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UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

UNITED STATES OF AMERICA *ex rel.* BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC. *et al.*, Defendants.	No. CV 16-08697 MWF (SSx) AMENDED JOINT RULE 26(f) REPORT DATE: April 9, 2018 TIME: 11 a.m. COURTROOM: 5A

The Parties submit this amended Joint Report to the Court regarding the Rule 26(f) conference that counsel for the Parties conducted by telephone on December 8, 2017. At the Rule 26(f) conference, the Parties discussed the topics set forth in Rule 26(f), along with the topics set forth in the Court's February 28, 2018 Order Setting Scheduling Conference. The Parties then submitted a Joint Report on December 22, 2017 (Dkt. No. 191), which this Report updates and supersedes. The Parties' respective positions regarding each topic are set forth in detail below.

A. Statement of the Case

United States and Relator's Position: This is a civil fraud action under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, as well as for restitution and common law damages, for monies unlawfully obtained and retained by Defendant UnitedHealth Group, Inc. and various of its direct and indirect subsidiaries ("Defendants") involved in Parts C and D of the Medicare Program.[1] Pursuant to its First Claim for Relief set forth in its First Amended Complaint ("FAC"), filed on November 17, 2017 (Dkt. No. 171), the United States alleges that Defendants violated 31 U.S.C. § 3729(a)(1)(G), known as the "reverse false claims" provision, by knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) concealing or knowingly and improperly avoiding their obligations to repay significant sums of money to the Medicare Program.[2] Specifically, for over a decade, Defendants have been knowingly concealing and knowingly and improperly avoiding their contractual and regulatory obligations to repay risk adjustment payments to which they were not entitled from the Medicare Program. In particular, Defendants failed

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[1] On February 12, 2018, this Court issued an Order granting Defendants' motion to dismiss the United States' Second, Third, and Fourth Claims for Relief under the False Claims Act but denying the motion as to the United States' First, Fifth, and Sixth Claims for Reliefs. (Dkt. No. 212) Accordingly, this statement about the case focuses on the First, Fifth, and Sixth Claims for Relief.

[2] On May 16, 2017, Plaintiff-Relator Benjamin Poehling filed his Second Amended Complaint (Dkt. No. 117) against Defendants. He is not pursuing any claims beyond those asserted by the United States.

to comply with their well-established contractual and regulatory obligations to delete, withdraw, retract, or correct invalid diagnoses submitted by them to the Medicare Program for risk adjustment payments based on the health status of beneficiaries in their Medicare Advantage plans or to otherwise return to the Medicare Program the overpayments based on the invalid diagnoses. On information and belief, Defendants continue to engage in this unlawful conduct.

Pursuant to its Fifth Claim for Relief, the United States alleges that, based on the same wrongful conduct, Defendants have been unjustly enriched by receiving risk adjustment payments to which they were not entitled and must make restitution. Pursuant to the Sixth Claim for Relief, the United States seeks to recover the overpayments because they were paid by the United States based on the mistaken belief that Defendants' diagnosis data was valid.

The United States' claims relate in part to Defendants' very large national Chart Review Program, which they have conducted annually since 2005. The United States alleges that Defendants systematically ignored the negative results of their chart reviews, *i.e.*, results showing that diagnoses submitted by them for risk adjustment payments were not supported by their beneficiaries' medical records, and failed to comply with their obligations to delete the unsubstantiated diagnoses. The United States Court of Appeals for the Ninth Circuit, in *United States ex rel. Swoben v. UnitedHealthcare Ins. Co.*, 848 F.3d 1161, 1175-76 (9th Cir. 2016), held that this type of conduct – turning a blind eye to information about unsupported diagnoses – constitutes reckless disregard and deliberate ignorance toward the truth or falsity of the data submitted to the Medicare Program. On information and belief, Defendants have continued to ignore the negative results of their Chart Review Program and, thus, have continued to avoid repaying the Medicare Program overpayments based on invalid diagnoses. The United States seeks to recover all overpayments due to Defendants' violation of the FCA.

In addition, the United States' claims relate to Defendants' disregard of information from their Risk Adjustment Coding Compliance Review ("RACCR") Program about invalid diagnoses reported to them by their financially-incentivized capitated and gainsharing providers. The United States alleges that Defendants knew that these providers had a financial incentive to report invalid diagnoses to increase risk adjustment payments and, based on the results of the RACCR Program, that the providers actually or likely over-reported diagnoses, but Defendants nonetheless continued to submit diagnoses from these providers and knowingly and improperly avoided repaying Medicare for risk adjustment payments based on invalid diagnoses from these providers.

UnitedHealth's Position: This case arises from the United States' and Relator's effort to change the rules governing obligations of Medicare Advantage ("MA") plans to verify data submitted by third-party healthcare providers. The United States claims that UnitedHealth was obligated to undertake efforts to verify diagnostic data from third-party healthcare providers that the government itself does not undertake with respect to beneficiaries it insures under traditional Medicare. UnitedHealth believes that the United States is seeking to impose obligations that simply did not, and do not, exist. UnitedHealth submitted bids to care for a population of beneficiaries based on a set of statutory and regulatory rules administered by the Centers for Medicare and Medicaid Services ("CMS"). Those rules include CMS's risk adjustment methodology, which already reduces the amount that UnitedHealth and other MA plans receive in a way that builds in and reflects the existence of unsupported diagnosis codes. In addition, CMS applies a statutory coding intensity adjustor, reducing payments to MA plans, to account for Chart Review activities and other differences in coding patterns between MA plans and CMS FFS data. UnitedHealth has not been overpaid, unjustly enriched, or paid by mistake under those rules; to the contrary, requiring

UnitedHealth to delete unsupported diagnosis codes would result in UnitedHealth being *under*paid.

Furthermore, UnitedHealth was transparent with CMS about the extent to which it was reviewing diagnosis codes submitted to it by providers, and CMS officials confirmed it was not required to do so-called "two-way looks" to double-check provider submissions. This suit is a misguided attempt to second guess that CMS guidance and oversight of the MA program, pursuing a windfall for the United States and Relator by forcing UnitedHealth to suffer a loss for playing by the rules CMS originally set up more than a decade after the fact. UnitedHealth has therefore asserted counterclaims for (1) Breach of Contract; (2) Breach of Covenant of Good Faith and Fair Dealing; (3) Fraudulent Inducement; (4) Negligent Misrepresentation; and (5) Promissory Estoppel.

B. Subject Matter Jurisdiction

United States and Relator's Position: This Court has subject matter jurisdiction over Plaintiffs' claims pursuant to 28 U.S.C. §§ 1331, 1345, & 1367(a) and 31 U.S.C. § 3732(a)-(b). The Court does not possess subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1367 or Federal Rule of Civil Procedure 13 over Defendants' counterclaims.

UnitedHealth's Position: As to the counterclaims, this Court has subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1367, as well as Federal Rule of Civil Procedure 13. To the extent jurisdiction is proper under the Complaint, it is also proper under the counterclaims, which arise out of the same transactions and occurrences alleged in the Complaint.

C. Legal Issues

United States and Relator's Position: Many, if not most, of the key legal issues presented by this case have already been decided by the Ninth Circuit in its opinion in *Swoben*, including that (1) Defendants were not entitled to risk adjustment payments for diagnoses unsubstantiated by their beneficiaries' medical

records, 848 F.3d at 1168 ("Each diagnosis code submitted must be supported by a properly documented medical record") (citations omitted); (2) Defendants were obligated to exercise due diligence to ensure the validity of the diagnosis data they submitted for risk adjustment payments and to take affirmative steps to address errors in the diagnosis data they submitted for such payments, *id*. at 1174 ("The defendants' contention that they were under no obligation to take affirmative steps to address errors . . . ignores § 422.503, which since 2005 has required Medicare Advantage organizations to have effective compliance programs in place, including 'procedures for internal monitoring and auditing" and for 'ensuring prompt response to detected offenses'") (citing 42 C.F.R. § 422.503(b)(4)(vi), (vi)(F), (vi)(G) (2005)); (3) Defendants were obligated to withdraw diagnoses unsupported by their beneficiaries' medical records, *id*. at 1185 n. 8 ("[I]f a Medicare Advantage organization relied on medical record X to justify submitting a particular diagnosis code to CMS initially, and the retrospective reviewer concludes X does not support that diagnosis, then the code should be withdrawn"); and (4) Defendants acted with actual knowledge that the diagnoses they submitted were false when they withheld known errors from CMS and acted with reckless disregard and deliberate ignorance about the falsity of the data submitted to CMS when they turned a blind eye to the errors and did not withdraw them, *id*. at 1175-76. The Court also rejected Defendants' argument that, because CMS does not verify diagnoses submitted under different parts of the Medicare Program (which pay providers based on services rendered, not diagnoses submitted), Defendants are entitled to risk adjustment payments based on diagnoses unsubstantiated by their beneficiaries' medical records. 848 F.3d at 1179 (rejecting this so-called "actuarial equivalence" argument for "multiple reasons").

In addition, in its February 12, 2018 opinion on Defendants' Motion to Dismiss ("MTD") (Dkt. No. 212), this Court held that the United States' FAC adequately and "extensively alleges how central the diagnostic data is to the risk

adjustment payments CMS makes to Defendants" and "that the Government's FAC contains enough factual allegations of the effect of the submission of invalid diagnosis codes on the Government's risk adjustment payments, and on Defendants' retention of risk adjustment payment to which they are not entitled, to satisfy the *Escobar* [materiality] standard." Order on MTD at 19-20. This Court further held that, with respect to the Government's claims based on the second part of the reverse false claims provision, 31 U.S.C. § 3729(a)(1)(G), "[t]he Government has adequately pled facts showing that the Defendants have knowingly avoided obligations to repay CMS by failing to delete invalid diagnosis codes, and that such failure was material" and that "the issue here is . . . the specific invalid diagnosis codes that Defendants submitted and failed to delete despite information available to them." *Id*. at 20-21. Accordingly, both the Ninth Circuit and this Court have recognized the direct link between the invalid diagnoses submitted by Defendants and the risk adjusted payments by Medicare. *Swoben*, 848 F.3d at 1167-68 ("diagnoses codes contribute to an enrollee's risk score, which is used to adjust a base payment rate"); Order on MTD at 15 ("not only do various contractual and regulatory materials require Defendants to submit accurate diagnostic data, but that data is central to the calculation of the amount of money CMS pays to Defendants"). Moreover, the Government believes that, consistent with the Ninth Circuit in *Swoben*, this Court has recognized that Defendants had a legal obligation to repay CMS by deleting invalid diagnosis codes, including diagnoses unsubstantiated by the beneficiaries' medical records. *Id*.

