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

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

24 Plaintiffs,

25 v.

26 UNITEDHEALTH GROUP, INC., *et al.*,

27 Defendants.

No. CV 16-08697 MWF (SSx)

PLAINTIFF'S OPPOSITION TO
UNITED'S MOTION TO DISMISS

28 Date: January 29, 2018

Time: 10:00 a.m.

Court: Hon. Michael W. Fitzgerald

MEMORANDUM OF POINTS AND AUTHORITIES

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INTRODUCTION

In this False Claims Act (“FCA”) action, the United States alleges that UnitedHealth Group Inc. and its various subsidiaries (“Defendants”) knowingly submitted false claims, made false statements, and improperly avoided their obligations to repay significant sums of money to the Medicare Program. Over the past decade, Defendants reviewed millions of medical records as part of a concerted effort to identify additional diagnosis codes to increase the payments they received from Medicare by billions of dollars. Am. Compl. ¶¶ 10-13 & 164-177. Those reviews also revealed that Defendants had submitted numerous invalid diagnoses to Medicare and obtained substantial sums of money based on those invalid diagnoses. *Id.* ¶¶ 13 & 235-38. But Defendants ignored this information and never returned the money paid them based on the invalid diagnoses. Although Defendants now attempt to cast themselves as innocent conduits of providers’ erroneous diagnostic data, the Amended Complaint details their decade-long scheme to generate and report skewed data to obtain over a billion dollars in improper payments.¹ Defendants also entered into agreements with many providers that incentivized them to report diagnoses to increase their own revenues. Defendants then ignored information from their own medical record reviews about the reporting of invalid diagnoses by these incentivized providers. *Id.* ¶¶ 15-18 & 239-92. Because of Defendants’ deliberate ignorance and reckless disregard of information about the invalidity of their payment data, they knowingly submitted false Risk Adjustment Attestations to the Medicare Program each year. *Id.* ¶¶ 5-6 & 293-327.

¹ The Ninth Circuit has already rejected Defendants’ attempt to miscast similar allegations. *United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1173 (9th Cir. 2016) (“[T]he defendants mischaracterize Swoben’s theory of the case. Swoben does not allege the defendants’ certifications are false merely because they passively forwarded to CMS unsupported diagnosis codes they received from their medical providers. . . . Instead, Swoben alleges the defendants took affirmative steps to generate and report skewed data.”).

Defendants’ motion to dismiss primarily focuses on their argument that the Government insufficiently alleged materiality. Defendants are incorrect because the Amended Complaint more than sufficiently alleges materiality.² Furthermore, the Ninth Circuit has already recognized the critical role that diagnosis codes play in the Government’s payment decision. *See Swoben*, 848 F.3d at 1167 (explaining that “[t]he risk adjustment methodology relies on enrollee diagnoses”). The Ninth Circuit also recognized that the accompanying Attestations provided a “further bulwark against fraud,” *id.* at 1168, enforceable, as here, through the prosecution of an FCA action. Moreover, the Supreme Court’s decision in *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989 (2016), recognizes that misrepresentations about violations of contractual or regulatory requirements that are “central” to payment are material. *Id.* at 2004. The Amended Complaint, which details Defendants’ knowing violation of the “central” requirements to submit valid diagnoses and delete invalid diagnoses, more than satisfies the demands of Rules 9(b) and 12(b)(6) of the Federal Rules of Civil Procedure.³

² *See, e.g.*, ¶ 12 (“Government would not have made risk adjustment payments based on these unsupported diagnoses or, if it had already made the payments, it would have recovered them from the Defendant MA Organizations or the other Defendants”); *id.* ¶ 13 (“Government would not have erroneously paid or would have recovered substantial sums of money (e.g., potentially over a billion dollars in risk adjustment payments for four payment years) to which the Defendant MA Organizations were not entitled”); *id.* ¶103 (“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”).

³ In deciding a motion to dismiss under Rule 12(b)(6), the Court must accept as true all well-pled factual allegations in the Complaint and draw all reasonable inferences in favor of the non-moving party, here, the United States. *See Wyler Summit P’ship v. Turner Broad. Sys. Inc.*, 135 F.3d 658, 661 (9th Cir. 1998). Furthermore, a complaint satisfies Rule 9(b) when it provides enough detail to give the defendant notice of the particular misconduct which is alleged to constitute the fraud so that it can defend against the claims and not just deny them. *Swoben*, 848 F.3d at 1180. The Amended Complaint more than sufficiently does that here.

Nonetheless, Defendants argue that they were permitted to submit invalid diagnosis codes and falsely certify that their data were accurate and truthful because such misconduct was purportedly necessary for them to achieve “actuarial equivalence” with “fee for service” providers under Parts A and B of Medicare. But Defendants’ tortured construction of this statutory term is not objectively reasonable and would lead to absurd results, such as allowing – perhaps even requiring – Defendants and other Medicare Advantage organizations (“MAOs”) to submit invalid diagnosis codes and to falsely certify to their accuracy and truthfulness. Moreover, even if Defendants’ purported grievance with the risk adjustment payment structure had merit (which it does not), it would not provide any basis for Defendants to engage in such “self-help” measures. Just as a physician who believes she should be paid more for a medical procedure cannot bill for an additional procedure she did not perform and then falsely certify that she performed two procedures, Defendants cannot knowingly fail to delete invalid diagnoses for which they had received payment from Medicare and then certify to the Government that these diagnoses are accurate and truthful.

Defendants' only other argument about retroactive application of § 3729(a)(1)(G) is also incorrect. The Government is not seeking a retroactive application here. Accordingly, Defendants' motion to dismiss should be denied in its entirety.

