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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) UNITED STATES' AND RELATOR POEHLING'S JOINT NOTICE OF MOTION AND MOTION PURSUANT TO RULE 16(b)(3) FOR ISSUANCE OF A SCHEDULING ORDER Date: September 17, 2018 Time: 10:00 a.m. Court: 5A. Hon. Michael W. Fitzgerald

PLEASE TAKE NOTICE that, on September 17, 2018, at 10:00 a.m., or as soon thereafter as the matter may be heard, in the courtroom of the Honorable Michael W. Fitzgerald, United States District Judge, Courtroom 5A, United States Courthouse, 350 West First Street, Los Angeles, California 90012, the United States of America and relator Benjamin Poehling will and hereby do move for the issuance of an order modifying the extent of discovery in this case.

This motion is and will be made pursuant to Rule 16(b)(3), Fed. R. Civ. P., on the grounds that good cause exists for the issuance of such a scheduling order at this time.

This motion is based upon the accompanying Memorandum of Points and Authorities, Declaration, Exhibits, [proposed] Order, the pleadings and other papers on file herein, and such evidence and argument as may be presented in connection with the hearing of this motion.

This motion is made following the conference of counsel pursuant to L.R. 7-3, which took place on July 13, 2018.

Respectfully submitted,

Dated: August 6, 2018

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Attestation

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

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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)

PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF JOINT MOTION PURSUANT TO RULE 16(b)(3) FOR ISSUANCE OF SCHEDULING ORDER MODIFYING EXTENT OF DISCOVERY

Date: September 17, 2018
Time: 10:00 a.m.
Court: Hon. Michael W. Fitzgerald

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I. INTRODUCTION

To ensure that this case is litigated in an efficient manner and that unnecessary discovery disputes do not overly and needlessly burden this Court or the Department of Health and Human Services (HHS), the United States and relator Poehling request that the Court enter a scheduling order limiting discovery to issues that are relevant in this case pursuant to Fed. R. Civ. P. 16(b)(3)(B) or, alternatively, Rule 26(c)(1)(A).

United seeks broad discovery purportedly relating to United's "defenses to the misconduct charges made by the government in this case." More particularly, for example, United has requested the production of documents discussing "any obligation or requirement that Medicare Advantage (MA) Plans validate the accuracy of diagnosis codes submitted on claims data before they submit claims data to CMS for purposes of Risk Adjustment." Defendants' Request for Production No. 39 (Exhibit 21).[1] United contends that its discovery is relevant to both materiality and knowledge. The Court should issue an order limiting this discovery for at least three reasons.

First, United seeks discovery on an issue that is not presented by this case. The United States has not alleged that United had a general duty to verify diagnosis codes, but rather that where, as here, it undertook reviews of those codes, it had a duty to delete any unsupported codes it found.

Second, as to the issue that is presented by this case, both the Ninth Circuit and this Court have already held as a matter of law that United was required to correct inaccurate codes revealed by the chart reviews it had undertaken. In the parlance used in this case, after United conducted reviews of beneficiary charts, it had an obligation "to look both ways" – meaning that when United used its chart reviews to report *additional* diagnosis codes for Medicare beneficiaries, it was also obligated to *delete* codes which its chart reviews had determined were unsupported by the medical records. Order on Mtn. to Dismiss (Dkt. 212) at 15. No amount of factual discovery United seeks can

[1] Copies of Exhibits 16-23, referenced herein, are attached to the Declaration of Martha Glover, filed concurrently herewith.

change what is at bottom a legal conclusion.

Third, even if this issue had not already been decided by the courts, as a logical matter, the discovery sought by United would not be probative of either materiality or knowledge. The structure of the MA program, as the courts have already recognized, is such that any eligible code, even if it is invalid, will automatically result in a higher payment and thus United's failure to delete invalid codes was inexorably material to the amount that the agency paid. And internal, non-public CMS documents by definition could not have affected United's knowledge of whether certain codes were invalid and should have been deleted.