Very recently, on March 23, 2018, Defendants filed an Answer to the FAC. The Answer includes 21 enumerated affirmative defenses, some of which raise new legal and factual issues. For example, Defendants contend that the wrongful conduct alleged in the FAC was the fault of third parties (affirmative defense 19) and that they are "not vicariously liable for the acts alleged in the" FAC

(affirmative defense 5), although Defendants also contend that they made a voluntary disclosure to the Department of Justice of their wrongful conduct pursuant to 31 U.S.C. § 3729(a)(2) (affirmative defense 21) and, thus, if they are liable, their liability is limited to only double (not treble) damages. Defendants also contend that the Government failed to mitigate damages (affirmative defense 6) although Defendants, in 2012, represented to the Department of Justice that they were developing a program to delete unsubstantiated diagnoses and would do so (FAC ¶ 190) and despite the fact that Defendants never informed CMS about the specific unsubstantiated diagnoses that they failed to delete. *See* Order on MTD at 21 ("[G]eneralized knowledge does not amount to actual knowledge of specific invalid diagnoses. Without such actual knowledge, CMS could not know how it should change the risk adjustment payments.") Other new issues raised by Defendants' affirmative defenses include, but are not limited to, that the "services and products reimbursed by the United States under Medicare were worth what the government paid" (affirmative defense 15), the Court does not possess subject matter jurisdiction because the Relator is not an "original source" (affirmative defense 16), and the Government's claims against one or more Defendants are improperly joined with its claims against other Defendants and must be severed (affirmative defense 17). Plaintiffs are currently evaluating all 21 affirmative defenses and presently anticipates moving to strike some of them under Rule 12(f)(2). Plaintiffs will need to conduct discovery relating to at least some of Defendants' affirmative defenses (depending on which remain), which may add significantly to the amount of discovery that they need to conduct in this action. For example, one of Defendants' affirmative defenses is that "[t]he services and products reimbursed by the United States under Medicare were worth what the government paid" (affirmative defense 15). If the Court does not strike this defense, then Plaintiffs would have to conduct extensive discovery about the

services and products that Defendants provided and whether they were worth what the Government paid.

Moreover, on March 23, 2018, Defendants filed five counterclaims against the Government. Defendants' counterclaims appear to be based in large part on their meritless "actuarial equivalence" argument. Defendants seek to avoid their legal obligations to delete diagnoses unsubstantiated by their chart reviews and to retain payments for the invalid diagnoses. This is based on their legally erroneous and entirely unreasonable interpretation of the terms "actuarial equivalence" and "same methodology" in that part of the Medicare Statute relating to payments to Medicare Advantage organizations ("MAOs"). There is nothing in the Medicare Statute, including the use of those terms in the Statute, which entitles Defendants to risk adjustment payments based on invalid diagnosis data. Defendants were never entitled to payments based on invalid data and had longstanding contractual and regulatory obligations to delete invalid diagnoses submitted by them for such payments. Their attempt to avoid their obligations and keep substantial sums (at least over one billion dollars for just four years) of Medicare funds and taxpayer dollars to which they were never entitled should be summarily rejected by this Court.

Plaintiffs believe that an early ruling by the Court on this "actuarial equivalence" legal issue will streamline discovery and resolution of this case. Alternatively, if Defendants are not asserting their "actuarial equivalence" argument in this case as they appear to represent in their statement of the legal issues (below), then they should stipulate that they are not asserting this argument here and withdraw their numerous and burdensome document requests relating to this issue.

The counterclaims also appear to be based on Defendants' contention that, in 2014, CMS purportedly misled them to believe that they could ignore the negative results of their chart reviews – the results showing the diagnoses that were

unsubstantiated by the beneficiaries' charts – and avoid their obligation to delete the invalid diagnoses. The Ninth Circuit, in *Swoben*, already rejected this argument. It explained that, although CMS decided in 2014 not to finalize the proposed rule prohibiting MAOs from designing chart reviews to only identify diagnoses for additional payments, CMS made clear that MAOs remained responsible for ensuring the validity of their data to avoid receiving or retaining overpayments. 848 F.3d at 1169-70. The Ninth Circuit further explained that, in 2014, CMS finalized a regulation that had the same effect as the proposed regulation because it required the return of overpayments resulting from the submission of diagnoses that are unsupported by the beneficiaries' medical records. *Id*. at 1185 n.4.[3] Furthermore, according to Defendants' own senior executives, in 2014, CMS told them that they could not ignore information about invalid diagnoses from their reviews of medical records and that CMS could not advise Defendants about their compliance with laws regarding their overpayment obligations. (FAC ¶ 226 & 228-29).

The Government presently anticipates moving to dismiss the counterclaims. Among other deficiencies with these counterclaims, it appears that Defendants' alleged damages are anticipatory, contingent, and unripe in that they are premised on this Court issuing a judgment requiring Defendants to repay the overpayments due to their failure to delete invalid diagnosis data. The primary intent of

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[3] The regulation that CMS finalized in 2014 is often referred to as the Overpayment Rule, 42 C.F.R. § 422.326. It is the regulation that Defendants challenge in their Administrative Procedure Act ("APA") case. That regulation was issued pursuant to the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 1320a-7k(d), which requires MAOs to report and return overpayments no later than 60 days after their identification of the overpayments; otherwise, their late overpayments become "obligations" under the FCA and the MAOs are subject to liability under the reverse false claims provision of the FCA even if they returned the overpayments after 60 days. The resolution of the APA case will not resolve this FCA case. *See UnitedHealthcare Ins. Co. v. Price*, 2017 WL 2623783, at 2-3 (D.D.C. June 14, 2017). This case does not involve the Overpayment Rule because Defendants were not just late in returning the overpayments; they never returned the overpayments. Nonetheless, in this case, Defendants are demanding the production of documents relating to the Overpayment Rule.

Defendants' meritless counterclaims appears to be to divert the Government's resources from focusing on its document production and other efforts in this matter.

Pursuant to Rule 12(a)(2), the Government's response to the counterclaims is due within 60 days after service of the counterclaims on the United States Attorney, to and including May 22, 2018. The Government and Relator also seek the same 60 days to move to strike some or all of the affirmative defenses. Plaintiffs recently sent Defendants a proposed stipulation that Plaintiffs will file their motions to dismiss and to strike by May 22, 2018; Defendants may file their oppositions by June 11, 2018; Plaintiffs may file their replies by June 25, 2018; and the motions shall be heard on July 9, 2018. If Defendants do not agree to this stipulation, Plaintiffs will file an application with this Court seeking this relief.

In addition to issues identified elsewhere in this Report, including Section M, Plaintiffs anticipate that other legal issues may arise as discovery continues.

UnitedHealth's Position: This case centers on a dispute about the reciprocal contractual, regulatory, and statutory obligations of MA plans and CMS in the MA program. As the Parties, as well as this Court, have previously recognized, the "central" issues in the dispute are currently being litigated in an Administrative Procedures Act suit in the District of Columbia. *See* Order Denying Motion to Transfer at 4, ECF No. 154 (noting the government's agreement that "'identical arguments'. . . are 'central' to the cases"); *see also UnitedhealthCare Ins. Co. v. Hargan*, No. CV-16-RMC (D.D.C.).[4] Those issues include whether MA plans are required to attempt to delete all unsupported diagnosis codes submitted to them by providers, even though the model CMS uses to determine payment amounts is based in part on unsupported codes that CMS itself collects in the Medicare Part A and B programs. CMS has acknowledged in the APA suit that it knowingly uses

[4] Upon the resignation of former Secretary of Health and Human Services Thomas Price, UnitedHealth's APA action was automatically re-captioned with the name of Acting Secretary Eric Hargan.

unsupported diagnosis codes to estimate its expected costs for Medicare patients whose care it pays for directly under Medicare Parts A and B. UnitedHealth has argued that CMS' choice has direct implications for the types of risk adjustment data it collects from MA plans. Specifically, Congress has required CMS to use the "same methodology" to determine payment amounts in the MA program, 42 U.S.C. § 1395w-23(b)(4), and has directed CMS to "ensure actuarial equivalence" between the two programs, 42 U.S.C. § 1395w-23(a)(1)(C)(i). In light of those statutory requirements, UnitedHealth believes that CMS cannot require MA plans to use a different approach to the diagnosis codes they submit than the one CMS itself uses, such as by requiring MA plans to delete all unsupported codes, unless CMS also provides a means of adjusting for the different methodologies.

UnitedHealth and the United States have already fully briefed cross-motions for summary judgment in the APA case addressing those issues. UnitedHealth believes it would be inappropriate, inefficient, and a waste of judicial resources to attempt to litigate those same issues here while they are already pending before the APA court. If the APA court upholds the validity of the regulation there based on a rejection of UnitedHealth's arguments described above, UnitedHealth will not seek to re-litigate the regulation's validity here. If the APA court finds the regulation *in*valid, then at that point the Parties will be able to address the implications of such a decision for the United States' claims here. The extent to which the "actuarial equivalence" and "same methodology" requirements will need to be addressed by this Court, and the timing of any such consideration by this Court, thus depends on the outcome in the APA case. UnitedHealth remains willing to discuss those issues with the United States in an attempt to avoid unnecessary and inefficient briefing on the United States' contemplated motion for partial summary judgment on this issue (and has been open to such discussions since the United States first raised the prospect of a motion for partial summary judgment on this issue in November 2017).

Depending on how the APA case is resolved, there may also be other FCA- and fact-specific issues to resolve in this case, including:

(i) Whether a physician's subjective clinical judgment regarding diagnostic coding may give rise to a false claim under the FCA;

(ii) Whether any regulatory or contractual violations UnitedHealth did commit were committed "knowingly," in light of the regulatory landscape and the government's knowledge and approval of UnitedHealth's chart review processes;

(iii) Whether any alleged noncompliance was material to payment under the FCA or the United States' unjust enrichment or payment by mistake claims;

(iv) Whether the acts of UnitedHealth resulted in damages actionable under the FCA or claims of unjust enrichment and payment by mistake; and

(v) Whether the United States can sustain claims for unjust enrichment and payment by mistake when valid contracts between the parties existed.

The United States has taken the position here, as it did on remand in *Swoben*, that the Ninth Circuit's *Swoben* decision resolves many of these questions in the United States' favor. That is incorrect. The Ninth Circuit's decision arose following a dismissal on Rule 8 and 9(b) grounds, and resolved only the narrow set of issues that were actually at issue there. Specifically, the Parties there disputed the extent of detail that Rule 9(b) requires at the pleading stage in a case like this one, and also the extent of the verification obligations imposed by the "best knowledge, information, and belief" standard contained in the contractual attestation. *See Swoben*, 848 F.3d 1178-79. The Ninth Circuit expressly *declined* to address whether the United States' allegations stated a claim under the reverse false claims provision. *Id.* at 1172 n.6. Accordingly, *Swoben* is of minimal guidance now that this Court has dismissed the United States' attestation-based claims (Dkt. 212), and the only FCA claim remaining is based on a theory that was not addressed by the Ninth Circuit.

In addition, contrary to the United States' contention, in granting in part UnitedHealth's motion to dismiss on February 12, 2018 (Dkt. 212), the Court did not "recognize[] that [UnitedHealth] had a legal obligation to repay CMS by deleting invalid diagnosis codes"—the Court merely held that, at this stage (where factual allegations must be accepted as true), the FAC contained sufficient allegations to plead materiality under the United States' remaining causes of action. (Order on MTD at 20-21.)