BACKGROUND

I. Risk Adjustment Payments Under The Medicare Advantage Program

Medicare Part C established the Medicare Advantage (“MA”) Program, which allows Medicare beneficiaries to receive their benefits through private health insurance plans offered by MAOs, which must provide enrollees the benefits and services (other than hospice care) that are available to beneficiaries under Parts A and B of Medicare and may also offer supplemental benefits approved by the Government. *See* 42 U.S.C. § 1395w-22(a)(1) & (3). While the Centers for Medicare and Medicaid Services (“CMS”), the government agency responsible for administering the Medicare Program, pays for medical services under Parts A and B under what has been generally described

1 as a “fee-for-service” regime, MAOs are paid a pre-determined monthly sum for each
2 person they cover under Part C, 42 U.S.C. § 1395w-23(a)(1)(A), based in part upon the
3 characteristics of the particular beneficiary. By statute, the payment depends on such
4 “risk factors” as the age, gender, and “health status” of the beneficiary, “as the Secretary
5 [of the Department of Health and Human Services] determines to be appropriate.” *Id.*
6 §1395w-23(a)(1)(C). Under this “risk adjustment” system, MAOs are paid the expected
7 cost of providing Medicare benefits to a given beneficiary even if they never actually
8 incur those costs. MAOs receive more for providing benefits to older and sicker people
9 and less for younger and healthier ones. Adjusting the payments in this way allows the
10 Secretary “to ensure actuarial equivalence,” *id.* § 1395w-23(a)(1)(C)(i), between the
11 average payments that CMS would expect to make on behalf of a given beneficiary
12 under fee-for-service Medicare, and the payments made to MAOs for covering an
13 individual with those same characteristics.

14 The Secretary has broad authority to determine how to risk adjust based on health
15 status. Am. Compl. ¶ 56. Since 2004, the Secretary has used the Hierarchical Conditions
16 Category (“HCC”) model. *Id.* ¶¶ 58-62. This model relies on the medical diagnoses
17 submitted by MAOs for beneficiaries enrolled in their plans in order to calculate each
18 beneficiary’s risk score using a relative numerical value – a multiplier – for each HCC
19 category. *Id.* ¶ 60. The Secretary currently determines the multiplier for each of the
20 HCC categories based on an analysis of the amount that it paid on average in past years
21 under Parts A and B of the Medicare Program for individuals with the medical
22 conditions in each category. *Id.*

23 Under the HCC model, medical diagnoses are the sole factor used to determine the
24 risk adjustment payments made based on health status. CMS determines how sick or
25 healthy each beneficiary is – and thus how much Defendants will be paid for that
26 beneficiary – based on the medical diagnoses submitted by Defendants. Defendants
27 submitted these codes through CMS’ Risk Adjustment Processing System (“RAPS”) in
28 order to make claims to Medicare for risk adjustment payments. Am. Compl. ¶ 64.

Each RAPS submission (*i.e.*, each claim) included only a few data fields: the Medicare beneficiary's identification number, the date of the medical encounter (the "date of service"), the type of provider, and the diagnosis code(s) reported by the provider for that date of service. *Id.* CMS relied on the submitted diagnosis code(s) to determine the risk score for each beneficiary, and the risk score, in turn, determined the amount of the adjustment made by CMS to the monthly payments to Defendants for that beneficiary.

II. Defendants' Legal Obligation To Submit Valid Medical Diagnoses And Delete Invalid Medical Diagnoses

Defendants were not entitled to risk adjustment payments for diagnoses that were not substantiated by their enrollees' medical records. *See* Am. Compl. ¶ 87. MAOs must ensure the "accuracy" and "truthfulness" of the risk adjustment data they submit. 42 C.F.R. § 422.504(*l*). And, CMS has long made it clear that, in order to be accurate and truthful, a diagnosis must be supported by medical record documentation. *See Swoben*, 848 F.3d at 1176 (explaining that "CMS requires medical diagnosis codes to be supported by a medical record."). What Defendants deride as "the premise that MA plans are entitled to risk adjustment payment only for medical conditions that are adequately documented in a patient's medical charts," Defs. Br. 1, has been firmly established for many years. Defendants themselves referred to their beneficiaries' medical records as the "source of truth." Am. Compl. ¶¶ 128 & 188.

Defendants were also legally obligated to "delete" or withdraw invalid diagnoses previously submitted by them. Am. Compl. ¶¶ 103-114. The RAPS system contained a field called a "Delete Indicator" that enabled Defendants to delete invalid diagnoses that they had previously submitted. *Id.* ¶ 65. The deletion of previously submitted invalid diagnoses enabled CMS to recalculate beneficiaries' risk scores and to avoid making improperly inflated risk adjustment payments to Defendants or to recover any improper payments that were already made for those invalid diagnoses. *Id.* ¶ 111.

Defendants' legal obligation to submit accurate and truthful medical diagnoses and delete inaccurate and untruthful medical diagnoses arose from various sources.

1 First, Defendants’ annual contracts with CMS required them to comply with CMS’
2 policies, instructions, and guidance, including the Medicare Managed Care Manual and
3 the Risk Adjustment Participant Guide. Am. Compl. ¶¶ 68-72. Since the early 2000s,
4 the Manual and Participant Guide have memorialized the medical record documentation
5 requirement, and the Participant Guide has expressly required Defendants to delete
6 erroneous diagnoses submitted to RAPS. *Id.* ¶¶ 89-90 & 104 (bullet point 4) & 107.
7 Second, when Defendants entered into their annual contracts with the Government, they
8 agreed to attest to the truthfulness of the data they submitted for risk adjustment
9 payments, which gave rise to an obligation to exercise good faith and due diligence to
10 ensure the validity of their data and to delete invalid data. *Id.* ¶¶ 66-72 (explaining that
11 the contracts included the regulatory requirement that Defendants submit annual Risk
12 Adjustment Attestations, *see* 42 C.F.R. § 422.504(l)). Third, when Defendants executed
13 the Electronic Data Interchange (EDI) Agreements, they agreed to submit truthful risk
14 adjustment data and investigate and correct risk adjustment data discrepancies. *Id.* ¶¶
15 73-82. Fourth, regulations required Defendants to implement effective compliance
16 programs to ensure the integrity of their payment data and to “detect and correct non-
17 compliance with CMS program requirements as well as ... [to] prevent, detect, and
18 correct fraud waste and abuse” **and** to take “corrective actions (for example, the
19 *repayment of overpayments* ...)” in response to compliance issues. *Id.* ¶¶ 95-97. Fifth,
20 in their annual Risk Adjustment Attestations, Defendants attested to the accuracy and
21 truthfulness of their risk adjustment data, which again gave rise to their obligation to
22 exercise good faith and due diligence to ensure that invalid data was deleted. *Id.* ¶¶ 98-
23 102.

24 Defendants could delete invalid diagnoses both before and after the final deadline
25 for RAPS data submissions, which occurs during the year following the payment year at
26 issue. Am. Compl. ¶ 110. (For example, for payment year 2013, risk adjustment
27 payments were based on diagnoses from the 2012 date of service year, and the final
28 deadline for submitting diagnoses from the 2012 date of service year was February 14,

1 2014.) However, when Defendants possessed or had access to information about the
2 invalidity of diagnoses prior to the final submission deadline, they were required to
3 delete those diagnoses by the deadline in order for their Risk Adjustment Attestations to
4 be truthful and their final reconciliation payments to be correct. *Id.* ¶¶ 111-14.