Given that the Ninth Circuit has now issued two opinions addressing risk-adjusted payments under Medicare Part C and the parties are fully briefing controlling issues in this action, the time is ripe for the Court to set relevance-based limits on discovery in an initial scheduling order pursuant to Rule 16(b)(3)(B). Specifically, the United States and relator Poehling request that, in conjunction with its consideration of the pending motions for partial summary judgment, to strike Defendants' affirmative defenses, and to dismiss Defendants' counterclaim, the Court limit discovery on matters that have been resolved or are irrelevant to the liability issues that remain in this case.

II. BACKGROUND

A. Procedural History

On December 22, 2017, the parties filed a Joint Rule 26(f) Report (Dkt. 191). In that Report, the United States noted that "[m]any of the 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 [*United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161(9th Cir. 2016)]. Discovery is therefore unnecessary to resolve these legal issues." (Dkt. 191 at 20). The United States further noted that "rulings on the United States' motion for partial summary judgment are likely to limit the scope of discovery regarding materiality and actuarial equivalence." (Dkt. 191 at 18.)

On April 2, 2018, the parties filed an Amended Joint Rule 26(f) Report. (Dkt. 224.) The United States again noted that "an early ruling by the Court on [Defendants'] 'actuarial equivalence' argument in this case . . . will streamline discovery and resolution of this case." (Dkt. 224 at 9.) On April 9, 2018, the Court held a scheduling conference and took the parties' proposed discovery cut-off dates under advisement. (Dkt. 227.) To date, the Court has not yet issued a scheduling order.

On May 22, 2018, the United States and relator filed Motions for Partial Summary Judgment (Dkt. 234), to Strike Defendants' Affirmative Defenses (Dkt. 235), and to Dismiss Defendants' Counterclaim (Dkt. 236). These motions are set for hearing on September 17, 2018. (Dkt. 241).

B. Defendants' Discovery Requests and Demands

Defendants have served three sets of document requests, comprising 108 separate requests (not counting subparts), on the United States, with the third request having been served only recently, on July 16, 2018. In response to the first two sets of requests, the United States has collected over seven million documents from the files of 143 custodians within components of the Department of Health and Human Services, which amount to five terabytes of electronic material. The government estimates that there are already over 675,000 documents that agency personnel and DOJ attorneys must review for privilege. The government's efforts to identify and review additional potentially responsive documents is ongoing. The volume of documents collected to date represents a small percentage of the expected production, and underscores the inordinate volume of documents that will need to be collected due to the overbreadth of the Defendants' discovery requests, unless the Court intervenes.

Defendants are now threatening to compel the production of internal deliberative material relating to the obligations of MA Organizations (MAOs) to validate the accuracy of diagnosis codes before they submit claims data to CMS for purposes of risk adjustment, as well as law enforcement sensitive information regarding the investigation of other MAOs, some of which are competitors of Defendants, purportedly to probe the

materiality of the diagnosis data United knowingly failed to delete and by which it obtained overpayment from Medicare, as well as United's knowledge of its duty to delete these invalid codes. *See, e.g.*, June 15, 2018 Letter from D. Rowe at 5 (Exhibit 20).

On July 12, 2018, the parties participated in an informal conference with Magistrate Judge Segal to address these motions. Judge Segal indicated during that conference that, while she could hear defendants' discovery motions, the relevance of certain discovery relating to legal issues such as the materiality of diagnosis data to the paying agency was a matter for this Court to decide. Transcript of Record, July 12, 2018, at 60, 63-64 (Exhibit 22). Judge Segal also suggested that the United States could seek a stay of discovery from this Court pending a ruling on this motion for a scheduling order setting discovery limits. *Id.* at 63.

III. ARGUMENT

The United States and relator seek a scheduling order from the Court foreclosing discovery of internal CMS deliberative materials and law enforcement sensitive information purportedly relating to (a) the legal obligation of Defendants' MAOs to delete diagnosis codes submitted to Medicare which they know are unsupported by beneficiary medical records, and (b) the materiality of Defendants' failure to delete those invalid diagnosis codes or to return the amounts Medicare overpaid them. In light of controlling Ninth Circuit precedent, the law of this case, and the structure of the MA program, the fundamental irrelevancy of the discovery Defendants now seek can and should be resolved at this time to avoid wasting the time of the parties, their counsel, high-level HHS officials, and ultimately Judge Segal in ruling on discovery disputes.[2]

