBIT 5

**CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)**

CONTRACT (H0543)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

UHC OF CALIFORNIA, INC.
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

#2357

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2014, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2013 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2013 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2013 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR O Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits—

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA Organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees' participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan's MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems.

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization as required in 42 CFR §422.504(a)(15) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also attest to *(based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(I)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(I)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

1. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

2. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide—

(a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any first tier, downstream, or related entity:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

- (i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.
- (ii) Financial statements for the current contract period and ten prior periods.
- (iii) Federal income tax or informational returns for the current contract period and ten prior periods.
- (iv) Asset acquisition, lease, sale, or other action.
- (v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.
- (vi) Franchise, marketing, and management agreements.
- (vii) Schedules of charges for the MA Organization's fee-for-service patients.
- (viii) Matters pertaining to costs of operations.
- (ix) Amounts of income received, by source and payment.
- (x) Cash flow statements.
- (xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

- (i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;
- (ii) The facilities of the MA Organization; and
- (iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless—

- (i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;
- (ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

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3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including —

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(viii) Information about beneficiary appeals and their disposition;

(ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's, request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

Article VII Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**
2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**
3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. Nonrenewal by the Organization.

(a) In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this paragraph; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under this subparagraph, CMS will not enter into a contract with the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(5), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

2. CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) For any of the reasons listed in 42 CFR §422.510(a) which would also permit CMS to terminate the contract.

(ii) The MA Organization has committed any of the acts in 42 CFR §422.952(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O. #2868

(iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by August 1 of the contract year, except in the event described in subparagraph (2)(a)(iii) of this paragraph, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with 42 CFR §422.644. **[422.506(b)]**

Article VIII

Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article. **[422.508(b)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(i) has failed substantially to carry out the terms of its contract with CMS.

(ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(iv) based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(v) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) fails to provide CMS with valid risk adjustment data as required under 42 CFR §§422.310 and 423.329(b)(3).

(viii) fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) substantially fails to comply with the prompt payment requirements in 42 CFR §422.520.

(x) substantially fails to comply with the service access requirements in 42 CFR §422.112.

(xi) fails to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(xii) substantially fails to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in subparagraph 1 (a) of this paragraph, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Expedited termination of contract by CMS.

(i) For terminations based on violations prescribed in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under subparagraph 1(a)(iv) or (v) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. [422.512]

Article IX Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. [422.504(h)]

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. [422.504(i)]

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Severability

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The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. APPROVAL TO BEGIN MARKETING AND ENROLLMENT

The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

E. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(17).

F. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars as required by 42 CFR §422.504(a)(18).

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price #2374

In witness whereof, the parties hereby execute this contract.
#2373

This document has been electronically signed by:

FOR THE MA ORGANIZATION

SCOTT THEISEN

Contracting Official Name

8/29/2013 8:51:35 PM

Date

UHC OF CALIFORNIA, INC.

5995 PLAZA DRIVE
CYPRESS, CA 90630

Organization

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES



9/26/2013 11:18:12 AM

Danielle R. Moon, J.D., M.P.A
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

Date

EXHIBIT 6

**CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)**

CONTRACT (H0543)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

UHC OF CALIFORNIA
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

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Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2015, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2014 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2014 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2014 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR O Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA Organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to CMS;

(iii) Financial reserves acceptable to CMS; or

(iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. Chronic Care Improvement Program

(a) Each MA organization must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees' participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan's MA population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems.

(a) The MA Organization must:

(i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization as required in 42 CFR §422.504(a)(15) by:

(a) Addressing and resolving complaints in the CMS complaint tracking system; and

(b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also attest to *(based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(I)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(I)]**

4. The MA Organization must certify based on best knowledge, information, and belief, that the information provided for the purposes of reporting and returning of overpayments under 42 CFR §422.326 is accurate, complete, and truthful. The form for this certification will be determined by CMS. **[422.504(I)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and related entities related to CMS contract with the MA organization;

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph B (1) of this Article directly from any first tier, downstream, to related entity;

3. For records subject to review under paragraph B(2) of this Article, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated; and

4. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide—

(a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this Article. **[422.504(i)(3)]**

3. A provision requiring that any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any first tier, downstream, or related entity:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and ten prior periods.

(iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

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(c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including —

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(viii) Information about beneficiary appeals and their disposition;

(ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

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(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part C and Part D Payments for the contract year as provided in 42 CFR §422.504(n) and, for Part D plan sponsors, 42 CFR §423.505(o).

Article VII Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**

2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**

3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. Nonrenewal by the Organization.

(a) In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

(i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this paragraph; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the MA Organization does not renew a contract under this subparagraph, CMS will not enter into a contract with the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(5), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**

2. CMS decision not to renew.

(a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(i) For any of the reasons listed in 42 CFR §422.510(a) which would also permit CMS to terminate the contract.

(ii) The MA Organization has committed any of the acts in 42 CFR §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the MA Organization by August 1 of the contract year, except in the event described in subparagraph (2)(a)(iii) of this paragraph, for which notice will be sent by September 1.

(ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with 42 CFR §422.644. **[422.506(b)]**

Article VIII

Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article. **[422.508(b)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(i) has failed substantially to carry out the terms of its contract with CMS.

(ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(iv) based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(v) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) fails to provide CMS with valid risk adjustment data as required under 42 CFR §§422.310 and 423.329(b)(3).

(viii) fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) substantially fails to comply with the prompt payment requirements in 42 CFR §422.520.

(x) substantially fails to comply with the service access requirements in 42 CFR §422.112.

(xi) fails to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(xii) substantially fails to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(b) CMS may make a determination under paragraph B(1)(a)(i), (ii), or (iii) of this Article if the MA Organization has had one or more of the following occur:

(i) based on creditable evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(ii) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(iii) substantially failed to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(iv) failed to provide CMS with valid data as required under 42 CFR §§422.310.

(v) failed to implement an acceptable quality assessment and performance improvement program as required under 42 CFR Part 422 Subpart D.

(vi) substantially failed to comply with the prompt payment requirements in 42 CFR §422.520.

(vii) substantially failed to comply with the service access requirements in 42 CFR §422.112.

(viii) failed to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(ix) substantially failed to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(x) Failed to comply with regulatory requirements contained in 42 CFR Parts 422 or 423 or both.

(xi) Failed to meet CMS performance requirements in carrying out the regulatory requirements contained in 42 CFR Parts 422 or 423 or both.

(xii) Achieves a Part C summary plan rating of less than 3 stars for 3 consecutive contract years.

(xiii) Has failed to report MLR data in a timely and accurate manner in accordance with 42 CFR §422.2460.

(c) Notice. If CMS decides to terminate a contract, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organizations Web site.

(d) Expedited termination of contract by CMS.

(i) For terminations based on violations prescribed in subparagraph 1(b)(i) or (b)(ii) of this paragraph or if CMS determines that a delay in termination would pose an imminent and serious threat to the health of the individuals enrolled with the MA Organization, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exceptions. If a contract is terminated under subparagraph 1(a)(iv) or (v) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI Miscellaneous

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. APPROVAL TO BEGIN MARKETING AND ENROLLMENT

The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

E. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(17).

F. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars as required by 42 CFR §422.504(a)(18).

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.
#2397

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN THOMPSON

Contracting Official Name

8/28/2014 10:38:59 AM

Date

UHC OF CALIFORNIA

5995 PLAZA DRIVE
CYPRESS, CA 90630

Organization

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES



9/11/2014 1:10:21 PM

Kathryn A. Coleman
Acting Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

Date

EXHIBIT 7

**CONTRACT WITH ELIGIBLE MEDICARE ADVANTAGE (MA) ORGANIZATION
PURSUANT TO SECTIONS 1851 THROUGH 1859 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A MEDICARE ADVANTAGE COORDINATED CARE PLAN(S)**

CONTRACT (H0543)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

UHC OF CALIFORNIA
(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR §422.503, agree to the following for the purposes of §§ 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

Article I
Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2016, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR §422.505(c) and as discussed in Paragraph A of Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D benefits also must execute an Addendum to the Medicare Managed Care Contract Pursuant to §§ 1860D-1 through 1860D-43 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II
Coordinated Care Plan

A. The MA Organization agrees to operate one or more coordinated care plans as defined in 42 CFR §422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.).

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

D. If the MA Organization had a contract with CMS for Contract Year 2015 under the contract ID number designated above, this document is considered a renewal of the existing contract. While the terms of this document supersede the terms of the 2015 contract, the parties' execution of this contract does not extinguish or interrupt any pending obligations or actions that may have arisen under the 2015 or prior year contracts.

E. This contract is in no way intended to supersede or modify 42 CFR, Part 422. Failure to reference a regulatory requirement in this contract does not affect the applicability of such requirements to the MA organization and CMS.

Article III
Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under 42 CFR §422.101 and, to the extent applicable, supplemental benefits under 42 CFR §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in 42 CFR §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a home skilled nursing facility, as defined at 42 CFR §422.133(b), according to the requirements of § 1852(l) of the Act and 42 CFR §422.133. **[422. 133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in 42 CFR Part 422, Subpart B.

2. The MA Organization shall comply with the provisions of 42 CFR §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with 42 CFR §§422.2, 422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in 42 CFR O Part 422, Subpart M governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in 42 CFR §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(3.a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(3.a.i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(3.a.ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(3.b) The MA Organization must provide for continuation of enrollee health care benefits-

(3.b.i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(3.b.ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(3.c) In meeting the requirements of this paragraph, other than the provider contract requirements specified in subparagraph 3(a) of this paragraph, the MA Organization may use—

(3.c.i) Contractual arrangements;

(3.c.ii) Insurance acceptable to CMS;

(3.c.iii) Financial reserves acceptable to CMS; or

(3.c.iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(2.a) The MA Organization must pay 95 percent of "clean claims" within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with §§ 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(2.b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(2.c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this paragraph, CMS may provide-

(2.c.i) For direct payment of the sums owed to providers; and

(2.c.ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with § 1852(e) of the Social Security Act and 42 CFR §422.152.

2. The MA Organization agrees to develop and operate a chronic care improvement program in accordance with the requirements of 42 CFR §422.152(c).

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(4.a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(4.b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(5.a) The MA Organization must:

(5.a.i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;

(5.a.ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;

(5.a.iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review: The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

7. The MA Organization agrees to address complaints received by CMS against the MA Organization as required in 42 CFR §422.504(a)(15) by:

(7.a) Addressing and resolving complaints in the CMS complaint tracking system; and

(7.b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the MA plan's main Web page.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of 42 CFR §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and 42 CFR §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and 42 CFR §422.118, the anti-discrimination requirements of §1852(b) of the Act and 42 CFR §422.110, the access to services requirements of §1852(d) of the Act and 42 CFR §422.112, the advance directives requirements of §1852(i) of the Act and 42 CFR §422.128, the provider participation requirements of §1852(j) of the Act and 42 CFR Part 422, Subpart E, and the applicable requirements described in 42 CFR §423.156, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of 42 CFR §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR §422.2260 and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with 42 CFR §422.2264. The file and use process set out at 42 CFR §422.2262 must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR §422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation § 1851(h) of the Act and 42 CFR § 422.111, 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. METHODOLOGY

CMS agrees to pay the MA Organization under this contract in accordance with the provisions of § 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM PAYMENTS

The MA Organization agrees to abide by the requirements in 42 CFR §§495.200 et seq. and §1853(l) and (m) of the Act, including the fact that payment will be made directly to MA-affiliated hospitals that are certified Medicare hospitals through the Medicare FFS hospital incentive payment program.

D. ATTESTATION OF PAYMENT DATA (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

(NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis.

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under 42 CFR §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must also attest to *(based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(I)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (an example of which is attached hereto as Attachment C) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposed bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposed bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.504(I)]**

4. The MA Organization must certify based on best knowledge, information, and belief, that the information provided for the purposes of reporting and returning of overpayments under 42 CFR §422.326 is accurate, complete, and truthful. The form for this certification will be determined by CMS. **[422.504(I)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of the first tier, downstream, and related entities related to CMS contract with the MA organization;

2. HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph B (1) of this Article directly from any first tier, downstream, or related entity;

3. For records subject to review under paragraph B(2) of this Article, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated; and

4. HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.504(i)(2)]**

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

1. Enrollee protection provisions that provide—

(1.a) Consistent with Article III, paragraph C, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(1.b) Consistent with Article III, paragraph C, provision for the continuation of benefits.

2. Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this Article.

3. A provision requiring that any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the MA Organization's contractual obligations. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any first tier, downstream, or related entity:

1. Each and every contract must specify delegated activities and reporting responsibilities.

2. Each and every contract must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

3. Each and every contract must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

4. Each and every contract must specify that either-

(4.a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(4.b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

5. Each and every contract must specify that the first tier, downstream, or related entity comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's contract with that organization must state that the CMS-contracting MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

1. Agrees that any physician incentive plan it operates meets the requirements of 42 CFR §422.208, and

2. Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with 42 CFR §422.208(f). **[422.208]**

Article VI Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that-

(1.a) Are sufficient to do the following:

(1.a.i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(1.a.ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(1.a.iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract. **304**

(1.a.iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(1.a.v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(1.a.vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(1.b) Include at least records of the following:

(1.b.i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(1.b.ii) Financial statements for the current contract period and ten prior periods.

(1.b.iii) Federal income tax or informational returns for the current contract period and ten prior periods.

(1.b.iv) Asset acquisition, lease, sale, or other action.

(1.b.v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(1.b.vi) Franchise, marketing, and management agreements.

(1.b.vii) Schedules of charges for the MA Organization's fee-for-service patients.

(1.b.viii) Matters pertaining to costs of operations.

(1.b.ix) Amounts of income received, by source and payment.

(1.b.x) Cash flow statements.

(1.b.xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(2.a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

(2.a.i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(2.a.ii) Compliance with CMS requirements for maintaining the privacy and security of protected health information and other personally identifiable information of Medicare enrollees;

(2.a.iii) The facilities of the MA Organization; and

(2.a.iv) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

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(c) The MA Organization agrees to make available, for the purposes specified in paragraph A of this Article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(2.d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(2.d.i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(2.d.ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(2.d.iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time.
[422.504(e)]

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor patient relationship, statistics and other information as described in the remainder of this paragraph. **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(2.a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(2.a.i) The cost of its operations;

(2.a.ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in 42 CFR §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in subparagraph (2)(a)(v) of this paragraph do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(2.a.iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(2.a.iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(2.a.iv.aa) Thirty five percent or more of the costs of operation of the MA Organization go to a party in interest.

(2.a.iv.bb) Thirty five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(2.a.v) Requirements for combined financial statements.

(2.a.v.aa) The combined financial statements required by this subparagraph must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(2.a.v.bb) Inter-entity transactions must be eliminated in the consolidated column.