5 The monthly risk adjustment payments made to Defendants during each payment
6 year were interim payments. After the final submission deadline for each payment year,
7 CMS determined if any adjustments to those interim monthly payments were necessary
8 based on all diagnoses submitted (and not deleted) by Defendants for each beneficiary up
9 until the final submission deadline. *Id.* ¶ 111. It did so by re-calculating each
10 beneficiary's risk score for the payment year to determine if it had changed and, if so, by
11 making an appropriate adjustment to the payment for the beneficiary. If the
12 beneficiary's risk score was higher because Defendants submitted additional diagnoses
13 for that beneficiary, CMS made a payment to Defendants to account for those additional
14 diagnoses as part of the final reconciliation payment process. Conversely, if the
15 beneficiary's risk score was lower because Defendants deleted diagnoses for that
16 beneficiary prior to the final submission deadline, CMS recovered the payments
17 associated with the deleted diagnoses as part of this final reconciliation process. *Id.*

18 Accordingly, if Defendants were in possession of or had access to information
19 about invalid diagnoses before the final submission deadline, they should have deleted
20 the invalid diagnoses to ensure that the final reconciliation payment that they were
21 claiming was correct. If they had done so, CMS would have adjusted the payment made
22 to Defendants to accurately reflect the risk adjusted status of the beneficiaries enrolled in
23 their plans. *Id.* ¶ 112.

24 Even if Defendants came into possession of or had access to information about
25 invalid diagnoses after the final submission deadline, they still had an obligation to
26 delete the invalid diagnoses. CMS would have recovered the payments as part of
27 additional processes it had in place. *Id.* ¶ 112.

1 **III. Defendants’ Violations Of The False Claims Act**

2 The United States’ First Claim for Relief is based on Defendants’ violation of the
 3 second part of 31 U.S.C. § 3729(a)(1)(G), which makes it unlawful to knowingly (as
 4 “knowingly” is defined by 31 U.S.C. § 3729(b)(1)) conceal or knowingly and improperly
 5 avoid or decrease an obligation to repay payments to which they were not entitled from
 6 the Medicare Program. Am. Compl. ¶¶ 341-43. The United States specifically alleges
 7 that Defendants knowingly and improperly failed to delete invalid diagnoses that they
 8 had submitted for risk adjustment payments or to otherwise return to the Medicare
 9 Program the overpayments based on the invalid diagnoses. The second part of
 10 § 3729(a)(1)(G) is premised on the intent of Congress that one cannot keep federal
 11 money it knows it has an obligation to repay. The FCA defines an “obligation” to mean
 12 “an established duty, whether or not fixed, arising from an express or implied contractual
 13 . . . relationship, from a fee-based or similar relationship, from statute or regulation, or
 14 from the retention of an overpayment.” 31 U.S.C. § 3729(b)(3). As explained above,
 15 Defendants’ legal obligation to repay arose from multiple contractual and regulatory
 16 sources, as well as from the “retention of an overpayment.” Each of these are separate
 17 and independent obligations to repay.

18 The Second Claim for Relief is based on Defendants’ violations of
 19 § 3729(a)(1)(A) of the FCA, which makes it unlawful to knowingly present or cause to
 20 be presented a false or fraudulent claim for payment. Am. Compl. ¶¶ 344-47. The
 21 United States specifically alleges that Defendants knowingly presented or caused to be
 22 presented to the Medicare Program false Risk Adjustment Attestations claiming risk
 23 adjustment payments from the Program. As recognized by the Ninth Circuit in *Swoben*,
 24 the attestations themselves were claims for payment. 848 F.3d at 1183. The attestations
 25 were submitted after the final submission deadline but before the final reconciliation
 26 payments were made. Am. Compl. ¶ 98. As explained above, that timing was meant to
 27 ensure that Defendants deleted invalid diagnoses prior to the final submission deadline if
 28 they possessed or had access to information about invalid diagnoses at that time. This

1 was necessary to ensure that the final reconciliation payments were correct based on
 2 information available to them. The United States alleges that Defendants’ attestations
 3 were factually false because Defendants certified that their risk adjustment data was
 4 accurate and truthful even though they had information that many diagnoses were
 5 inaccurate and untruthful. *Id.* ¶¶ 293-327.

6 The Third Claim for Relief is based on Defendants’ violation of § 3729(a)(1)(B)
 7 of the FCA, which makes it unlawful to make or use a false record or statement material
 8 to a false claim. Am. Compl. ¶¶ 348-51. The Fourth Claim for Relief is based on
 9 Defendants’ violation of the first part of § 3729(a)(1)(G) of the FCA, which makes it
 10 unlawful to make or use a false record or statement material to an obligation to pay
 11 monies to the Government, including an obligation to repay monies to the Government
 12 based on overpayments. *Id.* ¶¶ 352-55. In 2009, as part of the Fraud Enforcement and
 13 Recovery Act of 2009 (“FERA”), Pub. L. 111-21, Congress defined “materiality” to
 14 mean “having a natural tendency to influence, or capable of influencing the payment or
 15 receipt of money.” 31 U.S.C. § 3729(b)(4). The definition applies to the payment or
 16 receipt of money by the Government or the payment or receipt of money by the
 17 defendant, as the definition applies to both § 3729(a)(1)(B) and (G). In its Third and
 18 Fourth Claims, the United States alleges that Defendants’ Risk Adjustment Attestations
 19 were false records or statements and that they had a natural tendency to influence or
 20 were capable of influencing the amount of the final reconciliation payment.

21 ARGUMENT

22 I. The Amended Complaint Adequately Pleads Materiality

23 A. The FCA And *Escobar*’s Materiality Requirement

24 While Defendants contend that the United States’ various allegations fail to satisfy
 25 the FCA’s materiality requirement, Defendants ignore the FCA’s definition of
 26 materiality. They do not even cite it. Rather, they appear to argue that the Supreme
 27 Court in *Escobar* rewrote the statutory definition of material to require a “but for” test
 28 and an “actual effect.” But, *Escobar* did not do so. Instead, the Court reaffirmed that the

1 appropriate materiality standard is the “natural tendency” test. *Id.* at 1996 & 2002
 2 (citing the FCA’s definition of materiality). And, even if Defendants’ proffered reading
 3 were correct, here Defendants’ failure to delete invalid diagnosis codes unquestionably
 4 had an actual effect on the amount of money that they received.