The United States also fundamentally misconstrues UnitedHealth's counterclaims and affirmative defenses. UnitedHealth's counterclaims and affirmative defenses do not rely on the actuarial equivalence issues being separately litigated in the APA case. Rather, UnitedHealth's counterclaims are based on the fact that CMS failed to issue any rule or otherwise make clear any requirement to perform two-way looks, affirmatively represented to UnitedHealth that two-way looks were not required, knew that UnitedHealth understood it was not under an obligation to perform two-way looks and relied on that understanding in calculating its bids and entering into MA contracts with CMS, and continued to enter into and pay UnitedHealth under such contracts. Yet the United States, years after the fact, seeks to alter the fundamental assumptions built into UnitedHealth's bids, and thus, their contracts with CMS. The United States' conduct under these circumstances gives rise to UnitedHealth's valid assertion of counterclaims consisting of breach of contract, breach of the covenant of good faith and fair dealing, fraudulent inducement, negligent misrepresentation, and promissory estoppel. UnitedHealth is prepared to litigate any motions to dismiss and/or strike its counterclaims and affirmative defenses.

D. Parties, Evidence, etc.

1. Parties

The Parties are Plaintiff United States of America, Relator Benjamin Poehling, and Defendants UnitedHealth Group Incorporated, United HealthCare

Services, Inc., UnitedHealthcare, Inc., Ovations, Inc., Optum, Inc., and OptumInsight, Inc., as well as the numerous Medicare Advantage Organizations identified in paragraph 26 of the FAC. The full list of Defendants' parents and subsidiaries is available in UnitedHealth's Corporate Disclosure Statement, Dkt. No. 129, and UnitedHealth's Notice of Interested Parties, Dkt. 130.

2. Percipient Witnesses

United States and Relator's Position: Plaintiffs, at this early stage of the litigation and subject to the factual record developed during discovery, identify the following potential percipient witnesses in this case: The individuals identified in Plaintiffs' Initial Disclosures (served on Defendants on December 22, 2017) as individuals likely to have discoverable information that the Government and Relator may use to support their claims; Relator Benjamin Poehling; the current and former executives and employees of Defendants identified in paragraph 42 of the FAC; the individuals identified and/or described in the Declaration of Carol Wallack in Support of the United States' Opposition to United's Motion to Transfer, Dkt. No. 138-1; the current and former employees of the incentivized providers listed in Exhibits 14 and 15 of the FAC; the chart reviewers and diagnosis coders who reviewed charts and coded diagnoses as part of Defendants' Chart Review, Claims Verification, and RACCR Programs; certain current and former employees of CMS and its contractors, including Palmetto and ARDX; and certain current and former participants in a managed care industry group called the Industry Collaboration Effort ("ICE").

UnitedHealth's Position: In addition to the witnesses identified by the United States and the individuals identified in UnitedHealth's Initial Disclosures (served on the United States on December 22, 2017) as those likely to have discoverable information that UnitedHealth may use to support its claims and defenses, UnitedHealth anticipates, subject to the factual record developed during discovery, that the following may be key witnesses in this action: (1) Marilyn

Tavenner, the former Administrator of CMS; (2) Jonathan Blum, the former Principal Deputy Administrator and Director of CMS; (3) Sean Cavanaugh, the former Deputy Administrator and Director of CMS; (4) Cheri Rice, the Acting Deputy Director of the Center for Medicare at CMS; (5) Jeffrey Grant, the former Division Director, Capitated Payment; (6) Dan Farmer, the former Special Assistant at CMS; (7) Julia Gorner, Director, Division of Capitated Plan Audits at CMS; (8) Cynthia Tudor, Deputy Center Director, Parts C and D at CMS; (9) Lateefah Hughes, the former Acting Deputy Group Director of Payment Policy and Financial Management at CMS; (10) Tom Hutchinson, the former Director of the Medicare Plan Payment Group at CMS; (11) Sean Creighton, the former Deputy Group Director of Payment Policy and Financial Management at CMS; (12) Jennifer Harlow, the Acting Director and Deputy Director of Medicare Plan Payment Group, Division of Payment Systems at CMS; (13) Jonathan Smith, the Director of the Medicare Plan Payment Group, Division of Retiree Drug Subsidy at CMS; (14) current and former government officials who (a) devised the MA risk adjustment methodology; (b) reviewed UnitedHealth's annual MA plan bids setting forth its proposed capitated payment amounts; (c) established CMS' average cost and risk calculations within specific geographic regions; (d) developed the methodology CMS uses for its own audits of MA plans; and (e) set forth diagnosis coding and medical documentation criteria used by the government itself in auditing health plans; and (15) UnitedHealth employees who will testify to the fact that they believed, and still believe, that UnitedHealth was paid properly and never submitted false statements or claims and did not knowingly and improperly retain any overpayments or avoid or decrease any obligations.

3. Key Documents

United States and Relator's Position: Plaintiffs, at this early stage of the litigation and subject to the factual record developed during discovery, identify the following potential key categories of documents in this case: The documents and

electronically stored information ("ESI") identified in Plaintiffs' Initial Disclosures as documents and ESI that the Government and Relator may use to support their claims; the documents referenced in the FAC; documents relating to Defendants' Chart Review, Claims Verification, and RACCR Programs; documents relating to Defendants' knowledge (as that term is defined by the FCA) about inaccurate or untruthful diagnoses submitted by providers, including diagnoses unsubstantiated by the providers' medical records; documents relating to Defendants' obligation to submit accurate and truthful risk adjustment data to Medicare for risk adjustment payments, including the obligation to submit diagnoses substantiated by beneficiaries' medical records; documents relating to Defendants' obligation to retract, withdraw, or delete inaccurate or untruthful risk adjustment data submitted to Medicare, including the obligation to retract, withdraw, or delete diagnoses unsubstantiated by beneficiaries' medical records; documents relating to Defendants' submission of inaccurate or untruthful risk adjustment data to Medicare; documents relating to Defendants' failure to retract, withdraw, or delete inaccurate or untruthful risk adjustment data; documents relating to Defendants' contracts and other agreements with CMS and their attestations; medical records from the RACCR "financially incentivized" providers relating to the beneficiaries whose diagnoses are at issue; documents regarding liability accruals and reserves that one or more of the Defendants took relating to their Chart Review, Claims Verification, and RACCR Programs; documents relating to Defendants' communications with CMS about the above-mentioned issues; and documents related to damages.

UnitedHealth's Position: UnitedHealth anticipates, subject to the factual record developed during discovery, that the key categories of documents in this action include: (1) the documents and electronically stored information ("ESI") identified in UnitedHealth's Initial Disclosures as documents and ESI that UnitedHealth may use to support its claims and defenses; (2) documents

demonstrating that UnitedHealth was transparent with the government about its claims verification program; (3) documents demonstrating that there was no statutory or regulatory requirement for MA plans to "look both ways"; (4) documents demonstrating that UnitedHealth did not knowingly retain any alleged overpayments; and (5) documents demonstrating that the allegedly fraudulent conduct was not material to payment.

E. Damages

United States and Relator's Position: At this time, Plaintiffs' damages calculations for both its Chart Review and RACCR damages analyses do not involve sampling or extrapolation. Rather, at this time, Plaintiffs intend to identify the specific diagnoses that Defendants failed to delete. In addition, Defendants' contention below that the FCA damages in this case should be reduced by an undefined "benefit" conferred by them to the Medicare Program is unfounded. There was no benefit to the Medicare Program from Defendants' receipt and retention of payments based on invalid data.

Furthermore, contrary to Defendants assertion below, Plaintiffs do not seek Defendants' assistance in determining their damages theories. However, Plaintiffs do seek and have a right to obtain the data and related information in Defendants' possession that Plaintiffs need to calculate all of the damages to the Medicare Program.

Chart Review Damages: In this action, the Government seeks to recover its damages for the 2009 payment year and all subsequent years during which Defendants knowingly avoided their obligation to delete diagnoses invalidated by their own chart reviews. To date, the Government has data to determine its damages for payment years 2011 to 2014. Assuming that the Court will schedule this action for trial for early 2020, the Government will limit its damages claim for purpose of that trial to five additional payment years: 2009, 2010, and 2015 to

2017.[5] Accordingly, the Government is now seeking to obtain from Defendants the data for those additional payment years. Based on experience from the investigation, as recounted below, it will take Defendants a significant amount of time to produce the data for the other five years and, thus, for the Government to perform the damages analyses.

In the investigation of this matter, Defendants produced data and other information for the Government to assess its damages for four of the years at issue, the 2011 to 2014 payment years. The Government requested this data from Defendants in July 2015. It took Defendants one year, until July 2016, to produce the data for all four years. In addition, after July 2016, Defendants continued to provide supplement data and information necessary to perform the damages analysis. According to a December 2, 2016 letter from Defendants to the Government, for those four years, Defendants' initial production included 47 files containing 828 million rows of data and totaling 150 GB of data and subsequent productions included 60 supplemental and replacement files totaling an additional 150 GB of data. This was not surprising as Defendants have conducted millions of chart reviews. (FAC ¶ 169)

As alleged in paragraph 237 of the FAC, the Government determined that, for 2011 to 2014, Defendants failed to repay the Medicare Program at least $1.1 billion by failing to look both ways and delete diagnoses invalidated by their Chart Review Program. These damages are based on (1) a comparison of the results of Defendants' chart reviews for those four years with the diagnoses they submitted for payment for those years in order to identify the unsubstantiated diagnoses that should have been deleted, as alleged in paragraph 235 of the FAC, and (2) a computation of the overpayments made to Defendants based on those invalid diagnoses.

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[5] To the extent that Defendants are continuing to ignore the negative results of their current chart reviews and failing to delete the invalid diagnoses, the Government reserves its right to recover the damages for payment years after 2017.

On October 5, 2017, the United States served Defendants with its First Request for Production of Documents, which includes specific requests for the chart review and other data required to conduct the damages analyses for the 2009, 2010, and 2015 to 2017 payment years. To date, Defendants have not produced any of the requested data. In a letter dated March 7, 2018, Defendants stated that they anticipate producing data for 2015 to 2017 payment years by April 27, 2018, but that they reserve their right to modify what years are included and the data that Defendants will produce for the 2016 and 2017 payment years will not be complete. Defendants have not stated when they will produce the data for the 2009 and 2010 payment years.

Defendants are refusing to provide complete chart review and other data for the later payment years and to comply with Rule 26(e)'s requirement that discovery responses be supplemented or corrected if they are incomplete or incorrect. In a recent letter, Defendants state that they will not produce any chart review and other data necessary to assess damages after January 31, 2018. However, for the 2016 payment year, pursuant to a deadline set by CMS, Defendants (and other MAOs) are allowed to submit diagnoses to the Medicare Program until August 2, 2018. Thus, for that year, Defendants currently may be performing chart reviews in order to submit additional diagnoses to increase payments and they may continue to perform chart reviews and submit those additional diagnoses until August 2, 2018. Similarly, for the 2017 payment year, Defendants (and other MAOs) are allowed to submit diagnoses until September 14, 2018. Thus, for that year, Defendants also currently may be performing chart reviews in order to submit additional diagnoses to increase payments and they may continue to perform chart review and submit the additional codes until September 14, 2018. Accordingly, in order to obtain complete and accurate data to assess damages for payment years 2016 and 2017, Defendants must provide the Government with (i) the results of and other information about any chart reviews

relating to those years that were performed after January 31, 2018 and (ii) any supplemental or corrected data relating to the beneficiaries whose charts were reviewed for those years (for example, supplemental data would include any additional diagnoses submitted by providers for those beneficiaries for those years). Because Defendants have refused to do this, the Government will move to compel the production of complete and accurate data for the 2016 and 2017 payment years.