(2.a.v.cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(2.a.v.dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in this subparagraph with respect to a particular entity. **[422.516(c)]**

(2.a.vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities. **[422.516(e)]**

(2.b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)]**

(2.c) Patterns of utilization of the MA Organization's services. **[422.516(a)(2)]**

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(3.a) The benefits covered under the MA plan;

(3.b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(3.c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(3.d) Plan quality and performance indicators for the benefits under the plan including —

(3.d.i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(3.d.ii) Information on Medicare enrollee satisfaction;

(3.d.iii) The patterns of utilization of plan services;

(3.d.iv) The availability, accessibility, and acceptability of the plan's services;

(3.d.v) Information on health outcomes and other performance measures required by CMS;

(3.d.vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(3.d.vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(3.d.viii) Information about beneficiary appeals and their disposition;

(3.d.ix) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(3.d.x) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under 42 CFR §422.64 and, upon an enrollee's request, the financial disclosure information required under 42 CFR §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA —

(5.a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA). #2410

(5.b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in 42 CFR §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

8. The MA Organization acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part C and Part D Payments for the contract year as provided in 42 CFR §422.504(n) and, for Part D plan sponsors, 42 CFR §423.505(o).

9. The MA Organization agrees that it must subject information collected pursuant to 42 CFR §422.516(a) to a yearly independent audit to determine their reliability, validity, completeness, and comparability in accordance with specifications developed by CMS. **[422.516(g)]**

Article VII Renewal of the MA Contract

A. RENEWAL OF CONTRACT

In accordance with 42 CFR §422.505, following the initial contract period, this contract is renewable annually only if-

1. The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**
2. CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**
3. CMS informs the MA Organization that it authorizes a renewal.

B. NONRENEWAL OF CONTRACT

1. Nonrenewal by the Organization.

(1.a) In accordance with 42 CFR §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in this subparagraph.

(1.b) If the MA Organization does not intend to renew its contract, it must notify—

(1.b.i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to 42 CFR §422.506

(1.b.ii) Each Medicare enrollee by mail, at least 90 calendar days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, MA-PD plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.

(1.c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if -

(1.c.i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) of this paragraph; and

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(1.c.ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(1.d) If the MA Organization does not renew a contract under this subparagraph, CMS may deny an application for a new contract or a service area expansion from the Organization or with any organization whose covered persons, as defined at 42 CFR §422.506(a)(5), also served as covered persons for the non-renewing MA Organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[422.506(a)]**

2. CMS decision not to renew.

(2.a) CMS may elect not to authorize renewal of a contract for any of the following reasons:

(2.a.i) For any of the reasons listed in 42 CFR §422.510(a) which would also permit CMS to terminate the contract.

(2.a.ii) The MA Organization has committed any of the acts in 42 CFR §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.

(2.a.iii) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**

(2.b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:

(2.b.i) To the MA Organization by August 1 of the contract year, except in the event described in subparagraph (2)(a)(iii) of this paragraph, for which notice will be sent by September 1.

(2.b.ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(2.c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with 42 CFR §422.644. **[422.506(b)]**

Article VIII Modification or Termination of the Contract

A. MODIFICATION OR TERMINATION OF CONTRACT BY MUTUAL CONSENT

1. This contract may be modified or terminated at any time by written mutual consent.

(1.a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(1.b) If the contract is terminated by written mutual consent, except as provided in subparagraph 2 of this paragraph, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in paragraph B, subparagraph 2(b) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in paragraph B of this Article. **[422.508(b)]**

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3. As a condition of the consent to a mutual termination, CMS will require as a provision of the termination agreement language prohibiting the MA organization from applying for new contracts or service area expansions for a period of 2 years, absent circumstances warranting special consideration. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[422.508(c)]**

B. TERMINATION OF THE CONTRACT BY CMS OR THE MA ORGANIZATION

1. Termination by CMS.

(1.a) CMS may at any time terminate a contract if CMS determines that the MA Organization meets any of the following:

(1.a.i) has failed substantially to carry out the terms of its contract with CMS.

(1.a.ii) is carrying out its contract in a manner that is inconsistent with the efficient and effective implementation of 42 CFR Part 422.

(1.a.iii) no longer substantially meets the applicable conditions of 42CFR Part 422.

(1.b) CMS may make a determination under paragraph B(1)(a)(i), (ii), or (iii) of this Article if the MA Organization has had one or more of the following occur:

(1.b.i) based on credible evidence, has committed or participated in false, fraudulent or abusive activities affecting the Medicare, Medicaid or other State or Federal health care program, including submission of false or fraudulent data.

(1.b.ii) experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(1.b.iii) substantially failed to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(1.b.iv) failed to provide CMS with valid data as required under 42 CFR §§422.310.

(1.b.v) failed to implement an acceptable quality assessment and performance improvement program as required under 42 CFR Part 422 Subpart D.

(1.b.vi) substantially failed to comply with the prompt payment requirements in 42 CFR §422.520.

(1.b.vii) substantially failed to comply with the service access requirements in 42 CFR §422.112.

(1.b.viii) failed to comply with the requirements of 42 CFR §422.208 regarding physician incentive plans.

(1.b.ix) substantially failed to comply with the marketing requirements in 42 CFR Part 422 Subpart V.

(1.b.x) Failed to comply with regulatory requirements contained in 42 CFR Parts 422 or 423 or both.

(1.b.xi) Failed to meet CMS performance requirements in carrying out the regulatory requirements contained in 42 CFR Parts 422 or 423 or both.

(1.b.xii) Achieves a Part C summary plan rating of less than 3 stars for 3 consecutive contract years.

(1.b.xiii) Has failed to report MLR data in a timely and accurate manner in accordance with 42 CFR §422.2460.

(1.c) Notice. If CMS decides to terminate a contract, it will give notice of the termination as follows:

(1.c.i) CMS will notify the MA Organization in writing at least 45 calendar days before the intended date of the termination.

(1.c.ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 calendar days before the effective date of the termination.

(1.c.iii) The MA Organization will notify the general public of the termination at least 30 calendar days before the effective date of the termination by releasing a press statement to news media serving the affected community or county and posting the press statement prominently on the organizations Web site.

(1.d) Expedited termination of contract by CMS.

(1.d.i) For terminations based on violations prescribed in subparagraph 1(b)(i) or (b)(ii) of this paragraph or if CMS determines that a delay in termination would pose an imminent and serious threat to the health of the individuals enrolled with the MA Organization, CMS will notify the MA Organization in writing that its contract has been terminated on a date specified by CMS. If a termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(1.d.ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(1.d.iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(1.e) Corrective action plan

(1.e.i) General. Before providing a notice of intent to terminate a contract for reasons other than the grounds specified in subparagraph 1(a)(iv) or (v) of this paragraph, CMS will provide the MA Organization with notice specifying the MA Organization's deficiencies and a reasonable opportunity of at least 30 calendar days to develop and implement an approved corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(1.e.ii) Exceptions. If a contract is terminated under subparagraph 1(a)(iv) or (v) of this paragraph, the MA Organization will not be provided with the opportunity to develop and implement a corrective action plan.

(1.f) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510(d)]**

2. Termination by the MA Organization

(2.a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(2.b) Notice. The MA Organization must give advance notice as follows:

(2.b.i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(2.b.ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(2.b.iii) to the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(2.c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(2.d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(2.e) Effect of termination by the organization. CMS (2.e) may deny an application for a new contract or service area expansion from the MA Organization or with an organization whose covered persons, as defined in 42 CFR §422.512(e)(2), also served as covered persons for the terminating MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. This prohibition may apply regardless of the product type, contract type, or service area of the previous contract. **[422.512]**

Article IX Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

1. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC §§3729 et seq.) , and the anti-kickback statute (§ 1128B(b) of the Act): and

2. HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164. **[422.504(h)]**

B. Pursuant to § 13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), the MA Organization agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by § 13101 of the ARRA.

C. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

D. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. ALTERATION TO ORIGINAL CONTRACT TERMS

The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties. **312**

C. APPROVAL TO BEGIN MARKETING AND ENROLLMENT

The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. MA Organization agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 CFR § 422.504(a)(14).

E. MA Organization agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality improvement activities related to the delivery of Part C services as required by 42 CFR §422.504(a)(17).

F. MA Organization agrees to maintain a Part C summary plan rating score of at least 3 stars as required by 42 CFR §422.504(a)(18).

G. CMS may determine that an MA organization is out of compliance with a Part C requirement when the organization fails to meet performance standards articulated in the Part C statutes, regulations, or guidance. If CMS has not already articulated a measure for determining noncompliance, CMS may determine that an MA organization is out of compliance when its performance in fulfilling Part C requirements represents an outlier relative to the performance of other MA organizations. **[422.504(m)]**

H. **Business Continuity:** The MA organization agrees to develop, maintain, and implement a business continuity plan as required by 42 CFR §422.504(o).

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and appropriate changes in enrollees' status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to its accuracy, completeness, and truthfulness.

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE - DIAGNOSIS/ENCOUNTER) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

In witness whereof, the parties hereby execute this contract.

This document has been electronically signed by:

FOR THE MA ORGANIZATION

BRIAN THOMPSON

Contracting Official Name

8/28/2015 11:14:51 AM

Date

UHC OF CALIFORNIA

Organization

5995 PLAZA DRIVE
CYPRESS, CA 90630

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES



9/11/2015 1:04:06 PM

Kathryn A. Coleman
Director
Medicare Drug and Health
Plan Contract Administration Group,
Center for Medicare

Date

EXHIBIT 8

Sh0151

Medicare+Choice Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or

With Medicare+Choice Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. The Eligible Organization Agrees:

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.
3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
 - Beneficiary's name,
 - Beneficiary's health insurance claim number,
 - Date(s) of service,
 - Diagnosis/nature of illness
4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.
5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.
6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.
7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.
8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.

Sho151

9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.
10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with § 1106(a) of the Act).
11. That it will research and correct risk adjustment data discrepancies.
12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services Agrees To:

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.
2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.
3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.
4. The contractor will make alternative means available to any electronic biller to obtain such services.
5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.
6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's

Name: United Health Group- Ovations

Sho151

Title: Chief Financial Officer

Address: 9900 Bren Road East

MINNOC8-T440

City/State/ZIP: Minnetonka, MN 55343

By: Joseph A. Hofmann

Title: Joseph A. Hofmann Date: 1/25/05

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

M+CO EDI Enrollment

P.O. Box 100275, AG-570

Columbia, SC 29202-3275



Lynn Gendreau, Director
 Ovations Medicare Operations
 MN008-W140 9900 Bren Road East Minnetonka MN 55343
 Tel 952-936-3241 Fax 952-936-3080

MEMORANDUM

To: Jocelyn Williams
 CSSC Operations AG-570

Cc: William DeYoung

From: Lynn Gendreau

Date: April 18, 2005

Subject: Additional H# contracts for Submitter ID SH0151

Dear Ms. Williams,

We have one additional H# that needs to be added to United Health submitter ID – SH0151. Attached is also the required EDI Enrollment Form request signed by our Chief Financial Officer, Joseph Haferman.

They are as follows:

H0401	UnitedHealthcare of Arkansas, Inc.
H0624	Evercare Premier – Colorado
H1111	UnitedHealthcare of Georgia, Inc.
H1303	United HealthCare Insurance Company – Idaho
H1509	United HealthCare Insurance Company - Indiana
H1717	United HealthCare Insurance Company – Kansas
H2001	United HealthCare Insurance Company – Maine
H2003	United HealthCare Insurance Company – Evercare Maine
H3113	Oxford Health Plans of New Jersey, Inc. – Evercare New Jersey
H3209	Evercare New Mexico
H3812	United HealthCare Insurance Company – Oregon
H3921	United HealthCare Insurance Company – Pennsylvania
H4106	Evercare Premier – Rhode Island
H4522	United HealthCare Insurance Company – New Mexico/Texas
H5008	Evercare Washington
H5424	United HealthCare Insurance Company – Hawaii
H5440	Evercare Premier - Florida

Attachment: EDI Enrollment Form





Lynn Gendreau, Director
Ovations Medicare Operations
MN008-W140 9900 Bren Road East Minnetonka MN 55343
Tel 952-936-3241 Fax 952-936-1080

MEMORANDUM

To: Jocelyn Williams
CSSC Operations AG-570

Cc: William DeYoung

From: Lynn Gendreau *[Signature]*

Date: February 3, 2005

Subject: Additional H# contracts for Submitter ID SH051

Dear Ms. Williams,

Per your conversation with William DeYoung, we need to add additional H# contracts to the United Health submitter ID – SH051. Attached is also the required EDI Enrollment Form request signed by our Chief Financial Officer, Joseph Hafermann.

They are as follows:

H4406	United Healthcare of Tennessee, Inc.
H0319	Evercare Arizona
H0315	Evercare Arizona PPO
H0620	Evercare Colorado
H5417	Evercare Florida
H1108	Evercare Georgia
H2111	Evercare Maryland
H2228	Evercare Massachusetts <i>RI</i>
H2228	Evercare Rhode Island
H2408	United Health Care Insurance Co of Illinois - Private-Fee-For-Service
H4604	Salt Lake City
<i>H3326</i>	United Health Care Insurance Co of New York – PPO <i>loaded on 5/15/03</i>

Please let me know if you need any additional information or clarification.

Thank you in advance.

Attachment: EDI Enrollment Form



Lynn Gendreau, Director
 Ovations Medicare Operations
 MN008-W140 9900 Bren Road East Minnetonka MN 55343
 Tel 952-936-3241 Fax 952-936-3080

MEMORANDUM

To: Jocelyn Williams
 CSSC Operations AG-570

Cc: Susan Gruwell

From: Lynn Gendreau *Lynn Gendreau*

Date: October 25, 2005

Subject: Additional H# contracts for Submitter ID **SH1051**



SH1051
John

Dear Ms. Williams,

We have additional H#'s that need to be added to United Health submitter ID – SH1051. Attached is also the required EDI Enrollment Form request signed by our Chief Financial Officer, Jeff Putnam.

		<u>Effective Date</u>
H5500	United HealthCare Insurance Company – Alabama	1/1/06
H5507	United HealthCare Insurance Company – Missouri	1/1/06
H5515	United HealthCare Insurance Company - New York	1/1/06
H5516	United HealthCare Insurance Company - North Carolina	1/1/06
H5518	United HealthCare Insurance Company – Ohio	1/1/06
H5527	United HealthCare Insurance Company - Rhode Island	1/1/06
H5532	United HealthCare Insurance Company - Tampa, FL	1/1/06
R3175	United HealthCare Insurance Company - Regional PPO Hawaii	1/1/06
R5287	United HealthCare Insurance Company - Regional PPO Florida	1/1/06
R5342	United HealthCare Insurance Company - Regional PPO New York	1/1/09
H5652	United HealthCare Insurance Company - Erickson Advantage	10/1/05
H5678	United HealthCare Insurance Company - Erickson Advantage	1/1/06
H5697	United HealthCare Insurance Company - Erickson Advantage	1/1/06
H5754	United HealthCare Insurance Company - Erickson Advantage	1/1/06
H5918	United HealthCare Insurance Company - Erickson Advantage	1/1/06

Thank you in advance.