5 In *Escobar*, the Supreme Court noted that both the FCA and “common-law
 6 antecedents” applied in other federal fraud statutes define materiality as “having a
 7 natural tendency to influence, or being capable of influencing, the payment or receipt of
 8 money or property.” 136 S. Ct. at 2002 (quoting 31 U.S.C. § 3729(b)(4)). The Court
 9 then explained that, under any understanding of this concept, “materiality ‘look[s] to the
 10 effect on the likely or actual behavior of the recipient of the alleged misrepresentation’.”
 11 *Id.* at 2002 (quoting 26 R. Lord, *Williston on Contracts* § 69:12, p. 549 (4th ed. 2003)).
 12 The Court further indicated that courts should evaluate materiality using a holistic
 13 approach that focuses on various non-exclusive factors, including whether the
 14 requirement was labeled as a condition of payment, which the Court described as
 15 relevant but not dispositive; whether the requirement at issue went to the “essence of the
 16 bargain” between the parties; whether the violation was significant or “minor or
 17 insubstantial”; and what action the Government would likely undertake if it had actual
 18 knowledge of the violation of the requirement at issue. *Id.* at 2003-04. The Court also
 19 rejected any bright-line rules to sufficiently allege or prove materiality.

20 The Supreme Court’s main concern was that FCA liability should not occur
 21 “where noncompliance is minor or insubstantial” or be based on “insignificant regulatory
 22 or contractual obligations” just because the Government labelled them as conditions of
 23 payment and could decline to pay. *Id.* at 2003-04.⁴ In this case, that concern does not

24 ⁴ This is why the courts in *United States ex rel. Dresser v. Qualium Corp.*, 2016
 25 WL 3880763 (N.D. Cal. July 18, 2016), and *United States ex rel. Mateski v. Raytheon*
 26 *Co.*, 2017 WL 3326452 (C.D. Cal. 2017), dismissed the false certification of compliance
 27 theories. The *Qualium* court held that a misrepresentation could not be material solely
 28 because payment was conditioned on compliance with all laws and regulations. 2016
 WL 3880763 at *6. The *Mateski* court held that the relator had to allege something more

1 exist; the Amended Complaint sufficiently pleads that Defendants’ obligations
2 concerning the submission of valid diagnoses and the deletion of invalid diagnoses were
3 “central” to Defendants’ entitlement to obtain and retain risk adjustment payments based
4 on those diagnoses, Am. Compl. ¶¶ 87-114, and it further alleges that Defendants’
5 noncompliance with those obligations was substantial. *See, e.g., id.* ¶ 237 (alleging at
6 least over a billion dollars in damages for just four years). In addition, as recognized by
7 the Ninth Circuit in *Swoben*, accurate and truthful diagnosis data was central to payment
8 and the Attestations were expressly a condition of payment. 848 F.3d 1166-68. And
9 here, the materiality and gravity of Defendants’ manipulation of the risk adjustment
10 payment system is such that the Secretary of the Department of Health and Human
11 Services has authorized this FCA action that seeks not only repayment of amounts
12 wrongfully obtained from the Medicare Program, but also multiple damages and
13 penalties. Under such circumstances, a myopic focus on the Government’s continued
14 payment should not be used to shield Defendants from liability for their fraud. *See*
15 *United States ex rel. Campie v. Gilead Sciences, Inc.*, 862 F.3d 890, 906 (9th Cir. 2017)
16 (stating that “to read too much into the FDA’s continued approval [of the drugs after it
17 learned of certain compliance issues] – and its effect on the government’s payment
18 decision – would be a mistake” because it would allow the defendant to “use the
19 allegedly fraudulently-obtained FDA approval as a shield against liability for fraud”).

20 Defendants overlook the various factors set forth in the *Escobar* decision in
21 determining materiality and focus instead on only one. They argue that the Government
22 is required to allege that it would have stopped making payments to them had it known
23 about their one-sided chart review or even if it had “doubts about” the truthfulness of
24 their Attestations. Defs. Br. 14. Defendants’ articulation of the required materiality
25 analysis is wrong.

26
27 than that the defendant’s compliance with certain contract provisions was mandatory.
28 2017 WL 3326452 at *7. Here the Government alleges that the invalid diagnoses codes
had a direct, immediate, and substantial impact on the amount Defendants were paid.

1 First, the Court in *Escobar* did not hold that the relator had to allege or prove that
2 “but for” the defendant’s misrepresentation about its compliance with the regulatory
3 requirements, the Medicaid Program (at issue in that case) would not have paid the
4 claim. The Court used the phrase “would not have paid these claims” when describing
5 the relator’s allegations in the case, but it did not hold that materiality required such a
6 “but for” allegation or analysis. See *Escobar*, 136 S.Ct. at 2004. To the contrary, the
7 Court explained that no one factor is determinative. *Id.* at 2001 (quoting *Matrixx*
8 *Initiatives, Inc. v. Siracusano*, 563 U.S. 27, 39 (2011), for the proposition that
9 “materiality cannot rest on ‘a single fact or occurrence as always determinative’”).
10 Moreover, the very authorities repeatedly cited by *Escobar* expressly reject any “but for”
11 view of materiality. *Escobar* cited *Kungys v. United States*, 485 U.S. 759 (1988), which
12 rejected the argument that materiality employed a standard of “more likely than not,”
13 and indicated that something can be material even if it has less than a 30 percent chance
14 of influencing the decision maker. *Id.* at 2002 (citing *Kungys*, 485 U.S. at 771 (stating
15 that “[i]t has never been the test of materiality that the misrepresentation or concealment
16 would *more likely than not* have produced an erroneous decision”) (emphasis in the
17 original)). See also *id.* (citing 26 R. Lord, *Williston on Contracts* § 69:12 (4th ed. 2003)
18 (“it is not necessary to materiality that a misrepresentation have been the paramount or
19 decisive inducement, so long as it was a substantial factor”). Furthermore, courts
20 correctly applying *Escobar* have not mandated any particular “magic words” or made
21 any one factor dispositive of the materiality determination. For example, in *Escobar*
22 itself, the First Circuit on remand had “little difficulty in concluding that Relators . . .
23 sufficiently alleged the [defendant’s] misrepresentations were material.” *United States*
24 *ex rel. Escobar v. Universal Health Services, Inc.*, 842 F.3d 103, 110 (1st Cir. 2016)
25 (*Escobar II*). The First Circuit highlighted (1) the relators’ allegation that “regulatory
26 compliance was a condition of payment,” (2) the “centrality of the licensing and
27 supervision requirements . . . which go to the very essence of the bargain” between the
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1 government and the provider, and (3) the lack of any evidence that the government paid
2 claims “despite knowing of the violations.” *Id.*