In addition, since at least 2014, Defendants have submitted diagnoses through two separate systems to CMS, the Risk Adjustment Processing System (RAPS) and the Encounter Data Processing System (EDPS). Defendants have two separate databases that they use to report into each system. Defendants' database that submits diagnoses to RAPS is called IRADS. It includes data about all of the beneficiaries in Defendants' MA Plans, including the beneficiaries whose charts were reviewed in Defendants' Chart Review Program. This data includes, among many other things, the dates of services of the medical encounters that the beneficiaries had with providers, information identifying the providers, and the diagnoses submitted by the providers. Defendants' database that submits diagnoses to EDPS includes additional information about the beneficiaries, the providers, and the beneficiaries' health status. That additional data is likely to be very useful in assessing damages.

In its October 2017 Document Request, the Government requested data from both of Defendants' databases, IRADS and the database that submits to EDPS, in order to ensure that it has complete and accurate data to perform its damages analyses. So far, Defendants have not agreed to provide the data from their database that submits to EDPS. Accordingly, the Government will move to compel its production.

After the requested documents and data are produced, the Government will conduct the damages analyses for the 2009, 2010, 2015 to 2017 payment years.

The Government will present its damages pursuant to Rule 26(a)(2) relating to the disclosure of expert testimony.

For the Government to even attempt to make its initial damages expert disclosures by June 28, 2019 (the date proposed by Plaintiffs for initial expert disclosures), Defendants need to complete their production of the chart review and other data necessary to compute damages by September of 2018. In order for their productions to be deemed complete, Defendants must provide all information necessary for the Government to understand and interpret the data that they produce. It is the Government's understanding that Defendants will insist that the Government obtain this explanatory information through formal discovery (interrogatories and depositions). Obtaining this information through formal discovery will significantly add to the time and effort necessary for the Government to make its initial damages expert disclosures.

RACCR Damages: Defendants themselves estimated the amount of the overpayments they would have to return to the United States as a result of the RACCR Program in the tens of millions of dollars per year during the time period before they started phasing out the program. In December 2017, Plaintiffs served Defendants with interrogatories to obtain the information necessary to conduct the first phase of their determination of these overpayments. The interrogatories seek information necessary to identify which financially-incentivized (capitated and gainsharing) providers coded excessive numbers of diagnoses (more than three times the average rate), including those providers who were included in the RACCR Program and failed Defendants' sample validation test. The interrogatories also seek information about the diagnoses that these providers coded at these excessively high rates and the beneficiaries for whom they coded these diagnoses. Defendants have not yet provided all of the information requested by the interrogatories. After Defendants complete their provision of this information (and assuming the information that Defendants provide is sufficient),

Plaintiffs plan to conduct the second phase of their overpayment analysis, which will require obtaining medical records from the outlier providers and conducting medical record reviews to determine the invalid diagnoses that Defendants should have deleted. Defendants have not stated when they will complete their responses to these interrogatories.

Defendants' Alleged Damages: Based on Defendants' counterclaims, it appears that their purported damages are contingent entirely on their paying damages to the Government in this action. Accordingly, at this time, Plaintiffs do not believe that there will be a need to conduct separate damages analyses pertaining to Defendants' counterclaims. However, because Defendants have failed to provide any description of their purported damages or even a description of their theory of damages either in their pleading setting forth their counterclaims or in this report, Plaintiffs do not know whether their belief is correct. If it is incorrect, Plaintiffs will need additional time to conduct fact and expert witness discovery relating to Defendants' damages. Pursuant to Rule 26(e)(1)(B), the Court should order Defendants to supplement their Rule 26(a)(1)(A) initial disclosures to describe their damages as well as to list the witnesses and documents supporting their counterclaims.

UnitedHealth's Position: UnitedHealth denies that it owes any damages alleged in the FAC. UnitedHealth will have an alternate theory as to how damages should be calculated if liability is established in light of the contracts and reimbursement methodology and the FCA measure of damages, which take into account the benefit already conferred on the government. UnitedHealth anticipates challenging the propriety of sampling and extrapolation and asserting that a fee-for-service adjustor must be applied to account for unsupported codes in the diagnostic data of fee-for-service beneficiaries.

At this point in the litigation, UnitedHealth does not have sufficient information to estimate damages associated with its counterclaims against the United States regarding its obligations under the MA program.

UnitedHealth notes that the United States and Relator's position above on Damages details discovery-related issues instead of setting forth "[t]he realistic range of provable damages," as required by the Court's Order Setting Scheduling Conference. UnitedHealth addresses the United States' mischaracterization of these discovery issues below in the proper section, Status of Discovery (Section I). The notion that the United States needs significantly more time to conduct routine discovery in a case it brought—despite the advantages of a multi-year investigation, detailed responses to dozens of complex (and sometimes improper and nonsensical) interrogatories, more than 20 Civil Investigative Demand oral examinations, over 630,000 documents produced by UnitedHealth during the investigation and in *Swoben*, 6 document productions totaling nearly 66,000 documents already in this litigation, and 5 spreadsheets of over 125,000 lines of data produced by UnitedHealth in response to the United States' First Set of Written Interrogatories to Defendants—rings hollow.

The United States chose to bring this lawsuit, and it cannot now complain about conducting routine discovery to which UnitedHealth is entitled and that UnitedHealth needs to defend itself. The United States effectively is seeking UnitedHealth's assistance in not only determining what their theory of damages is, but also in determining whether there are any damages (there are not). This is wholly improper and does not justify the United States delaying discovery or failing to meet its discovery obligations.

F. Insurance

Coverage is available to UnitedHealth for certain claims in the FAC under UnitedHealth's insurance policies, and UnitedHealth has agreed to make certain documents relating to those policies available to Plaintiffs.

G. Motions

The United States and Relator's Position: As explained in Section C (Legal Issues), the Government presently anticipates filing a motion to dismiss Defendants' counterclaims. In addition, the Government and the Relator presently anticipate filing a separate motion to strike certain of Defendants' affirmative defenses. As explained in Sections E (Damages) and I (Status of Discovery), Defendants refuse to produce certain very relevant documents and Plaintiffs presently anticipate moving to compel the production of these documents.

In addition, the Government reserves the right to seek leave to (i) add any Medicare Advantage Organizations (or Part D Sponsors) directly or indirectly owned, affiliated with, or controlled by UnitedHealth Group that should be included in the list of such organizations set forth in paragraph 26 of the FAC; and, (ii) if necessary to recover its damages, to add any other entities affiliated with UnitedHealth Group that owned, controlled, or managed the Medicare Advantage Organizations. Information that has recently come to Plaintiffs attention indicates that some Medicare Advantage Organizations (or Part D Sponsors) directly or indirectly owned, affiliated with, or controlled by UnitedHealth Group may not have been expressly named in the FAC or may have been identified incorrectly. As needed, Plaintiffs will seek to stipulate with Defendants to amend the FAC to address these types of issues.

In addition to the motions identified in Section M, Plaintiffs anticipate considering additional motions as issues arise throughout the litigation. Plaintiffs may also file motions to exclude certain documents as evidence for use both in supporting summary judgment motions and at trial.

UnitedHealth's Position: UnitedHealth has engaged in good-faith discussions and negotiations on all issues raised by the United States during the course of discovery either to resolve or narrow any areas of disagreement between the Parties. Those discussions and negotiations are ongoing, and UnitedHealth is

committed to working with the United States to avoid or limit the necessity for seeking intervention from the Court.

In addition, UnitedHealth reserves the right to seek leave to amend its counterclaims to add or substitute any Medicare Advantage Organizations (or Part D sponsors) that may subsequently be added or substituted by the United States in its FAC.

Both Parties reserve the right to file non-dispositive pretrial motions, including but not limited to motions related to discovery disputes, motions *in limine*, and motions to exclude experts. Dispositive motions are addressed below.

H. Manual for Complex Litigation

The Parties do not believe the Manual for Complex Litigation should be utilized in this case.

I. Status of Discovery

The United States and Relator's Statement:

In July 2017, the Court provided that "the Parties may engage in written discovery (document requests and interrogatories) and may do so before a Rule 26(f) conference." (Dkt. No. 133) Defendants have served the Government with two sets of document requests and the Relator with one set of document requests. The Government has also served Defendants with two sets of document requests. The Government has also served Defendants with several interrogatories to which Defendants are responding by producing documents.

Government's Production of Documents: The Government fully appreciates that Defendants have a right to obtain documents and other information relevant to the claims and defenses that are appropriately a part of this case. The Government has been and will continue to be fully cooperative with Defendants in that regard.

The Government has been working cooperatively with Defendants in responding to their 97 separate document requests (the total number in both sets), which cover a very wide range of documents on many subject matters. The

Government spent many hours working with Defendants in the drafting of mutually-agreeable proposed protective orders relating to the treatment of confidential documents and other information and relating to the non-waiver of privilege and protected documents. These protective orders were entered by the Court on January 16, 2018. (Dkt. Nos. 197 & 198) In addition, on a regular basis over the last six months, the Government has been in contact with Defendants about their document collection and production activities through emails, letters, telephone calls, and meetings. The Government spent many hours providing Defendants with an extensive amount of information about its document collection efforts and document review protocols and discussing these efforts and protocols with Defendants' counsel. The Government identified its numerous document custodians and multi-access email accounts from which it has collected documents, and the Parties have agreed to provide titles and dates of employment for each of their document custodians. The Government also identified the search terms used to collect potentially responsive documents in the custodians' electronic files. In addition, the Government provided Defendants with detailed information about its Technology Assisted Review methodology being used to identify the responsive documents in its enormous collection of electronic documents.

The Government also has spent many hours responding to Defendants' requests that it expand its efforts to locate and collect documents, revise its search terms for collecting electronic documents, and revise its Technology Assisted Review methodology. The Government has complied with many of these requests. The Government has also compromised and tried to minimize the burden of discovery disputes needed to be resolved by the Court by agreeing to produce documents relating to various issues that are irrelevant to this case, including, for example, documents relating to CMS' methodology for conducting administrative audits and the calculation of the statutory coding intensity adjustment that applies

to all MAOs. (However, the Government may still file one or more motions as necessary to limit or prevent such wasteful discovery.)

The Government has also agreed to produce documents and privilege logs on a rolling basis. In addition, it has agreed to prioritize the production of various documents at Defendants' request so long as it is given reasonable notice and Defendants' also agree to requests by the Government to prioritize the production of certain documents such as the production of the data necessary to perform the Government's damages analyses.

In response to Defendants' document requests, the United States has so far collected over four terabytes of data, constituting over five million documents, from more than 150 custodians at CMS and other parts of the Department of Health and Human Services ("HHS"). The United States is still in the process of collecting documents in response to Defendants' requests that it expand the search terms that it is using to collect potentially responsive documents and expects to collect a substantial amount of additional documents within the next several months. In response to other requests made by Defendants, the United States is also continuing to identify additional document custodians, including custodians at the Office of the Secretary of HHS.