Attachment: EDI Enrollment Form

New Regionals



Lynn Gendreau, Director
Ovations Medicare Operations
MN008-W140 9900 Bren Road East Minnetonka MN 55343
Tel 952-936-3241 Fax 952-936-3080
Email Lynn_Gendreau@uhc.com

MEMORANDUM

To: Jocelyn Williams
CSSC Operations AG-570

Cc: William DeYoung

From: Lynn Gendreau 

Date: April 21, 2005

Subject: EDI Enrollment Form for SH0151

Dear Ms. Williams,

Per our discussion on 4/20/05, attached is an original EDI enrollment form for our newly submitted H#s (see below) signed by our Chief Financial Officer, Joseph Hafermann. Please send confirmation of H# linkage to our Submitter ID to me either via email or fax as noted above. Thank you again for your assistance and prompt response.

(Original list submitted 4/18/05)

H0401	UnitedHealthcare of Arkansas, Inc.
H0624	Evercare Premier – Colorado
H1111	UnitedHealthcare of Georgia, Inc.
H1303	United HealthCare Insurance Company – Idaho
H1509	United HealthCare Insurance Company - Indiana
H1717	United HealthCare Insurance Company – Kansas
H2001	United HealthCare Insurance Company – Maine
H2003	United HealthCare Insurance Company – Evercare Maine
H3113	Oxford Health Plans of New Jersey, Inc. – Evercare New Jersey
H3209	Evercare New Mexico
H3812	United HealthCare Insurance Company – Oregon
H3921	United HealthCare Insurance Company – Pennsylvania
H4106	Evercare Premier – Rhode Island
H4522	United HealthCare Insurance Company – New Mexico/Texas
H5008	Evercare Washington
H5424	United HealthCare Insurance Company – Hawaii
H5440	Evercare Premier - Florida

Attachment: EDI Enrollment Form

RECEIVED

APR 22 2005

MEDICARE PART A
DOCUMENT CONTROL

EXHIBIT 9



Medicare+Choice Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

ONLY for the Collection of Risk Adjustment Data and/or

With Medicare+Choice Eligible Organizations

H0543

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. A. The Eligible Organization Agrees:

1. 1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.
2. 2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.
3. 3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
 - • Beneficiary's name,
 - • Beneficiary's health insurance claim number,
 - • Date(s) of service,
 - • Diagnosis/nature of illness
4. 4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.
5. 5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.
6. 6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.
7. 7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.
8. 8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.
9. 9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

H054

10. 10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).
11. 11. That it will research and correct risk adjustment data discrepancies.
12. 12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. B. The Centers for Medicare & Medicaid Services Agrees To:

1. 1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.
2. 2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.
3. 3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.
4. 4. The contractor will make alternative means available to any electronic biller to obtain such services.
5. 5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.
6. 6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

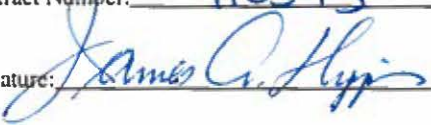
This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. C. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization's Name: Ovations, United Health Group

Contract Number: H0543

Signature: 

Name: James Higgins

H0543

Title: Director

Address: 3100 LAKE CENTER

City/State/ZIP: Santa Ana, CA 92704

Phone: 714-825-5425

Email: jim.higgins@phs.com

Date: September 14, 2006

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

**M+CO EDI Enrollment
CSSC Operations AG-570
P.O. Box 100275
Columbia, SC 29202-3275**

**Phone (877) 534-2772
www.csscooperations.com**

EXHIBIT 10



Medicare Advantage Organization

Electronic Data Interchange Enrollment Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

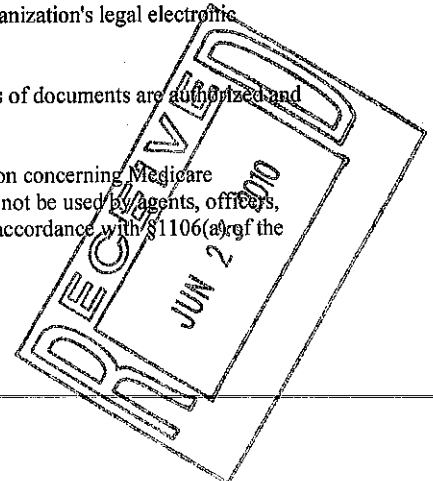
ONLY for the Collection of Risk Adjustment Data and/or

With Medicare Advantage Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare risk adjustment data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS's contractors.

A. The Eligible Organization Agrees:

1. That it will be responsible for all Medicare risk adjustment data submitted to CMS by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.
3. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:
 - Beneficiary's name, *e PR*
 - Beneficiary's health insurance claim number,
 - Date(s) of service,
 - Diagnosis/nature of illness
4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.
5. Based on best knowledge, information, and belief, that it will submit risk adjustment data that are accurate, complete, and truthful.
6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare risk adjustment data for a period of at least 6 years, 3 months after the risk adjustment data is received and processed.
7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each risk adjustment data electronically transmitted to the contractor.
8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.
9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.
10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).
11. That it will research and correct risk adjustment data discrepancies.





12. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services Agrees To:

1. Transmit to the eligible organization an acknowledgment of risk adjustment data receipt.
2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.
3. Ensure that no contractor may require the eligible organization to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest.
4. The contractor will make alternative means available to any electronic biller to obtain such services.
5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.
6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare risk adjustment data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

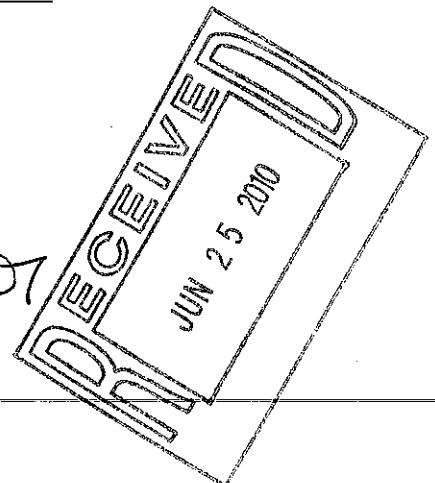
Eligible Organization's Name: Ingenix

Contract Number: Third Party

Signature: [Signature]

Name: PAT RASMUSSEN

Title: MANAGER, RISK ADJUSTMENT





Address: PO BOX 9472

City/State/ZIP: MINNEAPOLIS, MN 55440-9472

Phone: 469-633-8720

Email: PATRICIA-R-RASMUSSEN@INGENIX.COM

Date: 06-17-2010

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

Medicare Advantage EDI Enrollment
CSSC Operations AG-570
2300 Springdale Drive Bldg. One
Camden, SC 29020-1728

Phone (877) 534-2772
www.csscoperations.com

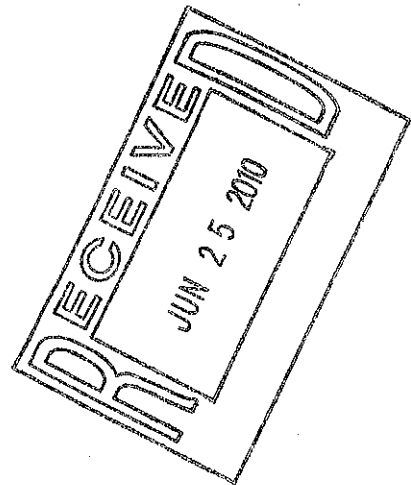


EXHIBIT 11



12125 Technology Drive
Eden Prairie, MN 55344
T 888-445-8745
F 952-833-7201
www.optum.com

Palmetto GBA
CSSC Operations
P.O. Box 100275, AG-570
Columbia, SC 29202-3275

To Whom It May Concern:

Please be advised that Ingenix is now OptumInsight, a part of Optum – a leading health service business.

Your records should be updated to include the following for RAPS and EDPS submissions.

Technical Contact:

Mike Smed
mike.smed@optum.com

Operations Contact:

Pat Rasmussen
patricia.rasmussen@optum.com

Impacted Submitter IDs:

SH9533, SH9542, SH9543, SH9561, SH9575, SH9580, ENC0022

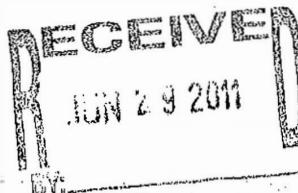
Impacted Contracts:

H0151, H0251, H0303, H0316, H0319, H0321, H0351, H0401, H0408, H0410, H0543, H0562
H0609, H0620, H0624, H0710, H0752, H0755, H1080, H1108, H1111, H1286, H1303, H1364
H1509, H1717, H1944, H2001, H2111, H2182, H2226, H2228, H2229, H2256, H2406, H2409
H2410, H2450, H2458, H2654, H2802, H2803, H2905, H2931, H2961, H3057, H3107, H3113
H3164, H3209, H3307, H3379, H3387, H3435, H3456, H3659, H3749, H3805, H3812, H3887
H3912, H3920, H3921, H4102, H4106, H4406, H4449, H4456, H4514, H4522, H4590, H4604
H4720, H4779, H4837, H4971, H5005, H5008, H5253, H5417, H5424, H5435, H5439, H5440
H5507, H5516, H5520, H5532, H5652, H5678, H5697, H5698, H5749, H5754, H5918, H5998
H6228, H6793, H6815, H7187, H7226, H7526, H7949, H8748, H9011, H9149, R3175, R5287
R5342, R5674, R7444

Sincerely,

Pat Rasmussen
Manager, Encounter Operations
OptumInsight
PO Box 9472
Minneapolis, MN 55440-9472

Ph: 469-633-8720
Fax: 877-247-5010



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JUN 27 2011

MED B DOC. CONTROL
CAMDEN GM-220

ENC0017-ENC0022
335
EXHIBIT 11

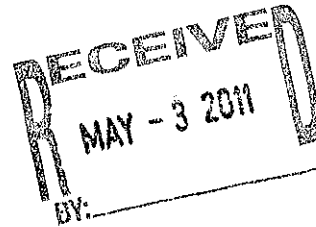
EXHIBIT 12



UnitedHealthcare Medicare & Retirement
9701 Data Park
Minnetonka MN 55343

April 27, 2011

Medicare Advantage EDI Enrollment
CSSC Operations AG-570
2300 Springdale Drive, Bldg. One
Camden, SC 29020-1728



RE: Letter of Authorization
Encounter Data Front-End System

Effective May 1, 2011, Ingenix is authorized to begin transmitting encounter data for the following Medicare Advantage Health Plans and contract numbers:

Contract Number	Legal Entity Name
H0151	UNITEDHEALTHCARE OF ALABAMA, INC.
H0251	UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.
H0303	PACIFICARE OF ARIZONA, INC
H0316	UNITEDHEALTHCARE OF ARIZONA, INC.
H0319	UNITEDHEALTHCARE INSURANCE COMPANY
H0321	ARIZONA PHYSICIANS IPA, INC.
H0401	UNITEDHEALTHCARE OF ARKANSAS, INC.
H0408	UNITEDHEALTHCARE INSURANCE COMPANY
H0543	PACIFICARE OF CALIFORNIA
H0609	PACIFICARE OF COLORADO, INC
H0620	UNITEDHEALTHCARE INSURANCE COMPANY

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H0624	UNITEDHEALTHCARE INSURANCE COMPANY
H0710	UNITEDHEALTHCARE INSURANCE COMPANY
H0752	OXFORD HEALTH PLANS (CT), INC.
H0755	HEALTH NET OF CONNECTICUT.
H1080	UNITEDHEALTHCARE OF FLORIDA, INC.
H1108	UNITEDHEALTHCARE INSURANCE COMPANY
H1111	UNITEDHEALTHCARE OF GEORGIA, INC.
H1286	UNITEDHEALTHCARE INSURANCE COMPANY
H1303	UNITEDHEALTHCARE INSURANCE COMPANY
H1509	UNITEDHEALTHCARE INSURANCE COMPANY
H1717	UNITEDHEALTHCARE INSURANCE COMPANY
H1944	UNITEDHEALTHCARE INSURANCE COMPANY
H2001	UNITEDHEALTHCARE INSURANCE COMPANY
H2111	UNITEDHEALTHCARE INSURANCE COMPANY
H2182	UNITEDHEALTHCARE INSURANCE COMPANY
H2226	UNITEDHEALTHCARE INSURANCE COMPANY
H2228	UNITEDHEALTHCARE INSURANCE COMPANY
H2406	UNITEDHEALTHCARE INSURANCE COMPANY
H2654	UNITEDHEALTHCARE OF THE MIDWEST, INC.
H2802	UNITEDHEALTHCARE OF THE MIDLANDS, INC.
H2803	UNITEDHEALTHCARE INSURANCE COMPANY

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H2905	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC,
H2931	HEALTH PLAN OF NEVADA, INC.
H3107	OXFORD HEALTH PLANS (NJ), INC.
H3113	OXFORD HEALTH PLANS (NJ), INC.
H3164	AMERICHoice OF NEW JERSEY, INC
H3209	UNITEDHEALTHCARE INSURANCE COMPANY
H3307	OXFORD HEALTH PLANS (NY), INC.
H3379	UNITEDHEALTHCARE OF NEW YORK, INC.
H3387	UNITEDHEALTHCARE OF NEW YORK, INC.
H3456	UNITEDHEALTHCARE OF NORTH CAROLINA, INC.
H3659	UNITEDHEALTHCARE OF OHIO, INC.
H3749	PACIFICARE OF OKLAHOMA, INC.
H3805	PACIFICARE OF OREGON, INC.
H3812	UNITEDHEALTHCARE INSURANCE COMPANY
H3887	UNITEDHEALTHCARE INSURANCE COMPANY
H3912	UNITEDHEALTHCARE INSURANCE COMPANY
H3920	UNITEDHEALTHCARE OF PENNSYLVANIA, INC.
H3921	UNITEDHEALTHCARE INSURANCE COMPANY
H4102	UNITEDHEALTHCARE OF NEW ENGLAND, INC.
H4406	UNITEDHEALTHCARE OF TENNESSEE, INC.
H4456	UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