3 Second, the issue is not, as Defendants maintain, whether the Government has
4 some reason to believe that providers reported some invalid diagnoses to Defendants or
5 some “doubts about” Defendants’ Attestations. Rather, the inquiry must focus on what
6 the Government’s reaction may have been if it had possessed *actual knowledge* (and not
7 merely reason to suspect) that a defendant had violated the requirements at issue. *See*
8 136 S. Ct. at 2003-04 (twice referring to the Government’s “actual knowledge that
9 certain requirements were violated”); *Campie*, 862 F.3d at 906-07 (holding that, in
10 assessing materiality, the inquiry focuses on the Government’s actual knowledge of the
11 violations and that the “relators allege more than the mere possibility that the
12 government would be entitled to refuse payment if it were aware of the violations”).

13 Third, the issue is also not whether the Government had general knowledge about
14 Defendants’ one-way chart review program. Instead, under *Escobar* and *Campie*, the
15 issue is how the Government may have responded if it had specific knowledge of the
16 violations – here, the pertinent violations are Defendants’ knowing failure to delete the
17 invalid diagnoses based on information in their possession or available to them. It is
18 Defendants’ noncompliance with their contractual and regulatory obligations to delete
19 invalid diagnoses that is at issue, not their chart review process more generally. *See*
20 *Escobar*, 136 S. Ct. at 2003-04 (explaining that the question was whether compliance
21 with the state Medicaid regulatory requirements relating to the provision of mental
22 health services (the facility, licensing, and supervision requirements) was material to the
23 payment decision).

24 Fourth, to satisfy the materiality requirement, CMS was not required to terminate
25 payments to Defendants once the Relator filed his *qui tam* action in 2011.⁵ Nor did any

26 ⁵ Relators filed over 600 *qui tam* actions in Fiscal Year 2017 alone.
27 [https://www.justice.gov/opa/pr/justice-department-recovers-over-37-billion-false-claims-](https://www.justice.gov/opa/pr/justice-department-recovers-over-37-billion-false-claims-act-cases-fiscal-year-2017)
28 [act-cases-fiscal-year-2017](https://www.justice.gov/opa/pr/justice-department-recovers-over-37-billion-false-claims-act-cases-fiscal-year-2017). Government agencies cannot be expected to stop payment
each time a *qui tam* is filed, even before the relators’ allegations can be verified.

1 materiality requirement dictate that CMS terminate payments in response to Defendants’
2 decision in 2014 that they would no longer delete invalid diagnosis codes based on the
3 results of their chart reviews. Am. Compl. ¶¶ 226-34. In 2014, CMS did not know
4 which of the millions of codes submitted by Defendants lacked support in the medical
5 charts, precisely because Defendants kept this information from the Government. CMS
6 also had another remedy available to it, which was this FCA action. Contrary to
7 Defendants’ contention, nothing in the FCA or *Escobar* dictates that the Government
8 must take both administrative action (which would be required to stop or withhold
9 payments) *and* file an FCA action. There is nothing in the text or legislative history to
10 suggest that Congress intended to require agencies to pursue administrative actions as a
11 condition of filing an FCA complaint, and courts have rightly rejected any exhaustion
12 requirement. *See, e.g., United States v. Lahey Clinic Hosp., Inc.*, 399 F.3d 1, 17 (1st Cir.
13 2005) (explaining that Congress did not limit the recovery of overpayments to
14 administrative remedies but allowed them to be recovered under the FCA); *United States*
15 *v. Tenet Healthcare Corp.*, 343 F.Supp.2d 922, 934-35 (C.D. Cal. 2004) (holding that
16 where the Government itself decides to pursue a judicial remedy, there is no requirement
17 that administrative remedies be tried first). Indeed, “Congress intended to allow the
18 government to choose among a variety of remedies, both statutory and administrative, to
19 combat fraud.” *United States ex rel. Onnen v. Sioux Falls Indep. Sch. Dist. No. 49-5*,
20 688 F.3d 410, 414-15 (8th Cir. 2012). *Escobar* did not even suggest that the
21 Government must always take administrative action in order to establish that certain
22 types of violations are material to payment. Indeed, in *Escobar*, the fact that the State
23 chose not to stop, withhold or recoup payment did not compel either the Supreme Court
24 or the First Circuit on remand to conclude that the alleged violations were not material.
25 *Escobar*, 136 S. Ct. at 1997; *see also Escobar II*, 842 F.3d at 112. Moreover, as
26 previously stated, legal action was the remedy specified by Defendants’ Attestations and
27 the remedy that each of them acknowledged as part of the bargain between the parties:
28 “[t]he MA Organization acknowledges . . . that misrepresentations to CMS about the

1 accuracy of such [risk adjustment] information may result in Federal civil action and/or
 2 criminal prosecution.” This FCA lawsuit is thus the very “result” expressly specified by
 3 the Attestations.⁶

4 In this case, the United States has sufficiently alleged that the Government does
 5 not wittingly pay for invalid diagnoses; rather, it recalculates payment rates when it has
 6 actual knowledge about specific invalid diagnoses that were submitted for payment.
 7 Am. Compl. ¶ 330. Moreover, the Amended Complaint alleges that in 2012, Defendants
 8 led the Government to believe that they were complying with their obligations to delete
 9 invalid diagnosis codes and that they were not defrauding the Government. *Id.* ¶ 190
 10 (alleging that, in September 2012, Defendants informed the Government that they were
 11 developing a Claims Verification Program to ensure the accuracy of the diagnosis data
 12 they submitted to CMS and look both ways at the results of their chart reviews). Until
 13 the Government pursued its investigation of the allegations in the Amended Complaint,
 14 CMS did not have actual knowledge about any specific invalid diagnoses that
 15 Defendants should have deleted based on the results of their chart reviews.