The United States must review all of the documents that it has collected and will collect over the next several months. It must review these documents for responsiveness, confidentiality (for example, for patient identifiable data and information relating to other insurance companies which participate in the Medicare Advantage Program), and privilege. To expedite the task of reviewing and producing responsive, non-privileged documents, the United States is utilizing targeted searches, Technology Assisted Review, and manual review. Even utilizing these methods, however, the task of identifying responsive, non-privileged documents and determining which of those are confidential is enormous. The Government currently estimates that there are at least 500,000 documents that

its attorneys must manually review for privilege and this does not include the manual, eyes-on privilege review that will need to be conducted for documents that the Government has not yet collected. Contrary to Defendants' assertion below, Relator's counsel cannot perform this privilege review of Government documents. Government attorneys must exclusively perform this review. Furthermore, contrary to Defendants' assertion below, the Government is not inappropriately relying on the deliberative process privilege or applying the privilege too broadly. *See NLRB v. Sears, Roebuck & Co*., 421 U.S. 132, 150 (1975) (privilege protects documents that "reflect[] advisory opinions, recommendations and deliberations comprising part of a process by which governmental decisions and policies are formulated"); *Hongsermeier v. Commissioner of Internal Revenue*, 621 F.3d 890, 904 (9th Cir. 2010) (privilege protects documents that are "predecisional" and "deliberative").

The Government's initial goal was to make rolling productions of documents on a regular basis throughout 2018 and to substantially complete its production by the end of 2018. This goal was premised on the hope that Defendants would agree to withdraw at least some of its requests for irrelevant documents, but they have not. In addition, this goal was premised on the hope that the Court would agree with the Government's proposal that fact witness depositions by both Parties commence after both Parties substantially complete their document productions. However, over the last several months, Defendants diverted the Government's resources because of their insistence that they conduct expedited depositions of certain Government witnesses. This was exacerbated by a change in Defendants' position in insisting that the Government also produce documents relating to these witnesses on an expedited basis even though neither Defendants' deposition notice nor subpoena relating to these witnesses had requested such documents. In order to accommodate the noticed depositions of two senior Government witnesses (including a former Administrator of CMS),

which went forward notwithstanding the Government's objection that they were premature, the Government had to interrupt its document collection and review efforts in response to Defendants' 97 document requests (sets one and two) in order to prioritize the collection, review and production of documents relating to these two deponents. This has impeded the Government's document review and production efforts.

Furthermore, the Government's resources are now being diverted by responding to Defendants' counterclaims and affirmative defenses. Government counsel is now focused on preparing motions to dismiss the counterclaims and strike some of the affirmative defenses.

To date, the Government has produced approximately 10,000 documents. The tasks of identifying responsive documents and conducting manual, "eyes-on" privilege and confidentiality reviews have consumed and will continue to consume significant Government's resources until these reviews are completed. The Government proposes that phased discovery, with fact witness depositions commencing in November 2018, would significantly facilitate its completion of the production of documents. If Defendants continue to expedite the depositions of Government witnesses, the Government's resources will be diverted to defending those depositions and producing attendant documents and, thus, discovery will proceed in a piecemeal fashion. This diversion will be in addition to the diversion caused by moving to dismiss Defendants' counterclaims and strike their affirmative defenses. This diversion will further delay the Government's completion of its production of documents.

It should not be surprising to Defendants that it would require significant time for the Government to produce documents in response to their numerous and broad requests. In the investigation, the approximately 600,000 documents produced by Defendants were produced over a 4 year time period, from December 2012 to December 2016. Furthermore, the Government also believes that

Defendants will not substantially complete their document production in this action until at least the end of 2018.

Relator's Production of Documents: Relator has served his responses and objections to Defendants' document requests and is in the process of making a relatively small production of non-privileged, relevant documents. Following his departure from UnitedHealth in 2012, Relator gave UnitedHealth all non-privileged documents in his possession generated in the course of and directly related to his work at UnitedHealth (that is, UnitedHealth's documents). Moreover, pursuant to agreements between UnitedHealth and Relator, he destroyed all such UnitedHealth documents in his possession other than his performance reviews.

Defendants' Production of Documents: Plaintiffs presently anticipate moving to compel Defendants' production of various documents that they have refused to produce. As explained in Section E (Damages), this includes chart review and other data that is necessary to assess damages for payment years 2016 and 2017. As another example, this includes documents from the electronic and hard copy files of Steve Hemsley, the Chief Executive Officer of UnitedHealth Group from 2006 to 2017, and Janis Leafgren, Mr. Hemsley's Administrative Assistant, who (for instance) sent and received emails on behalf of Mr. Hemsley. On March 27, 2018, Defendants sent the Government a letter stating that it needs some undefined amount of additional time to decide whether it will produce documents from these relevant custodians' files. However, Mr. Hemsley engaged in activities relevant to this case. Among other things, Mr. Hemsley chaired Defendants' Risk Adjustment Advisory Board (FAC ¶ 42); the executives who managed Defendants' Medicare Advantage Plans regularly reported to Mr. Hemsley with respect to risk adjustment payment-related issues (*id.*); according to a 2011 documents produced by Defendants, Mr. Hemsley was "significantly involved in the oversight and management of" Defendants' "Medicare business"

(*id*.); and, Mr. Hemsley was aware of risk adjustment payment compliance issues (*id*. at ¶¶ 154 & 188). Moreover, Mr. Hemsley was intimately involved in the decision to terminate Defendants' Claims Verification Program and revert to ignoring the negative results of Defendants' chart reviews and failing to delete the diagnoses invalidated by those reviews. Mr. Hemsley is the one who directed Messrs. Renfro, Johnson, Nelson, and Schumacher and Ms. Erickson to speak with CMS about Defendants' termination of their Claims Verification Program. (FAC ¶¶ 224-26, 230-31, & 234) Defendants have provided no valid justification for not searching these custodians' files.

Plaintiffs also anticipate that they may challenge many of Defendants' privilege assertions, including privilege assertions pertaining to the rendering of non-legal advice, the attendance of Defendants' attorneys at business meetings to shield those meetings from discovery, and the participation of Defendants' attorneys in non-legal communications to shield those communications from discovery.

UnitedHealth's statement:

UnitedHealth's statement on the collection and production of documents: The United States opted to bring this lawsuit, yet it now balks at the notion of meeting its discovery obligations and allowing UnitedHealth to pursue discovery to which UnitedHealth is entitled so that it may properly and effectively defend itself. The United States complains about its resources being "diverted" by other standard litigation matters—such as defending depositions and responding to counterclaims and affirmative defenses—and attempts to justify its failure to meet its original document production deadline because of these "diverted resources." Despite the advantage of conducting a multi-year investigation related to this matter, the United States curiously now appears to claim that it lacks the resources to properly litigate this matter and to meet its discovery deadlines. The notion that Plaintiffs—which currently have thirteen government attorneys and twenty active

attorneys for Relator (including twelve partners)—lack the resources to conduct routine discovery in a timely manner is absurd.

Prior to filing the FAC, DOJ investigated this matter for more than five years. During that time, UnitedHealth produced over 600,000 documents, compiled detailed responses to dozens of complex interrogatories, and produced more than twenty witnesses for Civil Investigative Demand oral examinations. In *United States ex rel. Swoben v. Secure Horizons*, Case No. CV-09-5013 JFW (JEMx), UnitedHealth produced over 34,000 documents, which are also responsive in this case. The United States, in contrast, made two small productions totaling less than 600 documents, the majority of which were publically available and re-produced from another action.

In response to the United States' Complaint in this case, UnitedHealth has been collecting documents from 118 custodians and 7 email distribution lists and has collected approximately 70 million documents to date. In addition to the more than 634,000 documents produced during the investigation and the *Swoben* litigation, UnitedHealth has produced over 65,845 documents in this litigation. On January 29, 2018, UnitedHealth produced 5 spreadsheets of over 125,000 lines of data requested by the United States in its First Set of Written Interrogatories to Defendants. UnitedHealth has also produced two privilege logs thus far—in addition to the more than ten it produced during the investigation—and intends to continue producing privilege logs on a monthly basis.

In contrast, the United States failed to produce a single document until late February 2018—and only did so at the direction of Magistrate Judge Segal after initially refusing to comply with its discovery obligations related to the depositions of Marilyn Tavenner and Jeffrey Grant. The United States' first two productions consisted of 893 documents total. Although the United States' deadline for its first Technology Assisted Review production was the week of March 19, it failed to make its production until March 28, when it produced approximately 9,500

documents—approximately one-sixth of the number of documents produced by UnitedHealth in this litigation alone. UnitedHealth also notes that Relator has yet to produce a single document in this matter, despite UnitedHealth serving document requests on Relator on January 19, 2018.

UnitedHealth has already agreed that the United States need not log certain categories of likely privileged documents (such as communications with the Department of Justice or the Office of General Counsel), so the United States' assertion that it will have to review over 500,000 documents (and counting) for privilege is not primarily tied to attorney-client or work product privilege concerns. Rather, it is the product of the United States' inappropriately broad view of the qualified deliberative process privilege, as demonstrated by the United States' first privilege log that it produced on March 30, 2018. The United States has asserted deliberative process privilege over every single document on that log for which CMS is a custodian—approximately eighty percent of the entire log. This specious, over-expansive view is nothing more than a strategic attempt to yet again deprive UnitedHealth of key information that UnitedHealth needs to defend itself in a lawsuit that the United States chose to bring. For example, the United States brazenly attempts to assert deliberative process privilege over documents the government itself produced previously in response to a FOIA request. In response to that request, these documents were produced partially redacted, suggesting they had already undergone review by the relevant government agency outside of this litigation and deemed appropriate for public disclosure.

UnitedHealth has also provided the United States with information regarding its document collection efforts and document review protocols and will continue to work cooperatively with the United States on discovery. UnitedHealth engaged in good-faith negotiations with the United States and exchanged detailed information about its Technology Assisted Review protocol, and the Parties have now agreed on respective Technology Assisted Review protocols. While UnitedHealth

proposed that the Parties exchange additional information, including custodians' job titles and employment history, regarding custodians on December 20, 2017, the United States was not prepared to do so.

UnitedHealth's statement regarding data productions: The United States' Damages section (Section E, above) is replete with inaccuracies and misleading statements, and it is highly inappropriate for a Rule 26(f) Joint Report. To avoid any prejudice resulting from the United States' tactics, UnitedHealth will briefly respond to set the record straight, but UnitedHealth does not believe this Joint Report is the proper vehicle to respond to each and every one of the United States' assertions.