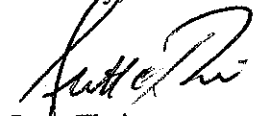
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H4514	EVERCARE OF TEXAS, LLC
H4522	UNITEDHEALTHCARE INSURANCE COMPANY
H4590	PACIFICARE OF TEXAS, INC.
H4604	UNITEDHEALTHCARE OF UTAH, INC.
H4837	UNITEDHEALTHCARE OF WISCONSIN
H4971	UNITEDHEALTHCARE INSURANCE COMPANY
H5005	PACIFICARE OF WASHINGTON, INC.
H5008	UNITEDHEALTHCARE INSURANCE COMPANY
H5253	UNITEDHEALTHCARE OF WISCONSIN, INC
H5417	UNITEDHEALTHCARE INSURANCE COMPANY
H5424	UNITEDHEALTHCARE INSURANCE COMPANY
H5435	UNITEDHEALTHCARE INSURANCE COMPANY
H5440	UNITEDHEALTHCARE INSURANCE COMPANY
H5507	UNITEDHEALTHCARE INSURANCE COMPANY
H5516	UNITEDHEALTHCARE INSURANCE COMPANY
H5532	UNITEDHEALTHCARE INSURANCE COMPANY
H5652	UNITEDHEALTHCARE INSURANCE COMPANY
H5749	UNITEDHEALTHCARE INSURANCE COMPANY
H5998	UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.
H6952	UNITEDHEALTHCARE OF THE GREAT LAKES HLTH PLAN, INC

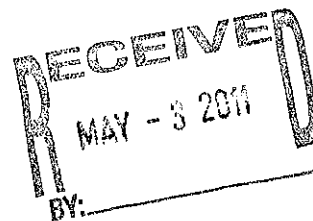
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H7187	UNITEDHEALTHCARE INSURANCE COMPANY
H7949	PACIFICARE OF NEVADA, INC.
H8748	UNITEDHEALTHCARE INSURANCE COMPANY
H9011	UNITEDHEALTHCARE OF FLORIDA, INC.
R3175	UNITEDHEALTHCARE INSURANCE COMPANY
R5287	UNITEDHEALTHCARE INSURANCE COMPANY
R5342	UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
R5674	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC,
R7444	UNITEDHEALTHCARE INSURANCE COMPANY

Sincerely,



Scott Theisen
Chief Financial Officer



ENC0022



CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Advantage Organization

Electronic Data Interchange Agreement Form

MANAGED CARE ELECTRONIC DATA INTERCHANGE (EDI) AGREEMENT FORM

ONLY for the Collection of Encounter Data and/or

With Medicare Advantage Eligible Organizations

The eligible organization agrees to the following provisions for submitting Medicare encounter data electronically to The Centers for Medicare & Medicaid Services (CMS) or to CMS contractors.

A. The Eligible Organization Agrees:

1. That it will be responsible for all Medicare encounter data submitted to CMS by itself, its employees, or its agents.
2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law.
3. That it will ensure that every electronic entry can be readily associated and identified with an original source document.
4. That the Secretary of Health and Human Services or his/her designee and/or the contractor has the right to audit and confirm information submitted by the eligible organization and shall have access to all original source documents and medical records related to the eligible organization's submissions, including the beneficiary's authorization and signature.
5. Based on best knowledge, information, and belief, that it will submit encounter data that are accurate, complete, and truthful.
6. That it will retain all original source documentation and medical records pertaining to any such particular Medicare encounter data for a period of at least 6 years, 3 months after the encounter data is received and processed.
7. That it will affix the CMS-assigned unique identifier number of the eligible organization on each encounter data electronically transmitted to the contractor.
8. That the CMS-assigned unique identifier number constitutes the eligible organization's legal electronic signature.
9. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.
10. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).
11. That it will research and correct encounter data discrepancies.
12. That it will notify CMS or its contractor within 2 business days if any transmitted data are received in an unintelligible or garbled form.

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BY: _____

RECEIVED
JUN 30 2011
MEDICARE DC
CAMDEN



B. The Centers for Medicare & Medicaid Services Agrees To:

1. Transmit to the eligible organization an acknowledgment of encounter data receipt.
2. Affix the intermediary/carrier number, as its electronic signature, on each response/report sent to the eligible organization.
3. Ensure that no CMS contractor may require the eligible organization to purchase any or all electronic services from the CMS contractor or from any subsidiary of the CMS contractor or from any company for which the CMS contractor has an interest.
4. The contractor will make alternative means available to any electronic biller to obtain such services.
5. Ensure that all Medicare electronic transmitters have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the contractor sells directly, indirectly, or by arrangement.
6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the eligible organization. The responsibilities and obligations contained in this document will remain in effect as long as Medicare encounter data are submitted to CMS or the contractor. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.



C. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Contract Number:	n/a - Third Party Submitter
Eligible Organization's Name:	OPTUMinsight (Formerly Ingenix)
Address:	12125 Technology Drive
City/State/ZIP:	Eden Prairie, MN 55344
Phone:	(952) 833-7223
Email:	jeff.dumcum@ingenix.com
Signature:	<i>Jeff Dumcum</i>
Printed Name:	Jeff Dumcum
Title:	Sr. Vice President
Date:	May 10, 2011

cc: Regional Offices

Please retain a copy of all forms submitted for your records.

Complete and mail this form with original signature to:

**Medicare Advantage EDI Agreement
CSSC Operations AG-570
2300 Springdale Drive Bldg. One
Camden, SC 29020-1728**

**Phone (877) 534-2772
www.csscoperations.com**

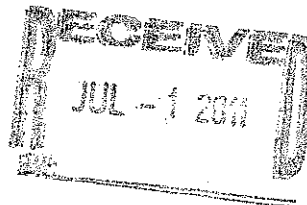
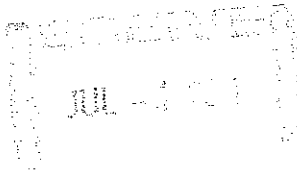


EXHIBIT 13

Examples of Invalid Diagnosis Submitted But Not Deleted By United

Examples of invalid diagnoses about which United knew but that it failed to delete based on its Chart Review Program for the 2011 through the 2014 payment years include the following:¹

1. United reviewed medical records relating to Beneficiary A as part of its Chart Review Program for payment year 2011. The prior year (date of service year 2010), one of Beneficiary A's providers reported diagnoses to United that mapped to HCC 7 and RxHCC 11 for Metastatic Cancer and Acute Leukemia, and to HCC 96 and RxHCC 97 for Ischemic or Unspecified Stroke. However, the results of United's review of this provider's medical records for this beneficiary failed to validate these diagnoses, and no other provider reported these diagnoses (or any other diagnosis mapping to these HCCs) for this beneficiary for this year. United submitted these invalid diagnoses to the Medicare Program for risk adjustment payments, but knowingly and improperly failed to delete them. The beneficiary's Part C risk score was 3.239 for payment year 2011, but deleting the invalid diagnoses would have decreased it to .92, a difference of 2.319. Under Part C of the Medicare Program, United was paid \$24,380 based on its submission of these invalid diagnoses. Accordingly, Medicare has been damaged by at least \$24,380 (and possibly more under Part D) because of United's failure to delete the invalid diagnoses or otherwise return the overpayments.

2. United reviewed medical records relating to Beneficiary B as part of its Chart Review Program for payment year 2011. The prior year (date of service year 2010), one of Beneficiary B's providers reported a diagnosis to United that mapped to HCC 45 for Disorders of Immunity. However, the results of United's review of the provider's medical records failed to validate this diagnosis, and no other provider reported this diagnosis (or any other diagnosis mapping to this HCC) for this beneficiary for this year.

¹ Information identifying the beneficiaries will be separately provided to Defendants.

1 United submitted this invalid diagnosis to the Medicare Advantage Program for risk
2 adjustment payments, and knowingly and improperly failed to delete it. The
3 beneficiary's Part C risk score was originally 3.328, but deleting the invalid diagnosis
4 would have decreased it to 2.495, a difference of .833. Under Part C of the Medicare
5 Program, United was paid \$8,267 based on its submission of this invalid diagnosis.
6 Accordingly, Medicare has been damaged by that amount because of United's failure to
7 delete the invalid diagnosis or otherwise return the overpayments.

8 3. United reviewed the medical records relating to Beneficiary C as part of its Chart
9 Review Program for payment year 2011. The prior year (date of service year 2010), one
10 of Beneficiary C's providers reported diagnoses to United that mapped to HCC 45 for
11 Disorders of Immunity, HCC 44 for Severe Hematological Disorders, and RxHCC 50 for
12 Aplastic Anemia and Other Significant Blood Disorders. However, the results of
13 United's review of this provider's medical records failed to validate these diagnoses, and
14 no other provider reported these diagnoses (or any other diagnoses that mapped to these
15 HCCs) for this beneficiary for this year. United submitted these invalid diagnoses to the
16 Medicare Advantage Program for risk adjustment payments, and knowingly and
17 improperly failed to delete them. The beneficiary's Part C risk score was originally
18 4.569, but deleting the invalid diagnoses would have decreased it to 1.863, a difference
19 of 2.706. Under Part C of the Medicare Program, United was paid \$25,202 based on its
20 submission of these invalid diagnoses. Accordingly, Medicare has been damaged by at
21 least that amount (and possibly more under Part D) because of United's failure to delete
22 the invalid diagnoses or otherwise return the overpayments.

23 4. United reviewed the medical records relating to Beneficiary D as part of its Chart
24 Review Program for payment year 2011. The prior year (date of service year 2010), one
25 of Beneficiary D's providers reported diagnoses to United that mapped to HCC 45 for
26 Disorders of Immunity, HCC 83 for Angina Pectoris/Old Myocardial Infarction, and
27 HCC 105 for Vascular Disease. However, the results of United's review of this
28 provider's medical records failed to validate these diagnoses, and no other qualified

1 provider reported these diagnoses (or any other diagnosis that mapped to these HCCs)
2 for this beneficiary for this year. United submitted these invalid diagnoses to the
3 Medicare Advantage Program for risk adjustment payments, and knowingly and
4 improperly failed to delete them. The beneficiary's Part C risk score was originally
5 4.719, but deleting the invalid diagnoses would have decreased it to 3.375, a difference
6 of 1.344. Under Part C of the Medicare Program, United was paid \$14,460 based on its
7 submission of these invalid diagnoses. Accordingly, Medicare has been damaged by that
8 amount because of United's failure to delete the invalid diagnoses or otherwise return the
9 overpayments.

10 5. United reviewed the medical records relating to Beneficiary E as part of its Chart
11 Review Program for payment year 2011. The prior year (date of service year 2010), one
12 of Beneficiary E's providers reported diagnoses to United that mapped to HCC 44 for
13 Severe Hematological Disorders, RxHCC 50 for Aplastic Anemia and Other Significant
14 Blood Disorders, and HCC 45 for Disorders of Immunity. However, the results of
15 United's review of this provider's medical records failed to validate these diagnoses, and
16 no other qualified provider reported these diagnoses (or any other diagnosis that mapped
17 to these HCCs) for this beneficiary for this year. United submitted these invalid
18 diagnoses to the Medicare Advantage Program for risk adjustment payments, and
19 knowingly and improperly failed to delete them. The beneficiary's Part C risk score was
20 originally 3.451, but deleting the invalid diagnoses would have decreased it to .746, a
21 difference of 2.705. Under Part C of the Medicare Program, United was paid \$25,279
22 based on its submission of these invalid diagnoses. Accordingly, Medicare has been
23 damaged by at least that amount (and possibly more under Part D) because of United's
24 failure to delete the invalid diagnoses or otherwise return the overpayments.

25 6. United reviewed the medical records relating to Beneficiary F as part of its Chart
26 Review Program for payment year 2011. The prior year (date of service year 2010), one
27 of Beneficiary F's providers reported diagnoses to United that mapped to HCC 7 for
28 Metastatic Cancer and Acute Leukemia, HCC 15 for Diabetes with Renal or Peripheral

1 Circulatory Manifestation, and RxHCC 14 for Diabetes with Complications. However,
2 the results of United's review of this provider's medical records failed to validate these
3 diagnoses, and no other qualified provider reported these diagnoses (or any other
4 diagnosis that mapped to these HCCs) for this beneficiary for this year. United
5 submitted these invalid diagnoses to the Medicare Advantage Program for risk
6 adjustment payments, and knowingly and improperly failed to delete them. The
7 beneficiary's Part C risk score was originally 2.841, but deleting the invalid diagnoses
8 would have decreased it to .447, a difference of 2.394. Under Part C of the Medicare
9 Program, United was paid \$25,607 based on its submission of these invalid diagnoses.
10 Accordingly, Medicare has been damaged by at least that amount (and possibly more
11 under Part D) because of United's failure to delete the invalid diagnoses or otherwise
12 return the overpayments.

13 7. United reviewed the medical records relating to Beneficiary G as part of its Chart
14 Review Program for payment year 2011. The prior year (date of service year 2010), one
15 of Beneficiary G's providers reported diagnoses to United that mapped to HCC 7 for
16 Metastatic Cancer and Acute Leukemia, HCC 80 for Congestive Heart Failure, and
17 RxHCC 86 for Pulmonary Hypertension and Other Pulmonary Heart Disease. However,
18 the results of United's review of this provider's medical records failed to validate these
19 diagnoses, and no other qualified provider reported these diagnoses (or any other
20 diagnosis that mapped to these HCCs) for this beneficiary for this year. United
21 submitted these invalid diagnoses to the Medicare Advantage Program for risk
22 adjustment payments and knowingly and improperly failed to delete them. The
23 beneficiary's Part C risk score was originally 5.065, but deleting the invalid diagnoses
24 would have decreased it to 1.977, a difference of 3.088. Under Part C of the Medicare
25 Program, United was paid \$27,804 based on its submission of these invalid diagnoses.
26 Accordingly, Medicare has been damaged by at least that amount (and possibly more
27 under Part D) because of United's failure to delete the invalid diagnoses or otherwise
28 return the overpayments.

1 8. United reviewed the medical records relating to Beneficiary H as part of its Chart
2 Review Program for payment year 2011. The prior year (date of service year 2010), one
3 of Beneficiary H's providers reported a diagnosis to United that mapped to HCC 44 and
4 RxHCC 50 for Severe Hematological Disorders. However, the results of United's
5 review of this provider's medical records failed to validate this diagnosis, and no other
6 qualified provider reported this diagnosis (or any other diagnosis that mapped to this
7 HCC) for this beneficiary for this year. The beneficiary's Part C risk score was
8 originally 3.901, but deleting the invalid diagnosis would have decreased it to 2.974, a
9 difference of .927. United submitted this invalid diagnosis to the Medicare Advantage
10 Program for risk adjustment payments, and knowingly and improperly failed to delete it.
11 Under Part C of the Medicare Program, United was paid \$9,582 based on United's
12 submission of the invalid diagnosis mapping to the HCC. Accordingly, Medicare has
13 been damaged by at least that amount (and possibly more under Part D) because of
14 United's failure to delete the invalid diagnosis or otherwise return the overpayments.