16 Finally, a materiality inquiry focused on the *Government’s* payment of a claim
 17 does not apply to the United States’ First and Fourth Claims for Relief under the reverse
 18 false claims provision of the FCA, § 3729(a)(1)(G). *Escobar* did not address materiality
 19 under this section of the FCA.⁷ Under the first part of § 3729(a)(1)(G), the inquiry

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 21 ⁶ *City of Chicago v. Purdue Pharma*, 211 F. Supp. 3d 1058 (N.D. Ill. 2016), did
 22 not involve false statements that expressly warned, in the body of the statements
 23 themselves, about the material consequence of the false statements: that is, that the false
 24 statements may result in civil action or criminal prosecution. In addition, *Purdue*
 25 involved allegations that the City had actual knowledge at the time of payment of
 26 noncompliance with a regulatory requirement, whereas the Amended Complaint in this
 27 case does not allege that CMS had actual knowledge at the time of payment that
 28 particular diagnoses were invalid and still paid for them.

⁷ Similarly, *Knudsen v. Sprint Communications Co.*, 2016 WL 4548924, at *13
 (C.D. Cal. Sept. 1, 2016) – the only other case cited by Defendants in support of their
 argument relating to the materiality with respect to the United States’ First Claim for

1 focuses on the materiality of the false statement – here, the false Attestations – on
 2 *Defendants’* “obligation to pay,” which includes repaying for an overpayment.
 3 Likewise, under the second part of § 3729(a)(1)(G), an implied materiality requirement
 4 logically would also focus on *Defendants’* obligation to repay the overpayment, although
 5 it would not be connected to any false statement as a false statement is not an element of
 6 a violation of the second part of § 3729(a)(1)(G). In *United States v. Bourseau*, 531 F.3d
 7 1159 (9th Cir. 2008), the Ninth Circuit addressed the application of the pre-FERA
 8 version of the reverse false claims provision (which is also a basis for the United States’
 9 Fourth Claim for Relief for the pre-FERA time period). Similar to this case, that case
 10 involved interim payments made to the defendants periodically throughout the year with
 11 a final reconciliation payment made based on the defendants’ submission of cost reports
 12 at the end of each year. *Id.* at 1162. The Ninth Circuit explained that the inquiry under
 13 the reverse false claims provision was whether the false cost reports were material to
 14 avoid or decrease paying money owed the Government or repaying the Government for
 15 an overpayment. *Id.* at 1170-71. Moreover, it concluded that the false reports
 16 “concealed and decreased amounts that [the defendants] were obligated to repay to
 17 Medicare” even though the cost reports were never reviewed by the Government. *Id.*

18 **B. The United States Has Sufficiently Alleged that Defendants’ Obligation**
 19 **To Delete Invalid Diagnoses Was Material**

20 Over the past decade, Defendants have submitted diagnosis codes through the
 21 RAPS system in order to claim the billions of dollars of risk adjustment payments that
 22 they received each year, and those diagnosis codes are “central” to the risk adjustment
 23 payments they received based on health status. Defendants’ argument that the diagnosis
 24 codes they submitted were merely ancillary to their claims, *see* Defs. Br. 17 (attempting
 25 to analogize diagnosis codes to staplers), is meritless. Diagnoses codes are the sole

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Relief (Defs. Br. 18) – did not involve materiality under the reverse false claims
 27 provision. In addition, in that case, the court found that the only allegation in the
 28 relator’s complaint was conclusory. *Id.* Knudsen’s factually-bereft single paragraph
 stands in sharp contrast to the numerous and detailed allegations in this case.

1 determinant in the calculation of the risk adjustment payments based on health status.
2 *See Swoben*, 848 F.3d at 1167 (explaining that “[t]he risk adjustment methodology relies
3 on enrollee diagnoses”). Without submitting their diagnoses, Defendants would not have
4 obtained risk adjustment payments based on those diagnoses.

5 The Amended Complaint contains numerous and particularized allegations
6 regarding Defendants’ contractual and regulatory obligations to submit valid diagnoses
7 and delete invalid diagnoses. Contrary to Defendants’ assertion, the United States has
8 sufficiently alleged that their contractual and regulatory obligations to delete invalid
9 diagnoses were “actually” material. For multiple reasons – including Defendants’ Parts
10 C and D contracts and EDI agreements with the Government, the compliance and
11 Attestation regulations, and the Manual and Participant Guide (with which Defendants
12 contractually agreed to comply) – Defendants’ obligation to delete invalid diagnoses was
13 unquestionably a “central” part of the bargain that they made with the Government when
14 they decided to participate in the MA Program and reap the benefit of billions of dollars
15 of risk adjustment payments annually.

16 The Amended Complaint also alleges that, if Defendants had complied with their
17 obligation to delete invalid diagnoses from RAPS, Medicare would have processed the
18 corrected data, recalculated the risk score for the beneficiaries for whom an invalid
19 diagnosis had been deleted, and adjusted the risk adjustment payments for those
20 beneficiaries. Am. Compl. ¶ 333. The system would have done this as part of either the
21 final reconciliation payment process or future reconciliations conducted by CMS for the
22 payment year at issue. *Id.* In addition, the Amended Complaint alleges that because
23 Defendants did not comply with their obligation to delete the invalid diagnoses from
24 RAPS, Medicare paid for the invalid diagnoses as part of any future reconciliation
25 payments to Defendants or, if it already paid for the invalid diagnosis as part of the
26 interim payments, did not recover the overpayments as part of the final reconciliation
27 payment process. *Id.* ¶ 334. Accordingly, the Amended Complaint more than
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1 sufficiently addresses the materiality of the validity of diagnoses to Defendants’
 2 entitlement to claim and retain risk adjustment payments.

3 Defendants, however, appear to deny that they had any legal obligation to return
 4 overpayments based on invalid diagnoses. Instead, they make the surprising argument
 5 that returning overpayments based on invalid diagnoses was voluntary. Defs. Br. 2-3 &
 6 16-18. The Ninth Circuit has already rejected this argument. In *Swoben*, the Ninth
 7 Circuit ruled that “[e]ach diagnosis code submitted must be supported by a properly
 8 documented medical record,” 848 F.3d at 1168 (citations omitted), and that Defendants
 9 were legally obligated to disclose to the Government information about invalid diagnosis
 10 codes (what it referred to as “over-reporting errors”) based on the results of their medical
 11 record reviews. *Id.* at 1175. Otherwise, their Risk Adjustment Attestations would be
 12 false. And even if this were a valid argument, it goes beyond the allegations in the
 13 Amended Complaint and is not appropriate at the motion to dismiss stage.