UnitedHealth has been working diligently and devoting substantial resources—in addition to the overlapping resources it is expending to respond to other document requests and interrogatories, deposing witnesses, moving to dismiss the FAC, answering the United States' 364-paragraph FAC, and developing its counterclaims, among other things—to collect and produce data responsive to various requests by the United States. UnitedHealth agreed to the United States' request that UnitedHealth prioritize dates of service years 2014 through 2016 and will be making a significant production on April 27, 2018, the government's unilaterally imposed deadline. Per the United States' request, UnitedHealth also agreed to produce the requested data for dates of service years 2008 and 2009 after April 27, 2018. UnitedHealth has been transparent with the United States about its data productions, and the United States' claim otherwise is preposterous. The United States appears to be dictating how much time UnitedHealth is going to require to produce responsive data to its extremely broad data requests, but UnitedHealth clearly is better positioned to make that determination. Accordingly, UnitedHealth has in good-faith proposed a discovery schedule that not only meets the United States' unilaterally imposed April 27, 2018

deadline but also gives UnitedHealth sufficient time to satisfy its discovery obligations.

J. Discovery Plan

1. Rule 26(a) Initial Disclosures – Rule 26(f)(3)(A)

The Parties made their initial disclosures on December 22, 2017.

United States and Relator's Position: In their initial disclosures, Plaintiffs provided Defendants with the results of their estimation of damages for the four payment years (2011 to 2014) for their violations of the FCA relating to their chart reviews. These results are also described in paragraphs 235 and 237 of the FAC. At this time, Plaintiffs claim a work product privilege with respect to the analyses underlying this damages estimate. In accordance with Rule 26(a)(2), the United States and Relator will make their expert damages disclosures at the time set forth in the Schedule entered by the Court.

As previously explained, Defendants have not produced documents and data required to compute damages due to their one-way chart reviews for payment years 2009, 2010, 2015, 2016, and 2017.[6] In addition, Defendants have agreed to provide certain information responsive to the Government's interrogatories concerning Defendants' RACCR program, but have not yet done so. Once Defendants have completed their provision of information responsive to the Government's interrogatories, Plaintiffs will use that information to propound subpoenas to third-party providers who participated in Defendants' RACCR program, to enable Plaintiffs to obtain and review medical records in the possession of those third-party providers.

The United States proposes that it will comply with the requirements imposed by Rule 26(a)(1)(A)(iii) when it makes its damages expert witness(es) disclosures pursuant to Rule 26(a)(2)(B). The United States needs sufficient time

[6] If Defendants' unlawful one-way Chart Review Program has continued past payment year 2017, the United States reserves its right to recover the additional damages.

(approximately nine months) to perform all the work, including, but not limited to, the document review and data analyses, necessary in order to compute damages and make its damages expert witness(es) disclosures after Defendants complete their production of the required documents and data (assuming that the Defendants also cooperate in producing the data in a usable format).

UnitedHealth's Position: The United States' discussion in this section is once again largely unnecessary and inappropriate in a Joint Report. The Parties exchanged initial disclosures on December 22, 2017 and will revise or supplement as required as the matter moves forward.

UnitedHealth continued to work diligently and to devote substantial resources to collect and produce data sought by the United States, and UnitedHealth will be making a significant production of data on April 27, 2018. Again, the notion that the United States needs significantly more time to conduct routine discovery and develop its damages theory and analysis is baseless. The United States chose to file this lawsuit after the benefit of a multi-year investigation, detailed responses to dozens of complex interrogatories, numerous Civil Investigative Demand oral examinations, and UnitedHealth's production of hundreds of thousands of documents. The United States must now engage in timely discovery and cannot continue to delay meeting its obligations.

2. Subjects and Timing of Discovery – Rule 26(f)(3)(B)

The Parties' positions as to the specific dates for Non-Expert and Expert Discovery Cut-Off are set forth below and in Exhibit A. The Parties' positions as to the subjects on which discovery may be needed, and whether discovery should be conducted in phases or be limited to or focused on particular issues, are as follows:

United States and Relator's Position: Certain key issues in this case are purely legal issues because the underlying facts are undisputed and most of those legal issues have already been decided by the Ninth Circuit in *Swoben*. Discovery

is therefore unnecessary to resolve these legal issues. In particular, the "materiality" of Defendants' submission of false risk adjustment data is a purely legal issue as are Defendants' legal obligations to delete unsubstantiated diagnoses. In addition, Defendants' "actuarial equivalence" argument (if Defendants are making it in this case) raises a purely legal issue about the meaning of that term as used in Part C of Medicare Statute. Accordingly, discovery relating to the "materiality" issue, Defendants' contractual and regulatory obligations to delete invalid diagnoses, and the "actuarial equivalence" issue should be precluded or, at a minimum, limited by the Court pursuant to Rule 26(b)(1).

Plaintiffs believe that discovery, including third party discovery, should focus on the results of Defendants' medical record reviews conducted as part of their Chart Review, Claims Verification, and RACCR Programs; Defendants' knowledge (as that term is defined by the FCA) about inaccurate or untruthful diagnoses submitted by providers, including diagnoses unsubstantiated by the providers' medical records; Defendants' knowledge (as that term is defined by the FCA) about their obligation to submit accurate and truthful risk adjustment data to Medicare for risk adjustment payments, including the obligation to submit diagnoses substantiated by beneficiaries' medical records; Defendants' knowledge (as that term is defined by the FCA) about their obligation to retract, withdraw, or delete inaccurate or untruthful risk adjustment data submitted to Medicare, including the obligation to retract, withdraw, or delete diagnoses unsubstantiated by beneficiaries' medical records; Defendants' submission of inaccurate or untruthful risk adjustment data to Medicare; Defendants' processes and procedures for submitting risk adjustment data to CMS and for withdrawing, retracting, or deleting such data; Defendants' failure to retract, withdraw, or delete inaccurate or untruthful risk adjustment data; Defendants' communications with CMS about the above-mentioned issues; Defendants' contractual and financial relationship with their "incentivized" capitated and gainsharing providers; the unsubstantiated and

invalid diagnoses that incentivized providers reported to Defendants and Defendants submitted to CMS for risk adjustment payments; any affirmative defenses that remain after the government and relator's motion to strike; and damages.

Plaintiffs propose that discovery proceed in phases and we describe these phases in detail below. Both Rules 16(c)(2)(F) and 26(d)(3) and the Court's February 28, 2018 Order Setting Scheduling Conference contemplate the use of phased discovery. Phased discovery is particularly appropriate in very large and complex cases such as this.

Plaintiffs believe that this approach is warranted to ensure that this very large case be conducted in the manner most efficient for the Court, the Parties, third parties, and witnesses. Plaintiffs also strongly believe that fact witness depositions should begin after (i) the Court resolves the Government's motion to dismiss Defendants' counterclaims, the Plaintiffs' motion to strike Defendants' affirmative defenses, and the motion for partial summary judgment on Defendants' "actuarial equivalence" argument (unless Defendants stipulate that they are not making this argument in this case); (ii) the Parties produce substantially all relevant documents to each other relating to the fact witnesses; and (iii) privilege issues and issues relating to the appropriate scope of discovery are resolved. Otherwise, there is a significant risk that (i) significant time will be spent deposing witnesses about issues relating to counterclaims that are later dismissed on legal grounds by the Court and/or defenses that the Court strikes or disposes of on the Government's motion for partial summary judgment; (ii) the Parties will seek to depose the same witnesses multiple times because, subsequent to their depositions, additional documents relating to the witnesses (or the topics on which they were deposed) were collected and produced; and (iii) the Court will be unnecessarily burdened with multiple motions for protective orders and motions to compel. By making this request for phased discovery, the Government does not seek to prevent

Defendants from obtaining any needed and relevant evidence, as Defendants may pursue all reasonable discovery efforts they desire. The Government simply seeks to ensure that discovery is conducted in the most efficient manner possible as appropriate for litigation of this magnitude.

In addition, Defendants' proposal that non-expert discovery be cut-off on January 28, 2019 is not realistic and is extremely prejudicial to Plaintiffs. This deadline will force Plaintiffs to take depositions of fact witnesses before Defendants produce documents relevant to their depositions. It will also force the Government to focus on defending depositions rather than completing its document production. In addition, this January 28, 2019 deadline will not provide the Government with sufficient time to analyze the chart review and other data that Defendants produce in order for the Government to assess damages and to obtain the additional information it needs to understand and interpret the data. As previously stated, the Government will need to obtain this information by deposing fact witnesses and serving interrogatories on Defendants. This deadline also will not provide Plaintiffs with sufficient time to determine the overpayments due to the incentivized providers' invalid diagnoses, which, as previously stated, requires that Plaintiffs subpoena medical records and other documents from these providers and then review the medical records.

Furthermore, Defendants' argument that Magistrate Judge Segal already decided that phased discovery should not occur in this case is incorrect. Magistrate Judge Segal allowed Defendants to conduct the depositions of only two Government witnesses over the Government's objection that the depositions were premature. Defendants represented to Magistrate Judge Segal that they would not re-depose those witnesses a second time in this matter. Magistrate Judge Segal did not hold a Rule 16(b) Scheduling Conference or consider the phased discovery plan set forth by Plaintiffs below.

Phase One:

- The Parties should focus on the completion of production of documents; the resolution of objections to the production of documents based on relevancy, burden, etc.; and the resolution of privileges being asserted to withhold the production of documents. It is likely that the Court's intervention may be required to resolve objections and privilege issues and, thus, that the Parties will need to brief these issues. Resolution of these objections and privilege issues before fact witness depositions will streamline such depositions and ensure that they are conducted appropriately.
- By April 30, 2018, Defendants must disclose in writing whether they will rely on an advice of counsel, and/or good faith reliance defense, and describe their defense(s) in sufficient detail to permit Plaintiffs to conduct relevant discovery. Disclosure of this information under the proposed deadline will permit Plaintiffs to seek additional discovery on these issues during phase one, including documents over which Defendants waive privilege, as applicable, through assertion of the defense(s).
- By September 30, 2018, Defendants must complete their production of documents and data responsive to the one-way chart review damages-related discovery requests that have been served. After the production of the data, Defendants should work cooperatively with Plaintiffs to explain and answer questions concerning the data produced, including explaining the format and source of the data, and any abbreviations. The Court's imposition of this intermediate deadline on Defendants ensures that Plaintiffs will have sufficient time to review Defendants' production of documents and data needed to compute damages, to clarify or resolve any issues, to take depositions of fact witnesses knowledgeable about such documents and data, to propound and receive answers to interrogatories about such documents and data, and to prepare the required disclosures of damages expert

witness(es) before opening expert reports are due.

- The Parties may take discovery relating to the preservation, collection, and production of documents, including the Defendants' production of data requested by Plaintiffs in order to compute damages.
- The Parties may serve subpoenas on third parties in order to obtain documents from them. Plaintiffs have already done so. For example, Defendants objected to producing documents and data about the results of their chart reviews on the ground that the results were in the possession of third-parties. Consequently, Plaintiffs served third party subpoenas on three companies that Defendants employed to review medical records as part of its Chart Review Program in order to obtain the results of these reviews. But then, two of the companies responded that Defendants directed them to provide the documents and data to Defendants and the companies have not yet produced the chart review results to Plaintiffs. In addition, Plaintiffs will seek medical records from incentivized providers who were outliers (i.e., diagnosed certain medical conditions at unusually high rates) and whose diagnoses had high invalidation rates based on the results of Defendants' RACCR reviews. Plaintiffs have sought information (through interrogatories) from Defendants identifying the beneficiaries whom those incentivized providers diagnosed with those conditions in order to serve the providers with subpoenas for those beneficiaries' medical records, and Defendants have agreed to provide certain information responsive to those interrogatories. Until Defendants complete their provision of information necessary to identify these beneficiaries, Plaintiffs cannot serve the providers with the subpoenas requesting their medical records. Review of those medical records will enable the Plaintiffs to identify the unsubstantiated diagnoses that Defendants submitted to the Medicare Program but deliberately ignored or recklessly disregarded.