15 9. United reviewed the medical records relating to Beneficiary I as part of its Chart
16 Review Program for payment year 2012. The prior year (date of service year 2011), one
17 of Beneficiary I's providers reported diagnoses to United that mapped to HCC 15 and
18 RxHCC 14 for Diabetes with Renal or Peripheral Circulatory Manifestation, HCC 104
19 for Vascular Disease with Complications, HCC 105 and RxHCC 101 for Vascular
20 Disease, and HCC 131 and RxHCC 125 for Renal Failure. However, the results of
21 United's review of this provider's medical records did not support these diagnoses, and
22 no other qualified provider reported these diagnoses (or any other diagnoses mapping to
23 these HCCs) for this beneficiary for this year. United submitted these invalid diagnoses
24 to the Medicare Advantage Program for risk adjustment payments, and knowingly and
25 improperly failed to delete them. The beneficiary's Part C risk score was originally
26 3.174, but deleting the invalid diagnoses would have decreased it to 1.844, a difference
27 of 1.33. Under Part C of the Medicare Program, United was paid \$11,395.92 based on
28 United's submission of the invalid diagnoses. Accordingly, Medicare has been damaged

1 by at least that amount (and possibly more under Part D) because of United's failure to
2 delete the invalid diagnoses or otherwise return the overpayments.

3 10. United reviewed the medical records relating to Beneficiary J as part of its Chart
4 Review Program for payment year 2012. The prior year (date of service year 2011), one
5 of Beneficiary J's providers reported diagnoses to United that mapped to HCC 37 and
6 RxHCC 38 for Bone/Joint/Muscle Infections/Necrosis, HCC 27 and RxHCC 25 for
7 Chronic Hepatitis, HCC 45 for Disorders of Immunity, HCC 108 and RxHCC 104 for
8 Chronic Obstructive Pulmonary Disease, and RxHCC 88 for Hypertension. However,
9 the results of United's review of this provider's medical records did not support these
10 diagnoses, and no other qualified provider reported these diagnoses (or any other
11 diagnoses mapping to these HCCs) for this beneficiary for this year. United submitted
12 these invalid diagnoses to the Medicare Advantage Program for risk adjustment
13 payments, and knowingly and improperly failed to delete them. The beneficiary's Part C
14 risk score was originally 2.544, but deleting the invalid diagnoses would have decreased
15 it to 1.345, a difference of 1.199. Under Part C of the Medicare Program, United was
16 paid \$13,439 based on United's submission of the invalid diagnoses. Accordingly,
17 Medicare has been damaged by at least that amount (and possibly more under Part D)
18 because of United's failure to delete the invalid diagnoses or otherwise return the
19 overpayments

20 11. United reviewed the medical records relating to Beneficiary K as part of its Chart
21 Review Program for payment year 2012. The prior year (date of service year 2011), one
22 of Beneficiary K's providers reported a diagnosis to United that mapped to HCC 7 for
23 Metastatic Cancer and Acute Leukemia. However, the results of United's review of this
24 provider's medical records did not support this diagnosis and no other qualified provider
25 reported this diagnosis (or any other diagnosis mapping to this HCC) for this beneficiary
26 for this year. United submitted this invalid diagnosis to the Medicare Advantage
27 Program for risk adjustment payments, and knowingly and improperly failed to delete it.
28 The beneficiary's Part C risk score was originally 2.83, but deleting the invalid

1 diagnoses would have decreased it to .792, a difference of 2.038. Under Part C of the
2 Medicare Program, United was paid \$22,843.44 based on United's submission of the
3 invalid diagnosis. Accordingly, Medicare has been damaged by that amount because of
4 United's failure to delete the invalid diagnosis or otherwise return the overpayments.

5 12. United reviewed the medical records relating to Beneficiary L as part of its Chart
6 Review Program for payment year 2012. The prior year (date of service year 2011), one
7 of Beneficiary L's providers reported a diagnosis to United that mapped to HCC 157 and
8 RxHCC 45 for Vertebral Fractures w/o Spinal Cord Injury. However, the results of
9 United's review of this provider's medical records did not support this diagnosis (or any
10 other diagnosis mapping to this HCC) for this beneficiary for this year. United
11 submitted this invalid diagnosis to the Medicare Advantage Program for risk adjustment
12 payments, and knowingly and improperly failed to delete it. The beneficiary's Part C
13 risk score was originally 2.541, but deleting the invalid diagnosis would have decreased
14 it to 2.145, a difference of .396. Under Part C of the Medicare Program, United was paid
15 \$3,439 based on United's submission of the invalid diagnosis. Accordingly, Medicare
16 has been damaged by that amount because of United's failure to delete the invalid
17 diagnosis or otherwise return the overpayments.

18 13. United reviewed the medical records relating to Beneficiary M as part of its Chart
19 Review Program for payment year 2012. The prior year (date of service year 2011), one
20 of Beneficiary M's providers reported a diagnosis to United that mapped to HCC 44 and
21 RxHCC 50 for Severe Hematological Disorders. However, the results of United's
22 review of this provider's medical records did not support this diagnosis (or any other
23 diagnosis mapping to this HCC) for this beneficiary for this year. United submitted this
24 invalid diagnosis to the Medicare Advantage Program for risk adjustment payments, and
25 knowingly and improperly failed to delete it. The beneficiary's Part C risk score was
26 originally 2.059, but deleting the invalid diagnosis would have decreased it to .223, a
27 difference of 1.836. Under Part C of the Medicare Program, United was paid \$16,697
28 based on United's submission of the invalid diagnosis. Accordingly, Medicare has been

1 damaged by that amount because of United's failure to delete the invalid diagnosis or
2 otherwise return the overpayments.

3 14. United reviewed the medical records relating to Beneficiary N as part of its Chart
4 Review Program for payment year 2012. The prior year (date of service year 2011), one
5 of Beneficiary N's providers reported a diagnosis to United that mapped to HCC 83 for
6 Angina Pectoris/Old Myocardial Infarction. However, the results of United's review of
7 this provider's medical records did not support this diagnosis (or any other diagnosis
8 mapping to this HCC) for this beneficiary for this year. United submitted this invalid
9 diagnosis to the Medicare Advantage Program for risk adjustment payments, and
10 knowingly and improperly failed to delete it. The beneficiary's Part C risk score was
11 originally 2.16, but deleting the invalid diagnosis would have decreased it to 1.941, a
12 difference of .219. Under Part C of the Medicare Program, United was paid \$1,866
13 based on United's submission of the invalid diagnosis. Accordingly, Medicare has been
14 damaged by that amount because of United's failure to delete the invalid diagnosis or
15 otherwise return the overpayments.

16 15. United reviewed the medical records relating to Beneficiary O as part of its Chart
17 Review Program for payment year 2013. The prior year (date of service year 2012), one
18 of Beneficiary O's providers reported diagnoses to United that mapped to HCC 96 and
19 RxHCC 97 for Ischemic or Unspecified Stroke and HCC 107 and RxHCC 103 for Cystic
20 Fibrosis. However, the results of United's review of this provider's medical records did
21 not support these diagnoses, and no other qualified provider reported these diagnoses (or
22 any other diagnoses that mapped to these HCCs) for this beneficiary for this year.
23 United submitted these invalid diagnoses to the Medicare Advantage Program for risk
24 adjustment payments, and knowingly and improperly failed to delete them. The
25 beneficiary's Part C risk score was originally 4.912, but deleting the invalid diagnoses
26 would have decreased it to 1.758, a difference of 3.154. Under Part C of the Medicare
27 Program, United was paid \$27,200 based on United's submission of the invalid
28 diagnoses. Accordingly, Medicare has been damaged by at least that amount (and

1 possibly more under Part D) because of United's failure to delete the invalid diagnoses
2 or otherwise return the overpayments.

3 16. United reviewed the medical records relating to Beneficiary P as part of its Chart
4 Review Program for payment year 2013. The prior year (date of service year 2012), one
5 of Beneficiary P's providers reported a diagnosis to United that mapped to HCC 44 and
6 RxHCC 50 for Severe Hematological Disorders. However, the results of United's
7 review of this provider's medical records did not support this diagnosis, and no other
8 qualified provider reported this diagnosis (or any other diagnosis that mapped to this
9 HCC) for this beneficiary for this year. United submitted this invalid diagnosis to the
10 Medicare Advantage Program for risk adjustment payments, and knowingly and
11 improperly failed to delete it. The beneficiary's Part C risk score was originally 2.762,
12 but deleting the invalid diagnosis would have decreased it to .442, a difference of 2.32.
13 Under Part C of the Medicare Program, United was paid \$18,030 based on United's
14 submission of the invalid diagnosis. Accordingly, Medicare has been damaged by at
15 least that amount (and possibly more under Part D) because of United's failure to delete
16 the invalid diagnosis or otherwise return the overpayments.

17 17. United reviewed the medical records relating to Beneficiary Q as part of its Chart
18 Review Program for payment year 2013. The prior year (date of service year 2012), one
19 of Beneficiary Q's providers reported a diagnosis to United that mapped to HCC 44 and
20 RxHCC 50 for Severe Hematological Disorders. However, the results of United's
21 review of this provider's medical records did not support this diagnosis, and no other
22 qualified provider reported this diagnosis (or any other diagnosis that mapped to this
23 HCC) for this beneficiary for this year. United submitted this invalid diagnosis to the
24 Medicare Advantage Program for risk adjustment payments, and knowingly and
25 improperly failed to delete it. The beneficiary's Part C risk score was originally 2.594,
26 but deleting the invalid diagnosis would have decreased it to .274, a difference of 2.32.
27 Under Part C of the Medicare Program, United was paid \$22,244 based on United's
28 submission of the invalid diagnosis. Accordingly, Medicare has been damaged by at

1 least that amount (and possibly more under Part D) because of United's failure to delete
2 the invalid diagnosis or otherwise return the overpayments.

3 18. United reviewed the medical records relating to Beneficiary R as part of its Chart
4 Review Program for payment year 2013. The prior year (date of service year 2012), one
5 of Beneficiary R's providers reported diagnoses to United that mapped to HCC 7 and
6 RxHCC 11 for Metastatic Cancer and Acute Leukemia and HCC 10 for Breast, Prostate,
7 Colorectal, and Other Cancers and Tumors. However, the results of United's review of
8 this provider's medical records did not support these diagnoses, and no other qualified
9 provider reported these diagnoses (or any other diagnoses that mapped to these HCCs)
10 for this beneficiary for this year. United submitted these invalid diagnoses to the
11 Medicare Advantage Program for risk adjustment payments, and knowingly and
12 improperly failed to delete them. The beneficiary's Part C risk score was originally
13 2.733, but deleting the invalid diagnoses would have decreased it to .689, a difference of
14 2.044. Under Part C of the Medicare Program, United was paid \$17,349 based on
15 United's submission of the invalid diagnoses. Accordingly, Medicare has been damaged
16 by at least that amount (and possibly more under Part D) because of United's failure to
17 delete the invalid diagnoses or otherwise return the overpayments.

18 19. United reviewed the medical records relating to Beneficiary S as part of its Chart
19 Review Program for payment year 2013. The prior year (date of service year 2012), one
20 of Beneficiary S's providers reported diagnoses to United that mapped to HCC 7 and
21 RxHCC 11 for Metastatic Cancer and Acute Leukemia and HCC 10 and RxHCC 10 for
22 Breast, Prostate, Colorectal, and Other Cancers and Tumors. However, the results of
23 United's review of this provider's medical records did not support these diagnoses, and
24 no other qualified provider reported these diagnoses (or any other diagnosis that mapped
25 to these HCCs) for this beneficiary for this year. United submitted these invalid
26 diagnoses to the Medicare Advantage Program for risk adjustment payments, and
27 knowingly and improperly failed to delete them. The beneficiary's Part C risk score was
28 originally 2.563, but deleting the invalid diagnoses would have decreased it to .52, a

1 difference of 2.043. Under Part C of the Medicare Program, United was paid \$18,961
2 based on United's submission of the invalid diagnoses. Accordingly, Medicare has been
3 damaged by at least that amount (and possibly more under Part D) because of United's
4 failure to delete the invalid diagnoses or otherwise return the overpayments.

5 20. United reviewed the medical records relating to Beneficiary T as part of its Chart
6 Review Program for payment year 2013. The prior year (date of service year 2012), one
7 of Beneficiary T's providers reported diagnoses to United that mapped to HCC 7 and
8 RxHCC 11 for Metastatic Cancer and Acute Leukemia, HCC 80 and RxHCC 87 for
9 Congestive Heart Failure, and RxHCC 20 for Thyroid Disorders. However, the results
10 of United's review of this provider's medical records did not support these diagnoses,
11 and no other qualified provider reported these diagnoses (or any other diagnosis that
12 mapped to these HCCs) for this beneficiary for this year. The beneficiary's Part C risk
13 score was originally 3.217, but deleting the invalid diagnoses would have decreased it to
14 .707, a difference of 2.51. United had submitted these invalid diagnoses to the Medicare
15 Advantage Program for risk adjustment payments, and knowingly and improperly failed
16 to delete them. Under Part C of the Medicare Program, United was paid \$22,760 based
17 on its submission of the invalid diagnoses. Accordingly, Medicare has been damaged by
18 at least that amount (and possibly more under Part D) because of United's failure to
19 delete the invalid diagnoses or otherwise return the overpayments.

20 21. United reviewed the medical records relating to Beneficiary U as part of its Chart
21 Review Program for payment year 2013. The prior year (date of service year 2012), one
22 of Beneficiary U's providers reported a diagnosis to United that mapped to HCC 7 and
23 RxHCC 11 for Metastatic Cancer and Acute Leukemia. However, the results of United's
24 review of this provider's medical records did not support this diagnosis, and no other
25 qualified provider reported this diagnosis (or any other diagnosis that mapped to this
26 HCC) for this beneficiary for this year. United submitted this invalid diagnosis to the
27 Medicare Advantage Program for risk adjustment payments, and knowingly and
28 improperly failed to delete it. The beneficiary's Part C risk score was originally 3.034,

1 but deleting the invalid diagnosis would have decreased it to .99, a difference of 2.044.
2 Under Part C of the Medicare Program, United was paid \$19,008 based on United's
3 submission of the invalid diagnosis. Accordingly, Medicare has been damaged by at
4 least that amount (and possibly more under Part D) because of United's failure to delete
5 the invalid diagnosis or otherwise return the overpayments.