14 Moreover, the Supreme Court’s discussion of materiality in *Escobar* compels the
 15 conclusion that the invalidity of Defendants’ diagnosis codes was material to their
 16 obligation to repay. As discussed, the Supreme Court’s over-arching concern in *Escobar*
 17 was whether compliance with the regulations at issue was part of the essence of the
 18 bargain between the parties. In this case, the Amended Complaint alleges that the
 19 obligation to delete invalid diagnoses was at the core of the parties’ bargain as shown by
 20 the contracts between the parties, the EDI agreements, and the compliance and
 21 Attestation regulations.

22 **C. The Government Has Never Agreed That Defendants Can Keep Risk**
 23 **Adjustment Payments Based On Invalid Diagnoses**

24 Defendants contend that they are, or should be, entitled to keep risk adjustment
 25 payments based on the invalid diagnosis codes they submitted.⁸ They argue that the
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27 ⁸ The one case cited by Defendants for this argument, *United States v. BAE Sys.*
 28 *Tactical Vehicle Sys.*, 2017 WL 1457493 (E.D. Mich. 2017), has nothing to do with the
 Medicare Statute or CMS’ payment of risk adjustment claims.

1 statutory requirement that CMS “ensure actuarial equivalence,” 42 U.S.C. § 1395w-
2 23(a)(1)(C)(i), between the average payments that it would expect to make for a given
3 beneficiary under a fee-for-service payment system and the payments made to MAOs for
4 covering an individual with the same characteristics and health status, somehow excuses
5 MAOs from deleting diagnoses that they know are invalid and entitles them to keep risk
6 adjustment payments based on the invalid diagnoses. However, nothing in the Medicare
7 Statute requires such an absurd result or insulates Defendants from FCA liability based
8 on their deliberate or reckless avoidance of their contractual and regulatory obligations
9 to delete invalid diagnoses. Defendants are not entitled to claim or retain payments
10 based on invalid diagnoses just because they believe that CMS has miscalculated the
11 multipliers for the HCC model.

12 The Government, including CMS, has never interpreted the term “actuarial
13 equivalence” in the manner that Defendants suggest. What Defendants characterize as
14 “an industry-wide regulatory discussion,” Defs. Br. 1, has consisted of insurers
15 repeatedly making this argument, which CMS has never accepted. The Part C risk
16 adjustment model, *i.e.*, the HCC model, is designed to satisfy the actuarial equivalence
17 provision by paying MAOs a sum equal to the expected cost of providing traditional
18 Medicare benefits to a given beneficiary. And that is what “actuarial equivalence”
19 means in this context: an equivalence between an expected cost, on the one hand, and a
20 known payment, on the other, achieved through the application of actuarial principles.
21 CMS has never interpreted “actuarial equivalence” as entitling Defendants to keep risk
22 adjustment payments for a certain percentage or number of invalid diagnoses submitted
23 by them for such payments. Nor has CMS accepted Defendants’ premise that, if they
24 submitted only valid diagnoses, they would be systematically underpaid. *See*
25 *UnitedHealthcare v. Hargan*, No. 16-CV-157, Defs.’ Summ. J. Mem., ECF No. 58 at 1-
26 2, 16-18, 37-40 (D.D.C. Dec. 4, 2017). In addition, contrary to Defendants’ contention,
27 in announcing its methodology for its Risk Adjustment Data Validation (“RADV”)
28 administrative audits in 2012, CMS did not somehow abandon *sub silentio* the long-

1 standing requirement that a diagnosis submitted by an MAO for payment purposes must
2 be supported by medical record documentation. As discussed at greater length in the
3 Government’s APA brief, CMS has consistently required medical record documentation
4 for diagnoses submitted for risk adjustment payments, and has never authorized insurers
5 to claim payment on the basis of invalid diagnosis codes. *Id.* at 1-3, 8-13, 23-27.

6 Defendants also appear to argue that the use of the term “actuarial equivalence” in
7 the statute means that their obligation to delete and repay Medicare for invalid payment
8 data – the invalid diagnoses – is immaterial. This argument is similarly baseless.
9 Nothing in the Medicare Statute, the Parts C and D contracts, the EDI Agreements, the
10 compliance and Attestation regulations, the Attestations themselves, the Manual, or
11 Participant Guide excused Defendants from their obligation to delete invalid diagnoses
12 based on their objectively unreasonable interpretation of the term “actuarial
13 equivalence.” Any objection Defendants may have to their compliance obligations or to
14 the multipliers for the various HCC categories does not give them a free pass for a
15 certain percentage or number of invalid claims for risk adjustment payments.
16 Defendants may not improperly retain Medicare funds to which they were never entitled
17 and, having been caught, challenge the method by which it was paid. *See Bryson v.*
18 *United States*, 396 U.S. 64, 68 (1969) (“One who elects [fraud] as a means of self-help
19 may not escape the consequences by urging that his conduct be excused because the
20 statute which he sought to evade is [invalid].”) (quoting *Dennis v. U. S.*, 384 U.S. 855,
21 867 (1966)); *Cedars-Sinai Medical Center v. Shalala*, 125 F.3d 765, 769 (9th Cir. 1997)
22 (“If the Hospitals did indeed knowingly submit false claims in order to receive payment
23 for devices not covered under the 1986 rule, the invalidity of the rule will be no
24 defense.”) (citing *Bryson*); *United States v. Weiss*, 914 F.2d 1514, 1522-23 (2d Cir.1990)
25 (holding that the fact that a Medicare Manual provision requiring filing of statements had
26 not undergone statutorily required approval procedures was no defense to charge of
27 filing false statements).

D. The United States Has Sufficiently Alleged That Defendants' False Risk Adjustment Attestations Were Material

Defendants' Risk Adjustment Attestations, by their very nature, were material as they related directly to the critical data element – diagnoses – that is the sole determinant of risk adjustment payments based on health status. The Amended Complaint contains detailed allegations that the submission of invalid diagnoses and failing to delete them are not minor or insubstantial infractions of Defendants' significant contractual and regulatory obligations to the Medicare Program. It follows that Defendants' Attestations to the accuracy and truthfulness of the diagnoses were also material.

The Amended Complaint alleges that the purpose of the Attestations was, first, to remind Defendants that they may not ignore or disregard information about invalid diagnoses; and, second, to enforce the fundamental program requirement that Defendants delete invalid diagnoses. Am. Compl. ¶ 336 (citing 65 Fed. Reg. 40,170, 40,268 (June 29, 2000) ("certifications would help ensure accurate data submissions"). When Defendants did not comply with these payment data integrity requirements and failed to delete invalid diagnostic data, the result was their submission of false Attestations that the data was truthful and accurate. Because Defendants did this with actual knowledge of information about invalid diagnoses or with deliberate ignorance or reckless disregard of information about invalid diagnoses, they violated the FCA.