- The Parties may also propound interrogatories on each other. Plaintiffs propose that each side may, without seeking leave of Court, serve up to 30 interrogatories relating to the Government's claims in this action. Plaintiffs further state that they will seek the Court's permission to serve additional interrogatories relating to Defendants' counterclaims that are not dismissed and the affirmative defenses that remain after the Court rules on their motions.
- The Parties may also serve requests for admissions, which number should not be limited.
- Plaintiffs anticipate that Phase I will be the principal phase for written and document discovery, although the Parties will not be precluded, prior to the close of fact discovery, from submitting additional discovery requests to address discrete issues that arise or become clear later in the litigation, or to establish the authenticity and admissibility of documentary evidence if those evidentiary issues cannot be resolved cooperatively.

Phase Two:

- During this phase, the Parties should focus on conducting fact witness depositions. Plaintiffs estimate that, with respect to their claims (not Defendants counterclaims or affirmative defenses), they will need at least 100 hours for depositions of fact witnesses and at least an additional 14 hours for depositions of corporate entities conducted pursuant to Rule 30(b)(6) (such depositions and topics may be the subject of more than one notice) and propose that this phase of discovery start November 1, 2018 and end by May 31, 2019. This estimate of the number of hours for and the time it will take for fact witness depositions is based on the assumptions that (i) Defendants will work informally and cooperatively with Plaintiffs to provide the information necessary for Plaintiffs to understand Defendants' data relating to damages (otherwise additional time would be needed to depose

fact witnesses knowledgeable about the data; and (ii) there are no major issues concerning the authenticity and admissibility of documents (which would also require additional time to depose fact witnesses). This estimate also does not include fact witness depositions relating to Defendants' counterclaims or affirmative defenses. In addition, if Defendants fail to work informally and cooperatively with Plaintiffs to provide the information necessary for Plaintiffs to understand and interpret the chart review and other data Defendants provide to determine damages, Plaintiffs seek an additional 25 hours for depositions of witnesses who can provide this information.

- Plaintiffs agree that the customary limitations regarding the duration of depositions (seven hours) should remain, and that no individual will be deposed more than once without a showing of good cause and leave of court. However, Plaintiffs believe that, on the whole, fact witness depositions should be limited by the number of total hours and not by the number of witnesses. Plaintiffs need to depose many fact witnesses, but we believe that many of them can be deposed in less than a full day. Defendants' request that the Court limit the number of fact witness depositions to ten deponents (with the Parties having the option to stipulate to more) is unreasonable. The Government's use of the testimony it took during the investigation is limited to impeachment and Defendants are currently producing additional documents relating to those deponents. Accordingly, Plaintiffs must re-depose many of those fact witnesses in this litigation. Furthermore, there are many important fact witnesses that the Government did not depose during the investigation. Defendants' proposed ten-deponent limit is also undermined by the Parties' estimate that each of them will call numerous witnesses at trial.

Phase Three:

- By June 28, 2019, approximately four weeks after the close of fact witness depositions, the Parties should make expert testimony disclosures pursuant to Rule 26(a)(2) addressing issues on which they bear the burden of proof. At this time, Plaintiffs anticipate that their disclosures will include experts on risk adjustment under Parts C and D of the Medicare Program; experts on diagnosis coding; and damages experts. However, because the Court has not yet had the opportunity to rule on various issues, Plaintiffs' disclosures may include other types of experts. Because of this uncertainty, it is also difficult to estimate the amount of time needed to conduct expert discovery, but Plaintiffs' current estimate is that responsive expert reports would be due by July 31, 2019, approximately four weeks after the opening expert reports, and expert depositions would be completed by September 30, 2019, approximately a month before summary judgment briefing. Accordingly, at this time, Plaintiffs estimate that expert discovery can be completed by September 30, 2019. Expert depositions should also be limited to 7 hours for each expert. In addition, as previously stated, Plaintiffs' ability to make their initial damages expert disclosures will depend on Defendants' timely production of the requested documents and data.

UnitedHealth's Position: The staged discovery process proposed by the United States appears intended to prevent UnitedHealth from obtaining the evidence it believes necessary to defend this case: the proposed restrictions and controls on discovery advocated by the United States will frustrate UnitedHealth from securing relevant and necessary evidence promptly. In this case, the United States already possesses a vast amount of documentary and testimonial information it obtained from UnitedHealth and other sources. UnitedHealth anticipates needing extensive discovery from the United States in order to prepare its defenses and counterclaims, including discovery relating to: the manner in which risk

adjustment factors are calculated; CMS' knowledge of UnitedHealth's and other MA Plans' chart reviews and its awareness of industry-wide diagnostic coding error rates and data verification practices during the relevant time period; any attempts by the United States to calculate a Medicare fee-for-service error rate; information concerning what those error rates are and their impact on payment calculations; the United States' analysis of the assumptions and disclosures contained in UnitedHealth's bids; the meaning of the "reasonable diligence" standard; the decision not to finalize the medical record review rule; meetings and communications between UnitedHealth and CMS regarding its obligations to perform a "two-way-look" in light of this proposed rule; and the May 2014 overpayment rule. UnitedHealth will also seek discovery, including third-party discovery, to identify what information, if any, Relator possesses, how Relator obtained that information, and the source of that information. UnitedHealth expressly reserves the right to conduct discovery on additional subjects and from additional persons or entities as necessary and appropriate, and to make appropriate objections to discovery requests.

UnitedHealth does not believe that phasing of discovery is necessary or appropriate in this case and respectfully submits that it is an improper attempt by the United States to impede UnitedHealth's efforts to defend itself. Rather than lead to a more efficient discovery process, the United States' proposal would prejudice UnitedHealth, and lead to both protracted discovery and increased costs. For example, if UnitedHealth is unable to depose certain witnesses at the outset, it will suffer delay in its attempt to effectively outline the scope of necessary documents and other materials it may need.

Moreover, phased discovery would further delay UnitedHealth's access to key fact witnesses and prejudice its ability to mount an effective defense in this action. As noted above, for over five years, UnitedHealth has produced over 600,000 documents, compiled detailed responses to dozens of complex

interrogatories, and produced more than twenty witnesses for Civil Investigative Demand oral examinations. While document productions are ongoing, UnitedHealth requires the ability to take testimony of a number of current and former government executives to effectively begin the defense of this action and to identify potential other sources of documents and relevant information. However, by the United States' proposal, UnitedHealth would be precluded from doing so for another *seven months*. Such an imbalance in the Parties' access to witnesses is antithetical to the spirit and purpose of the discovery rules, which advocate for liberal and expeditious discovery and mutual knowledge of all relevant facts. For similar reasons, Judge Segal noted during the Parties' informal discovery conference on November 20, 2017, that there is no such rule in the Federal Rules that says a party is entitled to complete written discovery or to resolve written discovery prior to the beginning of depositions. And, indeed, the Federal Rules of Civil Procedure do not contemplate the proposed phasing of discovery the United States advocates. During the Parties' informal discovery conference on February 8, 2018, Judge Segal again noted that delayed or phased discovery is not "built-in" in federal court and, when it is permitted, it is usually "with both parties' agreement about the usefulness of phasing." *See* February 8, 2018 Telephonic Conf. Tr. 25:16-20. Otherwise, if one side is able to dictate the phasing of discovery, it "can be used as a strategy point in a case" and gamesmanship. *See id*. 25:21-23.

The United States' suggestion that depositions should only begin after the Court resolves its forthcoming motion to dismiss UnitedHealth's counterclaims, motion to strike UnitedHealth's affirmative defenses, and motion for partial summary judgment is similarly unjustified. The United States in essence seeks a stay of depositions during the pendency of the motions, which is not provided for in the Federal Rules—otherwise, a case could be pending for months before significant progress in the litigation is made. Similarly, the United States'

conclusory and generalized assertion that there will be privilege issues does not justify postponing the commencement of depositions. Privilege issues exist in most cases, yet most cases do not stall the commencement of depositions for close to a year and a half after a complaint is filed, particularly where one side has already had access to more than twenty witnesses. The propriety of a privilege assertion cannot be addressed in a vacuum; it is typically best addressed in the context of a specific question and the assertion of privilege in response. The ordinary course is to resolve questions about the assertion of privilege in the specific contexts in which they arise, so that the Court has a specific topic to address.

UnitedHealth has only recently been afforded the opportunity to conduct affirmative discovery to defend itself from the United States' baseless claims. UnitedHealth is entitled to continue the process of reaching symmetry in the discovery of factual information through depositions. During the December 18, 2017 telephonic conference before Judge Segal regarding The United States' Motion for a Protective Order, Judge Segal stated that the United States had not made a showing of undue burden or good cause sufficient to prevent UnitedHealth from proceeding with depositions as laid out in the Federal Rules of Civil Procedure. Judge Segal also stated that a pending motion for partial summary judgment generally does not justify postponing depositions and that would be "the exception and not the common practice." *See* December 18, 2017 Telephonic Conf. Tr. 14:11-16. During the Parties' informal discovery conference on February 8, 2018, Judge Segal again stated that UnitedHealth "ha[s] a right to notice depositions" and reiterated that she likely would not enter a protective order because there is "nothing in the rules that would justify it here." *See* February 8, 2018 Telephonic Conf. Tr. 26:23-27:1. Consistent with Judge Segal's admonition that "given the complexity of this case . . . [it is not] inappropriate for a defendant to be moving quickly to try and gather information and prepare its defenses"

UnitedHealth should be permitted to continue deposing government witnesses. *See id*. 27:8-10.

Phased discovery would also introduce significant disputes regarding whether certain discovery should or should not have been conducted during a particular phase – disputes for which there is no case law or guidance in the Federal Rules. Moreover, UnitedHealth does not agree to disclose whether it will rely on any specific defense by any date unilaterally imposed by the United States. Such a deadline is not mandated by the Federal Rules of Civil Procedure.

Finally, the United States' proposed imposition of a unilateral deadline on UnitedHealth to complete production of documents responsive to damages-related discovery requests by September 2018 is unreasonable and inequitable, particularly in light of the fact that the United States has only just begun to produce documents in this matter. UnitedHealth is willing to work cooperatively with the United States to engage in mutual exchanges of information and to comply with its obligations under the Federal Rules.

3. Electronically Stored Information – Rule 26(f)(3)(C)

The Parties are aware of their duties regarding the preservation of discoverable information. The Parties have taken reasonable measures to comply with those duties as required by the Federal Rules of Civil Procedure and the Local Rules. The Parties have met and conferred pursuant to Federal Rule of Civil Procedure 26(f), and each represented that steps have been taken to preserve evidence relevant to this litigation. The Parties have agreed to a protocol for the exchange of Electronically Stored Information.