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[2] *See Tzu Chien Chen v. Thomas & Betts Corp.*, 2008 WL 510409, at *1 (9th Cir. Feb. 25, 2008) (summary disposition is allowed at a pretrial conference so long as the party has had a full and fair opportunity to present its arguments); *Telecredit Serv. Corp. v. Elec. Transaction Corp.*, 1992 WL 217982, at *2 (9th Cir. Sept. 4, 1992) ("Where additional discovery will not affect a district court's ruling on the merits, denying that discovery is not an abuse of discretion."); *Century 21 Real Estate Corp. v. Sandlin*, 846 F.2d 1175, 1181 (9th Cir. 1988) (district court did not abuse discretion when denying

Issuing a scheduling order that limits discovery to factual issues that are relevant and in genuine dispute will permit this case to proceed in a manner that comports with the limitations imposed by Rule 26(b).

Although Rule 26(b)(1) of the Federal Rules of Civil Procedure allows the parties to "obtain discovery regarding any non-privileged matter that is relevant to any party's claim or defense and proportional to the needs of the case," the Court may, under Rule 16(b), issue a scheduling order to "modify the extent of discovery." *See* Rule 16(b)(3)(B)(ii); 1 Steven S. Gensler, *Federal Rules of Civil Procedure, Rules and Commentary*, Rule 16 (2018 ed.) ("The Supreme Court has explicitly remarked on the broad discretion of trial courts – vested under Rule 26 and implemented through Rule 16 – to 'tailor discovery narrowly and to dictate the sequence of discovery.'" (quoting *Crawford-El v. Britton*, 523 U.S. 574, 598 (1998))). Because Rule 16(b) authorizes the use of scheduling orders to limit discovery to avoid undue burden, "Rule 26(c) Orders have become less important to address these concerns, which may often arise without the filing of a Rule 26(c) motion." 8A Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 2040 (3d ed. April 2018 update); s*ee also* Fed. R. Civ. P. 16(b) advisory committee's note to 1983 amendment ("The use of the term 'judge' in [Rule 16(b)] reflects the Advisory Committee's judgment that it is preferable that [scheduling orders] should be handled by a district judge rather than a magistrate").

In the alternative, the United States and relator Poehling seek a protective order under Rule 26(c)(1), which gives courts broad discretion to "issue an order to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense." Fed. R. Civ. P. 26(c)(1). While Rule 16 authorizes a district judge to control and facilitate discovery, "the governing standards by which the court can rule on discovery requests . . . are found in the discovery rules themselves." 6A Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 1528 (3d ed. April 2018

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additional time to conduct discovery of materials which would not "alter the district court's finding" on central issue in case).

update). Consistent with the preference that judges affirmatively manage case discovery, Rule 26 is "intended to encourage judges to be more aggressive in identifying and discouraging discovery overuse." Fed. R. Civ. P. 26 advisory committee's note to 2015 amendment. Indeed, a district court judge can forbid requested discovery altogether under Rule 26(c)(1)(A).

A. The Complaint Alleges that Defendants Failed to Correct Diagnosis Codes Which They Knew From Their Own Chart Reviews Were Unsupported

Defendants demand the production of internal CMS and law enforcement documents purportedly related to whether MA Plans were required to "validate the accuracy of diagnosis codes submitted on claims data before they submit claims data to CMS for purposes of Risk Adjustment." As was the case with its arguments in *Swoben*, United continues to misconstrue the nature of this case and its underlying obligations to the MA program. In *Swoben*, United argued that there was no "authority indicat[ing] that a [MAO] was obligated to undertake affirmative steps to unearth potentially unsupported codes" in claims by medical providers. 848 F.3d at 1173. The Ninth Circuit noted that this argument was inapposite, explaining that *Swoben* was "not a case about whether [MAOs] have to take affirmative steps to verify risk adjustment data. [United] indisputably took such steps by conducting retrospective chart reviews." *Id*. at 1179. Accordingly, the real question in *Swoben* was not whether United was obligated to verify diagnostic data in provider claims, but rather what United was required to do after it "indisputably . . . conduct[ed] retrospective chart reviews." *Id.* at 1179. The Ninth Circuit answered that question by holding that Defendants had an obligation to correct known unsupported diagnoses submitted for risk-adjusted payments. *Id.* at 1174-75, 1179.