As the Government alleges in the Amended Complaint, the Attestation was meant to serve as a powerful deterrent against "knowingly" submitting false claims for payment. As "bulwark[s] against fraud," *Swoben*, 848 F.3d at 1168, the Attestations reminded Defendants of their obligation to submit truthful information to their "best knowledge, information and belief." They also served as reminder that the submission of a knowingly false Attestation could trigger FCA liability. "[A]s under the False Claims Act, a certification is false under § 422.504(l) when the Medicare Advantage organization has actual knowledge of the falsity of the risk adjustment data or demonstrates either 'reckless disregard' or 'deliberate ignorance' of the truth or falsity of

the data.” *Id.* at 1169 (citing 65 Fed. Reg. 40,170, 40,268 (June 29, 2000)). *See also id.* at 1174. The Attestation thus warns of the serious legal implications of making false representations about the validity of diagnoses. It states that “[t]he MA Organization acknowledges . . . that misrepresentations to CMS about the accuracy of such [risk adjustment] information may result in Federal civil action and/or criminal prosecution.” *See* Exhibits 16-21 to the Amended Complaint. For these reasons, it is difficult to envision a false statement that is more material to a claim for payment under 3729(a)(1)(A) and (B) or to an obligation to repay under the first half of § 3729(a)(1)(G).

II. Section 3729(a)(1)(G) Is Not Being Applied Retroactively In This Case

Contrary to Defendants’ assertion, the United States is not seeking to retroactively apply the second part of § 3729(a)(1)(G), which was added to the FCA by FERA on May 20, 2009. Under the circumstances of this case, there is no retroactivity issue with respect to the application of the amendment to risk adjustment payments for payment (*i.e.*, calendar) year 2009, based on diagnoses from date of service year 2008, and to all subsequent payment and date of service years. Defendants’ retroactivity argument is limited to when an obligation to repay first arises based on the “retention of an overpayment.” Defs. Brf. 18-21. But, the “obligation” to repay in this case did not arise solely from the “retention of an overpayment.” Defendants’ “obligation” to repay also arose from their contractual relationship with CMS and from the compliance and attestation regulations and these contractual and regulatory obligations existed both prior to and after May 20, 2009, FERA’s effective date. Thus, whether the application of the amendment would be retroactive should be determined in light of the established duties imposed by those contracts and regulations to delete invalid codes and repay overpayments.⁹

⁹ In *OmniCare*, the relator argued that the defendant had an obligation to repay based on the “retention of an overpayment.” *United States ex rel. Stone v. OmniCare, Inc.*, 2011 WL 2669659 at **3-4 (N.D. Ill. July 7, 2011). There was no other basis – no contract or regulation – that gave rise to the obligation to repay. The court found that

1 For the 2008 date of service year and 2009 payment, there is also no retroactivity
2 issue because of the contractual and regulatory duties to delete invalid codes. Take the
3 following example: On May 18, 2009, Defendants reviewed Mr. Smith's medical
4 records for date of service year 2008. Based on the results of Defendants' review, a
5 diagnosis for leukemia reported by one of Smith's physicians was not supported by his
6 medical records. Arguably, Defendants first knowingly failed to delete the invalid
7 diagnosis on May 18 (although, as the facts in this case will show, there was always a lag
8 time, sometimes a significant one, between when a chart review was performed and the
9 date that Defendants added or deleted codes based on it). But, the obligation to delete
10 the leukemia diagnosis continued to exist on and after May 20, 2009 for several reasons.
11 One of the most important reasons is that, in March 2010, Defendants were required to
12 execute and submit and did execute and submit Risk Adjustment Attestations as to the
13 validity of their 2008 diagnosis data in order to claim entitlement to the final
14 reconciliation payment for 2009. And, as explained by the Ninth Circuit in *Swoben*, in
15 order to submit truthful risk adjustment attestations in March 2010, Defendants had to
16 exercise good faith and due diligence and delete invalid 2008 date of service diagnoses
17 based on information in their possession about the invalidity of such data. Second, after
18 May 18, 2009, Defendants had a contractual obligation under their existing 2009
19 contracts and EDI agreements with CMS to delete invalid diagnoses. Third, as
20 previously explained, the monthly risk adjustment payments were interim payments akin
21 to estimated payments under a construction contract. Defendants' obligation was to
22 delete invalid diagnoses to ensure that the final reconciliation payment was correct. That
23 is why the Attestations were executed after the final submission deadline but before the
24 final payment. Thus, it is the retention of overpayment associated with the final

25 _____
26 OmniCare had knowledge of the overpayments prior to FERA's effective date but had
27 no obligation to repay prior to that date. *Id.* In contrast, Defendants' contractual and
28 regulatory obligation to repay existed prior to FERA. A new obligation to repay is not
being applied retroactively in this case.

1 reconciliation payment that is most relevant and, for payment year 2009, that final
2 payment was not made until after Defendants' submission of their Attestations in March
3 2010. In fact, the final payment for payment year 2008 also may have been made after
4 May 20, 2009.¹⁰

5 For date of service years after 2008 and payment years after 2009, there is also no
6 retroactivity issue for various reasons. In particular, there could be no knowing retention
7 of an overpayment prior to May 20, 2009. For example, for provider-reported diagnoses
8 from the 2009 date of service year, Defendants did not even review charts until after
9 May 20, 2009. For the same reason, there is also no retroactivity issue with respect to
10 the results of the RACCR (Risk Adjustment Coding Compliance Review) Program, see
11 Am. Compl. ¶¶ 239-92, and medical record reviews that Defendants conducted in and
12 after 2010 relating to diagnoses for 2008 and subsequent date of service years.

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26 ¹⁰ To the extent that there are facts related to the determination of retroactivity that
27 are in dispute or unknown to the United States and the Court at this time, the
28 determination cannot be made on this motion to dismiss and is best presented to the
court or jury after discovery is completed.

CONCLUSION

For the foregoing reasons, United's Motion to Dismiss should be denied.

Respectfully submitted,

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Attestation

I hereby attest that the other signatory listed, on whose behalf the filing is submitted, concurs in the filing's content and has authorized the filing.

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