4. Privilege Issues – Rule 26(f)(3)(D)

The Parties negotiated a protective order governing non-waiver of privilege and protected material. Magistrate Judge Segal entered the order on January 16, 2018. (Dkt. No. 198)

5. Changes to Federal and Local Rules – Rule 26(f)(3)(E)

United States and Relator's Position: The changes that we propose are set forth in our proposed discovery plan set forth in Section J.2 above.

UnitedHealth's Position: UnitedHealth reiterates that phased discovery is inappropriate in this case. Exhibit A, and Subsections K and L below, address UnitedHealth's position on the timing of discovery and proposed discovery deadlines. UnitedHealth disagrees with the United States' hour-based calculation of depositions. UnitedHealth's position is that each side will likely need more than the 10 depositions permitted by the Federal Rules without leave, and that the Parties should meet-and-confer as the need for additional depositions matures. UnitedHealth agrees with the United States' proposal of 30 interrogatories by the United States and Relator jointly and 30 interrogatories by UnitedHealth.

6. Other Orders – Rule 26(f)(3)(F)

United States and Relator's Position: As discussed above, Plaintiffs request that the Court issue an order, pursuant to Rule 16(b)(3)(B)(i) and 16(c)(2)(F), modifying the timing of initial disclosures under Rule 26(a)(1)(A)(iii) relating to damages. The Government also provided Defendants with a proposed stipulation and order relating to the scope of expert disclosures and discovery in order to streamline that part of the case. The Government hopes that Defendants will agree to this.

Pursuant to Rule 16(b)(3(B)(ii), Plaintiffs also request that the Court limit the scope of discovery to only factual issues and preclude discovery relating to purely legal issues, including materiality, Defendants' legal obligations to delete invalid diagnoses, and actuarial equivalence. In addition, pursuant to Rule 16(c)(2)(C), Plaintiffs believe it may benefit the case to make rulings in advance on the authenticity and admissibility of certain evidence. This would include evidence that may be relied upon for summary judgment motions as well as trial.

Accordingly, Plaintiffs request that the Parties be permitted to file motions relating to authenticity and admissibility of documents at any time.

UnitedHealth's Position: UnitedHealth objects to the limiting of discovery pursuant to Rule 16(b)(3)(B)(ii). UnitedHealth believes that CMS would not have acted differently or sought repayment from UnitedHealth had it learned that UnitedHealth allegedly retained overpayments and is entitled to discovery on this topic, including discovery of facts which are relevant to UnitedHealth's ability to establish this and other defenses, including the views of CMS employees about the ambiguous regulatory requirements here at issue, which is relevant to scienter.

K. Discovery Cut-Off

United States and Relator's Position:

Plaintiffs propose that the non-expert discovery cut-off date be May 31, 2019.

UnitedHealth's Position:

UnitedHealth proposes that the non-expert discovery cut-off date be January 28, 2019.

L. Expert Discovery

The Parties agree to disclose expert witnesses consistent with the Federal Rules of Civil Procedure, the Local Rules, and any order entered by this Court. Plaintiffs' position with respect to the timing of expert witness disclosures (June 28, 2019 for initial disclosures and July 31, 2019 for rebuttal disclosures) and the expert discovery cut-off date (September 30, 2019) are set forth in Section J.2 above (its discovery plan) and Exhibit A.

UnitedHealth proposes the following dates for expert witness disclosures and expert discovery cut-off under Rule 26(a)(2).

Expert Disclosure – Initial	February 25, 2019
Expert Disclosure – Rebuttal	March 25, 2019
Completion of Expert Discovery	April 22, 2019

M. Dispositive Motions

The United States and Relator's Statement: The United States presently anticipates filing a motion to dismiss Defendants' counterclaims and the United States and Relator presently anticipate filing a motion to strike some of Defendants' affirmative defenses. The United States also intends to file a motion for partial summary judgment on Defendants' "actuarial equivalence" argument (unless Defendants stipulate that they are not asserting it in this case) because it presents a purely legal issue which can be adjudicated at this time and should be adjudicated at this time to avoid wasteful discovery. The United States may file other motions, including motions for summary judgment or partial summary judgment, on other issues concerning liability, damages, and issues raised in Defendants' Answer to the FAC. Plaintiffs may also file motions *in limine* because certain issues or defenses may be determined earlier on by such motions, especially with respect to the authenticity and/or admissibility of certain documents created by Defendants for purposes of litigation.

Plaintiffs propose that the last date to hear summary judgment motions be November 4, 2019.

UnitedHealth's Statement: UnitedHealth will oppose the United States' motion to dismiss and motion to strike. As noted above in Section C, UnitedHealth and the United States have already fully briefed cross-motions for summary judgment in the APA case addressing "actuarial equivalence" and it would be inappropriate, inefficient, and a waste of judicial resources to attempt to litigate those same issues here. In addition, as noted above in Section J, the United States has only recently begun to produce documents in this case. Accordingly, the filing of any summary judgment motion is drastically premature at this point in the litigation. UnitedHealth anticipates filing motions or cross motions for summary judgment, at the appropriate time and after the Parties have had the opportunity to conduct meaningful discovery.

UnitedHealth proposes the last date to hear summary judgment motions be May 20, 2019.

N. Settlement/Alternative Dispute Resolution (ADR)

The United States' Statement: In October 2016, pursuant to a request made by Defendants, the United States made a presentation to Defendants about their liability under the False Claims Act. After this presentation, Defendants' counsel notified the United States that it was not interested in discussing a settlement of this matter.

UnitedHealth's Position: In October 2016, the United States made a presentation concerning this case in which it refused even to acknowledge UnitedHealth's myriad defenses and asserted no formal settlement demand; accordingly, UnitedHealth did not make any settlement offer either. Based on the one-sided presentation the United States made in October 2016 and other discussions, UnitedHealth respectfully believes that settlement discussions are unlikely to be productive at this time.

A Notice to the Parties of Court-Directed ADR Program was entered on November 22, 2016, when this action was transferred to this Court. Dkt. No. 54. Pursuant to Local Rule 16-15.2, the Parties are filing concurrently a Request: ADR Procedure Selection. The Parties have agreed on ADR Procedure No. 3 (private dispute resolution).

O. Trial Estimate

The United States and Relator's Position: Plaintiffs estimate that their presentation of their claims at trial will take approximately 10-15 days and include approximately 25-30 witnesses (including experts), depending on whether the Court agrees that certain key issues are purely legal issues, the Court's resolution of dispositive motions, the Court's resolution of evidentiary issues prior to trial, the Parties' stipulation to the authenticity and admissible of documents, and the Parties' admission of undisputable facts. Plaintiffs estimate that Defendants'

presentation of their defenses should take an equal or less number of days. Accordingly, Plaintiffs have estimated a total of 20-30 days.

If the Court does not dismiss all of Defendants' counterclaims prior to trial, Plaintiffs request that any trial relating to any of those claims be severed and separate from the trial of their claims against Defendants, especially considering their apparent contingent nature. At this time, Plaintiffs do not have an estimate for the duration of a trial relating to the counterclaims.

UnitedHealth's Position: UnitedHealth estimates that the trial will take 24 to 32 days, including presentations by both sides. UnitedHealth anticipates calling 25-30 witnesses at trial, including experts.

UnitedHealth opposes the United States' request to sever or bifurcate UnitedHealth's counterclaims at trial. The United States fails to provide any substantive basis for its premature request to sever and bifurcate.

The Parties reserve their rights to modify these estimates as the case progresses and to ask for additional time for rebuttal witnesses.

P. Trial Counsel

United States: Edward Crooke, Carol Wallack, Justin Draycott, Paul Freeborne, John Lee, Jessica Krieg, and Paul Perkins from the U.S. Department of Justice.

Relator: Eric R. Havian, Jessica T. Moore, Henry C. Su, from Constantine Cannon; William Christopher Carmody, Arun Subramanian, from Susman Godfrey; and Stephen S. Hasegawa from Phillips & Cohen.

Defendants: David J. Schindler, Daniel Meron, Kathryn H. Ruemmler, and Abid R. Qureshi.

Q. Independent Expert or Master

At this time, the Parties do not anticipate a need for an independent expert or master.

R. Timetable

The Parties' completed Schedule of Pretrial and Trial Dates is attached as Exhibit A.

S. Other Issues

At this time, the Parties do not have other issues.

Respectfully submitted,

Dated: April 2, 2018

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Attestation

I hereby attest that the other signatories listed, on whose behalf the filing is submitted, concur in the filing's content and have authorized the filing.

Dated: April 2, 2018

/S/ John E. Lee

JOHN E. LEE
Assistant United States Attorney

JUDGE MICHAEL W. FITZGERALD
SCHEDULE OF PRETRIAL AND TRIAL DATES WORKSHEET

Case No.	16-08697
Case Name	United States ex rel. Poehling v. UnitedHealth Group, Inc. et al.

Matter	**Plaintiff(s)' Date mo / day	Defendant(s)' Date mo / day / year	Court Order
[X] Jury Trial *or* [ ] Court Trial **(Tuesday at 8:30 a.m.)** Duration Estimate:_____Days	2/18/2020; duration estimate = 20-30 days	8/27/2019; duration estimate = 24-32 days	
Final Pretrial Conference [LR 16] and Hearing on Motions *In Limine* **(Monday at 11:00 a.m. -- three (3) weeks before trial date)** Motions *In Limine* must be filed **three (3) weeks** before this date; oppositions are due **two (2) weeks** before this date; no reply briefs.	1/27/2020	8/5/2019	

Event	Weeks Before Trial	Plaintiff(s)' Date mo / day / year	Defendant(s)' Date mo / day / year	Court Order
Last Date to Hear Motion to Amend Pleadings / Add Parties		10/29/2018	10/29/2018	
Non-Expert Discovery Cut-Off (at least 4 weeks before last date to hear motions)	18	5/31/2019	1/28/2019	
Expert Disclosure (Initial)		6/28/2019	2/25/2019	
Expert Disclosure (Rebuttal)		7/31/2019	3/25/2019	
Expert Discovery Cut-Off	14 *	9/30/2019	4/22/2019	
Last Date to ***Hear*** Motions (**Monday at 10:00 a.m.**)	14	11/4/2019	5/20/2019	
Last Date to Conduct Settlement Conference	12	12/26/2019	6/3/2019	
For Jury Trial • File Memorandum of Contentions of Fact and Law, LR 16-4 • File Exhibit and Witness Lists, LR 16-5.6 • File Status Report Regarding Settlement • File Motions *In Limine*	6	1/6/2020	7/15/2019	
For Jury Trial • Lodge Pretrial Conference Order, LR 16-7 • File Agreed Set of Jury Instructions and Verdict Forms • File Statement Regarding Disputed Instructions, Verdicts, etc. • File Oppositions to Motions *In Limine*	5	1/13/2020	7/22/2019	
For Court Trial • Lodge Findings of Fact and Conclusions of Law, LR 52, and Summaries of Direct Testimony	3			

* The parties may choose to cut off expert discovery prior to MSJ briefing.
** If the Court dismisses Defendants' counterclaims, Plaintiffs may revise their proposed dates and estimated trial duration.

ADR [LR 16-15] Selection:

☐ Attorney Settlement Officer Panel ☒ Private Mediation ☐ Magistrate Judge (with Court approval)

EXHIBIT A