6 22. United reviewed medical records relating to Beneficiary V as part of its Chart
7 Review Program for payment year 2014. The prior year (date of service year 2013), one
8 of beneficiary V's providers reported a diagnosis to United that mapped to HCC 7 (V12)
9 and HCC 8 (V22) for Metastatic Cancer and Acute Leukemia. However, the results of
10 United's review of this provider's medical records failed to validate the diagnosis, and
11 no other qualified provider reported this diagnosis (or any other diagnosis that mapped to
12 these HCCs) for this beneficiary for this year. United submitted this invalid diagnosis to
13 the Medicare Advantage Program for risk adjustment payments, and knowingly and
14 improperly failed to delete it. The beneficiary's Part C risk score was originally 2.63,
15 but deleting the invalid diagnosis would have decreased it to .408, a difference of 2.222.
16 Under Part C of the Medicare Program, United was paid \$22,328 based on its
17 submission of this invalid diagnosis mapping to these HCCs. Accordingly, Medicare has
18 been damaged by that amount because of United's failure to delete the invalid diagnosis
19 or otherwise return the overpayments.

20 23. United reviewed the medical records relating to Beneficiary W as part of its Chart
21 Review Program for payment year 2014. The prior year (date of service year 2013), one
22 of Beneficiary W's providers reported a diagnosis to United that mapped to HCC 7
23 (V12) and HCC 8 (V22) for Metastatic Cancer and Acute Leukemia. However, the
24 results of United's review of this provider's medical records failed to validate this
25 diagnosis and no other qualified provider reported this diagnosis (or any other diagnosis
26 mapping to these HCCs) for this beneficiary for this year. United submitted this invalid
27 diagnosis to the Medicare Advantage Program for risk adjustment payments, and
28 knowing and improperly failed to delete it. The beneficiary's Part C risk score was

1 originally 2.816, but deleting the invalid diagnosis would have decreased it to .594, a
2 difference of 2.222. Under Part C of the Medicare Program, United was paid \$23,166
3 based on its submission of this invalid diagnosis mapping to these HCCs. Accordingly,
4 Medicare has been damaged by that amount because of United's failure to delete the
5 invalid diagnosis or otherwise return the overpayments.

6 24. United reviewed the medical records relating to Beneficiary X as part of its Chart
7 Review Program for payment year 2014. The prior year (date of service year 2013), one
8 of Beneficiary X's providers reported a diagnosis to United that mapped to HCC 7 (V12)
9 and HCC 8 (V22) for Metastatic Cancer and Acute Leukemia. However, the results of
10 United's review of this provider's medical records failed to validate this diagnosis, and
11 no other qualified provider reported this diagnosis (or any other diagnosis that mapped to
12 these HCCs) for this beneficiary for this year. United submitted this invalid diagnosis to
13 the Medicare Advantage Program for risk adjustment payments, and knowingly and
14 improperly failed to delete it. The beneficiary's Part C risk score was originally 2.773,
15 but deleting the invalid diagnosis would have decreased it to .7, a difference of 2.073.
16 Under Part C of the Medicare Program, United was paid \$20,523 based on its
17 submission of this invalid diagnosis mapping to these HCCs. Accordingly, Medicare has
18 been damaged by that amount because of United's failure to delete the invalid diagnosis
19 or otherwise return the overpayments.

20 25. United reviewed the medical records relating to Beneficiary Y as part of its Chart
21 Review Program for payment year 2014. The prior year (date of service year 2013), one
22 of Beneficiary Y's providers reported a diagnosis to United that mapped to HCC 7 (V12)
23 and HCC 8 (V22) for Metastatic Cancer and Acute Leukemia and a diagnosis that
24 mapped to HCC 104 (V12) and HCC 107 (V22) for Vascular Disease with
25 Complications. However, the results of United's review of this provider's medical
26 records failed to validate these diagnoses, and no other qualified provider reported these
27 diagnoses (or any other diagnoses that mapped to these HCCs) for this beneficiary for
28 this year. United submitted these invalid diagnoses to the Medicare Advantage Program

1 for risk adjustment payments, and knowingly and improperly failed to delete them. The
2 beneficiary's Part C risk score was originally 3.289, but deleting the invalid diagnoses
3 would have decreased it to .908, a difference of 2.381. Under Part C of the Medicare
4 Program, United was paid \$21,608 based on its submission of the invalid diagnoses
5 mapping to these HCCs. Accordingly, Medicare has been damaged by that amount
6 because of United's failure to delete the invalid diagnoses or otherwise return the
7 overpayments.

EXHIBIT 14

**Outlier Providers Included in the RACCR Program and
Located in the Central District of California**

A large percentage of the outlier providers reviewed in United's Risk Adjustment Coding and Compliance Reviews ("RACCR") program are located and are serving Medicare beneficiaries in the Central District of California, including:

Access Medical Group Inc.
Alliance Physicians Medical Group
Applecare Medical Group
Axminster Medical Group
Beaver Medical Group
Beaver/Redlands-Yucaipa Medical Group
Bristol Park MG
Choice Medical Group
Choice Physicians Network
Desert Oasis Healthcare
Edinger Medical Group
Facey Medical Foundation
Family Practice Medical Group
Greater Newport Physicians
HCP/MAGAN/PA/Talbert
Hemet Community Medical Group
Heritage Physicians Network/High Desert
Heritage Victor Valley MG
High Desert Medical Group
High Desert Primary Care MG
Lakeside Medical Group

1 Menifee Valley Community Medical Group
2 Monarch Healthcare
3 Pacific IPA
4 Physicians Associates
5 Primecare
6 Prospect/Gateway/Genesis/ProMed
7 Redlands – Yuca IPA MG
8 Regal Medical Group
9 Riverside Medical Center
10 San Bernardino Medical Group
11 Santa Barbara Select IPA
12 St. Vincent Medical Group IPA
13 Talbert MG
14 UCLA Medical Group/IPA
15 United Family Care
16 Valley Care IPA

EXHIBIT 15

Outlier Provider Groups That Failed RACCR Sample Reviews and Never Conducted 100% Reviews

2008 Date of Service (2009 Payment Year)¹			
Provider Group	HCC	Sample Size	Sample Validation %
Edinger Medical Group	069	47	0.00%
Edinger Medical Group	071	70	60.00%
Edinger Medical Group	101	49	32.65%
Edinger Medical Group	164	57	10.53%
Las Vegas Summit Network	021	15	73.33%
New West Physicians	015	67	17.91%
St. Anthony's Health Services	131	30	80.00%

2009 Date of Service (2010 Payment Year)				
Provider Group	HCC	Sample Size	Sample Validation %	# of Beneficiaries Not Reviewed
Beaver Redlands-Yucaipa Medical Group	052	28	67.86%	142
Cedar Hill Family Medicine	105	68	79.41%	129
Edinger Medical Group	069	49	4.08%	5
Edinger Medical Group	071	70	64.29%	128
Edinger Medical Group	111	29	10.34%	4

¹ The exact number of beneficiaries not included in the 100% reviews for these HCCs for 2008 DOS is unknown at this time.

HealthCarePartners	112	40	12.50%	224
Heritage Physicians Network/ High Desert	132	30	80.00%	46
Patients First Health Care LLC	015	16	62.50%	846
Primecare	015	20	10.00%	788
Primecare	071	33	51.52%	876

2010 Date of Service (2011 Payment Year)				
Provider Group	HCC	Sample Size	Sample Validation %	# of Beneficiaries Not Reviewed
Beaver Redlands-Yucaipa Medical Group	052	30	73.33%	7
Beaver Redlands-Yucaipa Medical Group	055	30	70.00%	129
Beaver Redlands-Yucaipa Medical Group	112	30	16.67%	18
Chinese American Independent Practice	027	29	58.62%	283
Edinger Medical Group	007	27	37.04%	5
Edinger Medical Group	069	28	0.00%	23
Edinger Medical Group	100	29	55.17%	2
Edinger Medical Group	164	26	15.38%	21
HealthCarePartners	051	30	6.67%	91
HealthCarePartners	101	12	50.00%	215
HealthCarePartners	112	7	57.14%	83

HealthCarePartners	157	15	66.67%	1,208
Monarch Healthcare	101	30	40.00%	4
Monarch Healthcare	157	29	24.14%	62
Primecare	071	28	50.00%	15
Sharp-Rees Stealy Medical	052	30	80.00%	1,664
Sharp-Rees Stealy Medical	157	30	46.67	476
UCLA Medical Group IPA	132	30	76.67%	33
WellMed//PIPA	045	30	33.33%	140
WellMed//PIPA	080	30	56.67%	250
WellMed//PIPA	119	28	60.71%	157
WellMed//PIPA	164	30	10.00%	7

2011 Date of Service (2012 Payment Year)				
Provider Group	HCC	Sample Size	Sample Validation %	# of Beneficiaries Not Reviewed
Chinese American Independent Practice	027	49	30.61%	236
Chinese American Independent Practice	045	50	0.00%	63
Edinger Medical Group	069	2	0.00%	4
Edinger Medical Group	111	3	33.33%	3
Edinger Medical Group	164	14	14.29%	18
Erickson	010	39	61.54%	449
Erickson	096	33	24.24%	193

Erickson	158	42	59.52%	88
St. Anthony's Health Services	079	50	72.00%	295
West Pasco Risk	037	31	16.13%	18

2012 Date of Service (2013 Payment Year)				
Provider Group	HCC	Sample Size	Sample Validation %	# of Beneficiaries Not Reviewed
Beaver Medical Group	112	10	30.00%	41
BIDPO	018	40	55.00%	23
Chinese American Independent Practice	027	13	76.92%	302
Coastal Community Physicians Network	079	44	75.00%	63
Coastal Community Physicians Network	157	39	30.77%	68
Erickson	010	46	50.00%	405
HealthCarePartners	045	47	70.21%	341
HealthCarePartners	051	35	57.14%	302
HealthCarePartners	074	43	74.42%	693
HealthCarePartners	112	36	50.00%	229
HealthCarePartners	119	45	77.78%	414
HealthCarePartners	157	44	43.18%	1,995
Health Texas Medical Group	021	49	77.55%	741
Health Texas Medical Group	161	8	0.00%	3

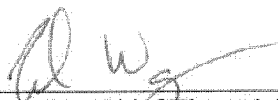
Hemet Community Medical Group	069	12	50.00%	2
Highline MSO (CMG)	018	41	34.15%	78
Imperial City County Physicians Medical Group	018	10	80.00%	49
Independent Physicians Network	015	49	14.29%	53
Monarch Healthcare	157	35	28.57%	193
Pacific IPA	027	28	75.00%	10
Primecare	104	30	46.67%	163
Santa Barbara Select IPA	104	33	6.06%	14
Santa Barbara Select IPA	131	47	59.57%	678
Santa Clara County IPA	018	24	33.33%	35
Sharp-Rees Stealy Medical	157	49	46.94%	521
SLO Select IPA SO County	069	12	16.67%	4
St. Vincent Medical Group IPA	021	28	67.86%	20
Texas Health Medical Group (FKA Medical Edge)	069	35	37.14%	83
WellMed//PIPA	045	43	51.16%	746
WellMed//PIPA	111	44	15.91%	201
WellMed//PIPA	157	46	56.52%	539

EXHIBIT 16

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contracts between the Centers for Medicare & Medicaid Services (CMS) and the UnitedHealth Group affiliate listed in Attachment 1, hereafter referred to as the MA Organization, governing the operation of the Medicare Advantage and Medicare Advantage-Prescription Drug plans listed in Attachment 1, the MA Organization hereby requests payment under the contract and, in doing so, makes the following attestation concerning CMS payments to the MA Organization.* The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS for the period of January 1, 2008 to December 31, 2008 all risk adjustment data available to the MA Organization as of December 31, 2008, with respect to the MA and MA-PD plans listed in Attachment 1. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.



John Way, Chief Financial Officer, SecureHorizons
On behalf of the UnitedHealth Group
entities listed in Attachment 1

3/19/09

DATE

* This Certification is based on facts reasonably available or made available to the MA Organization as of the date of this Certification and is not to be construed as a representation by the entities listed in Attachment 1, their affiliates, officers, representatives, or agents that the data to which the Certification relate may not require subsequent modification should additional information become available. Best knowledge, information, and belief means based on normal business practices. In addition, the scope of this Certification does not include risk adjustment data related to "long-term institutionalized" or "community," which the MA Organization is not required to report to or otherwise verify for CMS. Such designations are made by CMS based on a CMS data source and are subject to reconciliation by CMS in accordance with Section 91.4.2 of Chapter 7 of the Medicare Managed Care Manual. As previously communicated to CMS, we believe these designations are materially inaccurate. However, we acknowledge CMS' position that such designations are generally accurate.

Attachment 1

<u>Contract</u>	<u>Contracting Party</u>
H0151	United HealthCare of Alabama, Inc.
H0303	PacifiCare of Arizona, Inc.
H0316	United HealthCare of Arizona Inc.
H0401	United HealthCare of Arkansas, Inc.
H0543	PacifiCare of California
H0609	PacifiCare of Colorado, Inc.
H0752	Oxford Health Plans (CT), Inc.
H1080	United HealthCare of Florida, Inc.
H1111	United HealthCare of Georgia, Inc.
H1303	United HealthCare Insurance Company
H1509	United HealthCare Insurance Company
H1717	United HealthCare Insurance Company
H2001	United HealthCare Insurance Company
H2408	United HealthCare Insurance Company
H2654	United HealthCare of the Midwest, Inc.
H2802	United HealthCare of the Midlands, Inc.
H2803	United HealthCare Insurance Company
H2949	PacifiCare of Nevada, Inc.
H3107	Oxford Health Plans (NJ), Inc.
H3307	Oxford Health Plans (NY) Inc.
H3379	United HealthCare of New York, Inc.
H3456	United HealthCare of North Carolina, Inc.
H3659	United HealthCare of Ohio, Inc.
H3749	PacifiCare of Oklahoma, Inc.
H3805	PacifiCare of Oregon, Inc.
H3812	United HealthCare Insurance Company
H3921	United HealthCare Insurance Company
H4102	United HealthCare of New England, Inc.
H4406	United HealthCare of Tennessee, Inc.
H4456	United HealthCare Plan of the River Valley, Inc.
H4522	United HealthCare Insurance Company
H4590	PacifiCare of Texas, Inc.
H4604	United HealthCare of Utah
H4720	United HealthCare Insurance Company of New York
H5005	PacifiCare of Washington, Inc.
H5253	United HealthCare of Wisconsin, Inc.
H5417	United HealthCare Insurance Company
H5424	United HealthCare Insurance Company
H5435	PacifiCare Life & Health Insurance Company
H5507	United HealthCare Insurance Company
H5516	United HealthCare Insurance Company
H5532	United HealthCare Insurance Company
H9011	United HealthCare of Florida Inc.
R3175	United HealthCare Insurance Company
R5287	United HealthCare Insurance Company
R5342	United HealthCare Insurance Company of New York

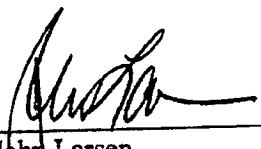
Annual Risk Adjustment Attestation/SecureHorizons

EXHIBIT 17

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contracts between the Centers for Medicare & Medicaid Services (CMS) and the UnitedHealth Group affiliate listed in Attachment 1, hereafter referred to as the MA Organization, governing the operation of the Medicare Advantage and Medicare Advantage-Prescription Drug plans listed in Attachment 1, the MA Organization hereby requests payment under the contract and, in doing so, makes the following attestation concerning CMS payments to the MA Organization.* The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS for the period of January 1, 2009 to December 31, 2009 all risk adjustment data for 2009 dates of service available to the MA Organization as of December 31, 2009, with respect to the MA and MA-PD plans listed in Attachment 1. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in such report and not subsequently deleted prior to the date hereof is accurate, complete, and truthful.


NAME: John Larsen
TITLE: Chief Financial Officer,
Public & Senior Markets Group
On behalf of the UnitedHealth Group
entities listed in Attachment 1

3/26/10
DATE

* This Certification is based on facts reasonably available or made available to the MA Organization as of the date of this Certification and is not to be construed as a representation by the entities listed in Attachment 1, their affiliates, officers, representatives, or agents that the data to which the Certification relate may not require subsequent modification should additional information become available. Best knowledge, information, and belief means based on normal business practices. In addition, the scope of this Certification does not include risk adjustment data related to "long-term institutionalized" or "community," which the MA Organization is not required to report to or otherwise verify for CMS. Such designations are made by CMS based on a CMS data source and are subject to reconciliation by CMS in accordance with Section 91.4.2 of Chapter 7 of the Medicare Managed Care Manual. As previously communicated to CMS, we believe these designations are materially inaccurate. However, we acknowledge CMS' position that such designations are generally accurate.

U-07155

Annual Risk Adjustment Attestation/United Medicare

Attachment 1
Page 1 of 2

<u>Contract</u>	<u>Contracting Party</u>
H0151	United HealthCare of Alabama, Inc.
H0251	United HealthCare Plan of the River Valley, Inc.
H0303	PacifiCare of Arizona, Inc
H0316	United HealthCare of Arizona Inc
H0321	Arizona Physicians IPA, Inc.
H0401	United HealthCare of Arkansas, Inc.
H0408	United HealthCare Insurance Company
H0410	United HealthCare Insurance Company
H0543	PacifiCare of California
H0609	PacifiCare of Colorado, Inc.
H0620	United HealthCare Insurance Company
H0624	United HealthCare Insurance Company
H0710	United HealthCare Insurance Company
H0752	Oxford Health Plans (CT), Inc.
H1080	United HealthCare of Florida, Inc.
H1108	United HealthCare Insurance Company
H1111	United Healthcare of Georgia, Inc.
H1286	United HealthCare Insurance Company
H1303	United HealthCare Insurance Company
H1509	United HealthCare Insurance Company
H1717	United HealthCare Insurance Company
H1944	United HealthCare Insurance Company
H2001	United HealthCare Insurance Company
H2003	United HealthCare Insurance Company
H2011	United HealthCare Insurance Company
H2182	United HealthCare Insurance Company
H2226	United HealthCare Insurance Company
H2228	United HealthCare Insurance Company
H2406	United HealthCare Insurance Company
H2654	United HealthCare of the Midwest, Inc.
H2802	United HealthCare of the Midlands, Inc.
H2803	United HealthCare Insurance Company
H2905	-Sierra Health and Life Insurance Company, Inc.
H2931	Health Plan Of Nevada, Inc
H2961	Health Plan of Nevada, Inc.
H3107	Oxford Health Plans (NJ), Inc.
H3113	Oxford Health Plans (NJ), Inc.
H3164	AmeriChoice Of New Jersey, Inc.
H3209	United HealthCare Insurance Company
H3307	Oxford Health Plans (NY) Inc.
H3379	United HealthCare of New York, Inc.
H3387	United HealthCare of New York, Inc.
H3456	United HealthCare of North Carolina, Inc.

U-07156

Annual Risk Adjustment Attestation/United Medicare

Attachment 1
Page 2 of 2

<u>Contract</u>	<u>Contracting Party</u>
H3659	United HealthCare of Ohio, Inc.
H3749	PacifiCare of Oklahoma, Inc.
H3805	PacifiCare of Oregon, Inc.
H3812	United HealthCare Insurance Company
H3887	United HealthCare Insurance Company
H3912	United HealthCare Insurance Company
H3921	United HealthCare Insurance Company
H4102	United HealthCare of New England, Inc.
H4106	United HealthCare Insurance Company
H4406	United HealthCare of Tennessee, Inc.
H4449	Sierra Health and Life Insurance Company, Inc.
H4514	Evercare of Texas, LLC
H4456	United HealthCare Plan of the River Valley, Inc.
H4522	United HealthCare Insurance Company
H4590	PacifiCare of Texas, Inc.
H4604	United HealthCare of Utah
H4720	United HealthCare Insurance Company of New York
H4837	United HealthCare of Wisconsin
H4971	United HealthCare Insurance Company
H5005	PacifiCare of Washington, Inc.
H5008	United HealthCare Insurance Company
H5253	United HealthCare of Wisconsin, Inc
H5417	United HealthCare Insurance Company
H5424	United HealthCare Insurance Company
H5435	PacifiCare Life & Health Insurance Company
H5440	United HealthCare Insurance Company
H5507	United HealthCare Insurance Company
H5516	United HealthCare Insurance Company
H5532	United HealthCare Insurance Company
H5678	United HealthCare Insurance Company
H5697	United HealthCare Insurance Company
H5749	United HealthCare Insurance Company
H5754	United HealthCare Insurance Company
H5918	United HealthCare Insurance Company
H6228	United HealthCare Insurance Company
H6793	United HealthCare Insurance Company
H6952	Great Lakes Health Plan, Inc.
H7187	United HealthCare Insurance Company
H7949	PacifiCare Of Nevada, Inc.
H8748	United HealthCare Insurance Company
H9011	United HealthCare of Florida Inc.
H9149	United HealthCare Insurance Company
R3175	United HealthCare Insurance Company

U-07157

Attachment 1
Page 3 of 2

<u>Contract</u>	<u>Contracting Party</u>
R5287	United HealthCare Insurance Company
R5342	United HealthCare Insurance Company of New York
R5674	Sierra Health and Life Insurance Company, Inc.
R7444	United HealthCare Insurance Company

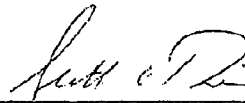
U-07158

EXHIBIT 18

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contracts between the Centers for Medicare & Medicaid Services (CMS) and the UnitedHealth Group affiliate listed in Attachment 1, hereafter referred to as the MA Organization, governing the operation of the Medicare Advantage and Medicare Advantage-Prescription Drug plans listed in Attachment 1, the MA Organization hereby requests payment under the contract and, in doing so, makes the following attestation concerning CMS payments to the MA Organization.* The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS for the period of January 1, 2010 to December 31, 2010 all risk adjustment data for 2010 dates of service available to the MA Organization as of December 31, 2010, with respect to the MA and MA-PD plans listed in Attachment 1. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in such report and not subsequently deleted prior to the date hereof is accurate, complete, and truthful.**



NAME: Scott Theisen

TITLE: Chief Financial Officer,

UnitedHealthcare Medicare & Retirement

On behalf of the UnitedHealth Group

entities listed in Attachment 1

3-25-11

DATE

* This Certification is based on facts reasonably available or made available to the MA Organization as of the date of this Certification and is not to be construed as a representation by the entities listed in Attachment 1, their affiliates, officers, representatives, or agents that the data to which the Certification relate may not require subsequent modification should additional information become available. Best knowledge, information, and belief means based on normal business practices. In addition, the scope of this Certification does not include risk adjustment data related to "long-term institutionalized" or "community," which the MA Organization is not required to report to or otherwise verify for CMS. Such designations are made by CMS based on a CMS data source and are subject to reconciliation by CMS in accordance with Section 91.4.2 of Chapter 7 of the Medicare Managed Care Manual. As previously communicated to CMS, we believe these designations are materially inaccurate. However, we acknowledge CMS' position that such designations are generally accurate.

** The MA Organization is engaged in a review of its risk adjustment processes and submission system. This review has identified areas for improvement and we will likely need to delete certain risk adjustment data for 2010 dates of service. The MA organization will delete any risk adjustment data for 2010 dates of service determined through this review to have been inappropriately submitted.

U-09710

Attachment 1
Page 1

Contract Number	Legal Entity Name
H0151	UNITEDHEALTHCARE OF ALABAMA, INC.
H0303	PACIFICARE OF ARIZONA, INC
H0316	UNITEDHEALTHCARE OF ARIZONA, INC.
H0319	UNITEDHEALTHCARE INSURANCE COMPANY
H0401	UNITEDHEALTHCARE OF ARKANSAS, INC.
H0408	UNITEDHEALTHCARE INSURANCE COMPANY
H0410	UNITEDHEALTHCARE INSURANCE COMPANY
H0543	PACIFICARE OF CALIFORNIA
H0609	PACIFICARE OF COLORADO, INC
H0620	UNITEDHEALTHCARE INSURANCE COMPANY
H0624	UNITEDHEALTHCARE INSURANCE COMPANY
H0710	UNITEDHEALTHCARE INSURANCE COMPANY
H0752	OXFORD HEALTH PLANS (CT), INC.
H0755	OXFORD HEALTH PLANS (CT), INC.
H1080	UNITEDHEALTHCARE OF FLORIDA, INC.
H1108	UNITEDHEALTHCARE INSURANCE COMPANY
H1111	UNITEDHEALTHCARE OF GEORGIA, INC.
H1286	UNITEDHEALTHCARE INSURANCE COMPANY
H1303	UNITEDHEALTHCARE INSURANCE COMPANY
H1509	UNITEDHEALTHCARE INSURANCE COMPANY
H1717	UNITEDHEALTHCARE INSURANCE COMPANY
H1944	UNITEDHEALTHCARE INSURANCE COMPANY
H2001	UNITEDHEALTHCARE INSURANCE COMPANY
H2111	UNITEDHEALTHCARE INSURANCE COMPANY
H2182	UNITEDHEALTHCARE INSURANCE COMPANY
H2226	UNITEDHEALTHCARE INSURANCE COMPANY
H2228	UNITEDHEALTHCARE INSURANCE COMPANY
H2406	UNITEDHEALTHCARE INSURANCE COMPANY
H2654	UNITEDHEALTHCARE OF THE MIDWEST, INC.

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Page 2

H2802	UNITEDHEALTHCARE OF THE MIDLANDS, INC.
H2803	UNITEDHEALTHCARE INSURANCE COMPANY
H2905	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
H2931	HEALTH PLAN OF NEVADA, INC.
H2961	HEALTH PLAN OF NEVADA, INC.
H3107	OXFORD HEALTH PLANS (NJ), INC.
H3113	OXFORD HEALTH PLANS (NJ), INC.
H3307	OXFORD HEALTH PLANS (NY), INC.
H3379	UNITEDHEALTHCARE OF NEW YORK, INC.
H3435	UNITEDHEALTHCARE INSURANCE COMPANY
H3456	UNITEDHEALTHCARE OF NORTH CAROLINA, INC.
H3659	UNITEDHEALTHCARE OF OHIO, INC.
H3749	PACIFICARE OF OKLAHOMA, INC.
H3805	PACIFICARE OF OREGON, INC.
H3812	UNITEDHEALTHCARE INSURANCE COMPANY
H3887	UNITEDHEALTHCARE INSURANCE COMPANY
H3912	UNITEDHEALTHCARE INSURANCE COMPANY
H3921	UNITEDHEALTHCARE INSURANCE COMPANY
H4102	UNITEDHEALTHCARE OF NEW ENGLAND, INC.
H4106	UNITEDHEALTHCARE INSURANCE COMPANY
H4406	UNITEDHEALTHCARE OF TENNESSEE, INC.
H4449	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
H4456	UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.
H4514	EVERCARE OF TEXAS, LLC
H4522	UNITEDHEALTHCARE INSURANCE COMPANY
H4590	PACIFICARE OF TEXAS, INC.
H4604	UNITEDHEALTHCARE OF UTAH, INC.
H4720	UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
H4779	UNITEDHEALTHCARE INSURANCE COMPANY
H4971	UNITEDHEALTHCARE INSURANCE COMPANY
H5005	PACIFICARE OF WASHINGTON, INC.
H5008	UNITEDHEALTHCARE INSURANCE COMPANY

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Attachment 1
Page 3

H5253	UNITEDHEALTHCARE OF WISCONSIN, INC
H5417	UNITEDHEALTHCARE INSURANCE COMPANY
H5424	UNITEDHEALTHCARE INSURANCE COMPANY
H5435	UNITEDHEALTHCARE INSURANCE COMPANY
H5440	UNITEDHEALTHCARE INSURANCE COMPANY
H5507	UNITEDHEALTHCARE INSURANCE COMPANY
H5516	UNITEDHEALTHCARE INSURANCE COMPANY
H5532	UNITEDHEALTHCARE INSURANCE COMPANY
H5652	UNITEDHEALTHCARE INSURANCE COMPANY
H5678	UNITEDHEALTHCARE INSURANCE COMPANY
H5697	UNITEDHEALTHCARE INSURANCE COMPANY
H5749	UNITEDHEALTHCARE INSURANCE COMPANY
H5754	UNITEDHEALTHCARE INSURANCE COMPANY
H5918	UNITEDHEALTHCARE INSURANCE COMPANY
H6228	UNITEDHEALTHCARE INSURANCE COMPANY
H6793	UNITEDHEALTHCARE INSURANCE COMPANY
H7187	UNITEDHEALTHCARE INSURANCE COMPANY
H7949	PACIFICARE OF NEVADA, INC. UNITEDHEALTHCARE INSURANCE COMPANY
H8748	UNITEDHEALTHCARE OF FLORIDA, INC.
H9011	UNITEDHEALTHCARE INSURANCE COMPANY
H9149	UNITEDHEALTHCARE INSURANCE COMPANY
R3175	UNITEDHEALTHCARE INSURANCE COMPANY
R5287	UNITEDHEALTHCARE INSURANCE COMPANY
R5342	UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
R5674	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
R7444	UNITEDHEALTHCARE INSURANCE COMPANY

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EXHIBIT 19

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contracts between the Centers for Medicare & Medicaid Services (CMS) and the UnitedHealth Group affiliates listed in Attachment 1, hereafter referred to as the MA Organization, governing the operation of the Medicare Advantage and Medicare Advantage-Prescription Drug plans listed in Attachment 1, the MA Organization hereby requests payment under the contract and, in doing so, makes the following attestation concerning CMS payments to the MA Organization.* The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS for the period of January 1, 2010 to December 31, 2010, all risk adjustment data for 2010 dates of service available to the MA Organization as of January 31, 2012, with respect to the MA and MA-PD plans listed in Attachment 1. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in such report and not subsequently deleted prior to the date hereof is accurate, complete, and truthful.**



NAME: Scott Theisen
TITLE: Chief Financial Officer,
UnitedHealthcare Medicare & Retirement
On behalf of the UnitedHealth Group
entities listed in Attachment 1

3 - 9 - 12

DATE

* This Certification is based on facts reasonably available or made available to the MA Organization as of the date of this Certification and is not to be construed as a representation by the entities listed in Attachment 1, their affiliates, officers, representatives, or agents that the data to which the Certification relate may not require subsequent modification should additional information become available. Best knowledge, information, and belief means based on normal business practices.

** The MA Organization is engaged in a review of its risk adjustment processes and submission system. This review has identified areas for improvement and, as a result, we will be deleting all risk adjustment data for 2010 dates of service that, to our knowledge, were inappropriately submitted.

Protected From Disclosure Under Federal Law.

Exempt from the Freedom of Information Act. See 5 U.S.C. §552(b).

Contains Confidential Commercial/Financial and Other Protected Information.

Contract Number	Legal Entity Name
Medicare & Retirement	
H0151	UNITEDHEALTHCARE OF ALABAMA, INC.
H0303	PACIFICARE OF ARIZONA, INC
H0316	UNITEDHEALTHCARE OF ARIZONA, INC.
H0319	UNITEDHEALTHCARE INSURANCE COMPANY
H0401	UNITEDHEALTHCARE OF ARKANSAS, INC.
H0408	UNITEDHEALTHCARE INSURANCE COMPANY
H0410	UNITEDHEALTHCARE INSURANCE COMPANY
H0543	PACIFICARE OF CALIFORNIA
H0609	PACIFICARE OF COLORADO, INC
H0620	UNITEDHEALTHCARE INSURANCE COMPANY
H0624	UNITEDHEALTHCARE INSURANCE COMPANY
H0710	UNITEDHEALTHCARE INSURANCE COMPANY
H0752	OXFORD HEALTH PLANS (CT), INC.
H1080	UNITEDHEALTHCARE OF FLORIDA, INC.
H1108	UNITEDHEALTHCARE INSURANCE COMPANY
H1111	UNITEDHEALTHCARE OF GEORGIA, INC.
H1286	UNITEDHEALTHCARE INSURANCE COMPANY
H1303	UNITEDHEALTHCARE INSURANCE COMPANY
H1509	UNITEDHEALTHCARE INSURANCE COMPANY
H1717	UNITEDHEALTHCARE INSURANCE COMPANY
H1944	UNITEDHEALTHCARE INSURANCE COMPANY
H2001	UNITEDHEALTHCARE INSURANCE COMPANY
H2111	UNITEDHEALTHCARE INSURANCE COMPANY
H2182	UNITEDHEALTHCARE INSURANCE COMPANY
H2226	UNITEDHEALTHCARE INSURANCE COMPANY
H2228	UNITEDHEALTHCARE INSURANCE COMPANY
H2406	UNITEDHEALTHCARE INSURANCE COMPANY
H2654	UNITEDHEALTHCARE OF THE MIDWEST, INC.
H2802	UNITEDHEALTHCARE OF THE MIDLANDS, INC.
H2803	UNITEDHEALTHCARE INSURANCE COMPANY
H3107	OXFORD HEALTH PLANS (NJ), INC.
H3113	OXFORD HEALTH PLANS (NJ), INC.
H3209	UNITEDHEALTHCARE INSURANCE COMPANY
H3307	OXFORD HEALTH PLANS (NY), INC.
H3379	UNITEDHEALTHCARE OF NEW YORK, INC.
H3435	UNITEDHEALTHCARE INSURANCE COMPANY
H3456	UNITEDHEALTHCARE OF NORTH CAROLINA, INC.
H3659	UNITEDHEALTHCARE OF OHIO, INC.
H3749	PACIFICARE OF OKLAHOMA, INC.
H3805	PACIFICARE OF OREGON, INC.
H3812	UNITEDHEALTHCARE INSURANCE COMPANY
H3887	UNITEDHEALTHCARE INSURANCE COMPANY
H3921	UNITEDHEALTHCARE INSURANCE COMPANY
H4102	UNITEDHEALTHCARE OF NEW ENGLAND, INC.
H4106	UNITEDHEALTHCARE INSURANCE COMPANY
H4406	UNITEDHEALTHCARE OF TENNESSEE, INC.
H4456	UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.

H4514	EVERCARE OF TEXAS, LLC
H4522	UNITEDHEALTHCARE INSURANCE COMPANY
H4590	PACIFICARE OF TEXAS, INC.
H4604	UNITEDHEALTHCARE OF UTAH, INC.
H4720	UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
H4779	UNITEDHEALTHCARE INSURANCE COMPANY
H4971	UNITEDHEALTHCARE INSURANCE COMPANY
H5005	PACIFICARE OF WASHINGTON, INC.
H5008	UNITEDHEALTHCARE INSURANCE COMPANY
H5253	UNITEDHEALTHCARE OF WISCONSIN, INC
H5417	UNITEDHEALTHCARE INSURANCE COMPANY
H5424	UNITEDHEALTHCARE INSURANCE COMPANY
H5435	UNITEDHEALTHCARE INSURANCE COMPANY
H5440	UNITEDHEALTHCARE INSURANCE COMPANY
H5507	UNITEDHEALTHCARE INSURANCE COMPANY
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H6228	UNITEDHEALTHCARE INSURANCE COMPANY
H6793	UNITEDHEALTHCARE INSURANCE COMPANY
H7187	UNITEDHEALTHCARE INSURANCE COMPANY
H7949	PACIFICARE OF NEVADA, INC.
H8748	UNITEDHEALTHCARE INSURANCE COMPANY
H9011	UNITEDHEALTHCARE OF FLORIDA, INC.
H9149	UNITEDHEALTHCARE INSURANCE COMPANY
R3175	UNITEDHEALTHCARE INSURANCE COMPANY
R5287	UNITEDHEALTHCARE INSURANCE COMPANY
R5342	UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
R7444	UNITEDHEALTHCARE INSURANCE COMPANY
S5805	UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
S5820	UNITEDHEALTHCARE INSURANCE COMPANY
S5917	UNITEDHEALTHCARE INSURANCE COMPANY
S5921	UNITEDHEALTHCARE INSURANCE COMPANY
Sierra	
H2905	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
H2931	HEALTH PLAN OF NEVADA, INC.
H2961	HEALTH PLAN OF NEVADA, INC.
H4449	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
R5674	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
PHC/Citrus	
H5407	CITRUS HEALTH CARE, INC.
H4527	PHYSICIANS HEALTH CHOICE OF TEXAS LLC
H3059	PHYSICIANS HEALTH CHOICE OF NEW MEXICO
H6120	PHYSICIANS HEALTH CHOICE OF FLORIDA
H7252	PHYSICIANS HEALTH CHOICE OF ARKANSAS

EXHIBIT 20

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contracts between the Centers for Medicare & Medicaid Services (CMS) and the UnitedHealth Group affiliates listed in Attachment 1, hereafter referred to as the MA Organization, governing the operation of the Medicare Advantage and Medicare Advantage-Prescription Drug plans listed in Attachment 1, the MA Organization hereby requests payment under the contract and, in doing so, makes the following attestation concerning CMS payments to the MA Organization.* The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS for the period of January 1, 2011 to December 31, 2011, all risk adjustment data for 2011 dates of service available to the MA Organization as of January 31, 2013, with respect to the MA and MA-PD plans listed in Attachment 1. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in such report and not subsequently deleted prior to the date hereof is accurate, complete, and truthful.**



NAME: Scott Theisen
TITLE: Chief Financial Officer,
UnitedHealthcare Medicare & Retirement
On behalf of the UnitedHealth Group
entities listed in Attachment A

4-9-13

DATE

* This Certification is based on facts reasonably available or made available to the MA Organization as of the date of this Certification and is not to be construed as a representation by the entities listed in Attachment 1, their affiliates, officers, representatives, or agents that the data to which the Certification relate may not require subsequent modification should additional information become available. Best knowledge, information, and belief means based on normal business practices.

** The MA Organization is engaged in a review of its risk adjustment processes and submission system. This review has identified areas for improvement and, as a result, we will be deleting all risk adjustment data for 2011 dates of service that, to our knowledge, were inappropriately submitted.

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H0316	UNITEDHEALTHCARE OF ARIZONA, INC.
H0319	UNITEDHEALTHCARE INSURANCE COMPANY
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H0543	PACIFICARE OF CALIFORNIA
H0609	PACIFICARE OF COLORADO, INC
H0620	UNITEDHEALTHCARE INSURANCE COMPANY
H0624	UNITEDHEALTHCARE INSURANCE COMPANY
H0755	OXFORD HEALTH PLANS (CT), INC.
H0710	UNITEDHEALTHCARE INSURANCE COMPANY
H0752	OXFORD HEALTH PLANS (CT), INC.
H1080	UNITEDHEALTHCARE OF FLORIDA, INC.
H1108	UNITEDHEALTHCARE INSURANCE COMPANY
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H1286	UNITEDHEALTHCARE INSURANCE COMPANY
H1303	UNITEDHEALTHCARE INSURANCE COMPANY
H1509	UNITEDHEALTHCARE INSURANCE COMPANY
H1717	UNITEDHEALTHCARE INSURANCE COMPANY
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H2228	UNITEDHEALTHCARE INSURANCE COMPANY
H2406	UNITEDHEALTHCARE INSURANCE COMPANY
H2654	UNITEDHEALTHCARE OF THE MIDWEST, INC.
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H3307	OXFORD HEALTH PLANS (NY), INC.
H3379	UNITEDHEALTHCARE OF NEW YORK, INC.
H3456	UNITEDHEALTHCARE OF NORTH CAROLINA, INC.
H3659	UNITEDHEALTHCARE OF OHIO, INC.
H3749	PACIFICARE OF OKLAHOMA, INC.
H3805	PACIFICARE OF OREGON, INC.
H3812	UNITEDHEALTHCARE INSURANCE COMPANY
H3887	UNITEDHEALTHCARE INSURANCE COMPANY
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H3921	UNITEDHEALTHCARE INSURANCE COMPANY
H4102	UNITEDHEALTHCARE OF NEW ENGLAND, INC.
H4406	UNITEDHEALTHCARE OF TENNESSEE, INC.
H4456	UNITEDHEALTHCARE PLAN OF THE RIVER VALLEY, INC.
H4514	EVERCARE OF TEXAS, LLC
H4522	UNITEDHEALTHCARE INSURANCE COMPANY
H4590	PACIFICARE OF TEXAS, INC.

Medicare Retirement

H4604	UNITEDHEALTHCARE OF UTAH, INC.
H4971	UNITEDHEALTHCARE INSURANCE COMPANY
H5005	PACIFICARE OF WASHINGTON, INC.
H5008	UNITEDHEALTHCARE INSURANCE COMPANY
H5253	UNITEDHEALTHCARE OF WISCONSIN, INC.
H5417	UNITEDHEALTHCARE INSURANCE COMPANY
H5424	UNITEDHEALTHCARE INSURANCE COMPANY
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H5652	UNITEDHEALTHCARE INSURANCE COMPANY
H5749	UNITEDHEALTHCARE INSURANCE COMPANY
H7187	UNITEDHEALTHCARE INSURANCE COMPANY
H7949	PACIFICARE OF NEVADA, INC.
H8748	UNITEDHEALTHCARE INSURANCE COMPANY
H9011	UNITEDHEALTHCARE OF FLORIDA, INC.
R3175	UNITEDHEALTHCARE INSURANCE COMPANY
R5287	UNITEDHEALTHCARE INSURANCE COMPANY
R5342	UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
R7444	UNITEDHEALTHCARE INSURANCE COMPANY
S5805	UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
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S5921	UNITEDHEALTHCARE INSURANCE COMPANY
Sierra	
H2905	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
H2931	HEALTH PLAN OF NEVADA, INC.
R5674	SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.
PHC/Citrus	
H5407	CITRUS HEALTH CARE, INC.
H4527	PHYSICIANS HEALTH CHOICE OF TEXAS LLC
XL Health	
H0084	CARE IMPROVEMENT PLUS OF TEXAS INSURANCE COMPANY
H6528	CARE IMPROVEMENT PLUS SOUTH CENTRAL INSURANCE CO.
H0294	CARE IMPROVEMENT PLUS WISCONSIN INSURANCE COMPANY
R3444	CARE IMPROVEMENT PLUS SOUTH CENTRAL INSURANCE CO.
R9896	CARE IMPROVEMENT PLUS SOUTH CENTRAL INSURANCE CO.
H5665	CARE IMPROVEMENT PLUS OF MARYLAND, INC.
R6801	CARE IMPROVEMENT PLUS OF TEXAS INSURANCE COMPANY
Preferred Care	
H1045	PREFERRED CARE PARTNERS INC.



April 9, 2013

Ms. Marilyn Hunter
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Mailstop C4-21-26
Baltimore, MD 21244

Reference: 2011 Risk Adjustment Attestation

Dear Ms. Hunter,

Please find the enclosed the signed 2011 Risk Adjustment Attestation for UnitedHealth Group Medicare business.

If you have any questions, I may be reached by telephone at 952-931-4654 or via email at sandra_k_rick@uhc.com.

Sincerely,

A handwritten signature in cursive script that reads 'Sandy Rick'.

Sandy Rick
Senior Regulatory Affairs Analyst
PSMG Regulatory Affairs

EXHIBIT 21

Review and Certify Risk Adjustment Data Confirmation - Payment Year 2013 (Dates of Service 2012)

Confirmation #: 454

ATTACHMENT B

ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC. (H2905), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage and Medicare Advantage-Prescription Drug plans 001, the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentation to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS for the period of January 1, 2012, to December 31, 2012, all risk adjustment data (INPATIENT HOSPITAL, OUTPATIENT HOSPITAL, AND PHYSICIAN) available to the MA Organization as of January 31, 2014, with respect to the above-stated MA and MA-PD plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

BRIAN THOMPSON on behalf of

SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC. (H2905)

4/30/2014