United now attempts to set up the same straw man already knocked down in *Swoben*. According to United, the government contends that MAOs "are required to delete unsupported codes they *could possibly have discovered* were unsupported by auditing separate submissions by providers." *See* Opposition to Plaintiff's Motion for

Partial Summary Judgment (Dkt. 250) at 2 (emphasis in the original). United then explains that this allegation is a "very different thing" than the allegation that "MA Plans are required to delete every code *they know* is unsupported." *Id.* (emphasis supplied). United's statements are only half right. United is correct that the contention that (1) United was required to look for errors *beyond those* revealed by the chart reviews it indisputably conducted is very different from the contention that United was required to delete *known* errors. United, however, is wrong that the first contention is part of this case. Notably, United does not cite the First Amended Complaint to support its assertion. That is because it is not in the pleading.

B. The Obligation to Correct Known Coding Errors Has Already Been Resolved as a Matter of Law

In addition to seeking documents pertaining to an MAO's broader obligation to verify diagnosis coding, United also has threatened to move to compel production of privileged information more particularly related to "the government's understanding of whether [MAOs] were required to 'look both ways'." *See* Ltr. from D. Rowe at 5 (Exhibit 20). Although this request may seem more in line with the contentions in the government's complaint, there is still no justification for United to seek internal CMS deliberative materials or law enforcement sensitive documents on this issue. As noted, in *Swoben*, the Ninth Circuit held as a matter of law that United had an obligation to correct diagnosis codes that it knew to be invalid. Notably, the Ninth Circuit recently reaffirmed *Swoben's* holdings in another opinion addressing the MA program. *See United States ex rel. Silingo v. Wellpoint, Inc.*, 895 F.3d 619 (9th Cir. 2018).

In *Silingo*, the Ninth Circuit again considered an MAO's legal obligations concerning accurate coding and the materiality of diagnosis codes to risk-adjusted payments by Medicare. The appellate court reaffirmed that a beneficiary's medical record is ultimately determinative of whether a diagnosis code is accurate. *Silingo*, 895 F.3d at 624 ("Every diagnosis code submitted to CMS must be based on a 'face-to-face' visit that is documented in the medical record."). The appellate court also emphasized

that CMS does not verify the accuracy of diagnosis codes submitted by MAOs and that MAOs are responsible for the accuracy of the diagnostic data they submit to CMS and must take measures "to correct non-compliance with CMS' program requirements." *Id.* ("CMS is unable to confirm diagnoses before calculating capitation rates [and] [i]nstead the agency accepts the diagnoses as submitted . . . ."). This Court likewise came to the same conclusion when ruling on United's motion to dismiss the government's complaint. Dkt. 212, at 5 ("MA Organizations have an obligation to withdraw, or delete, previously submitted invalid diagnosis codes.").

The legal obligation to delete unsupported diagnosis codes is also covered in the government's briefs in support of the motion for partial summary judgment (Dkt. 234-1) and the motion to dismiss defendants' counterclaim (Dkt. 236-1). As explained in those briefs, this obligation to delete invalid codes derives from the plain language of the controlling MA regulations, contracts between Defendants and CMS, and the manual provisions which are incorporated into those contracts, and has already been recognized by the Ninth Circuit. *See* Dkt. 234-1, at 6-13, 15-18; Dkt. 236-1, at 4-8, 15-24. No amount of discovery will change Defendants' legal obligations or the payment structure of the MA program. Nor is Defendants' improper attempt to re-litigate these issues a valid reason to impose unduly broad, burdensome, and costly discovery on the United States and the Department of Health and Human Services.

C. The Discovery Pursued by United is Not Relevant to Allegations in This Case

Even if the Ninth Circuit had not already ruled as a matter of law that MAOs have an obligation to correct diagnosis codes known to be false, the internal deliberative material and law enforcement information sought by United would be irrelevant to the factual issues for which they are being sought.

1. The Risk-Adjustment System By Design Relies on Diagnosis Codes to Determine Payment Amounts

United contends that the information that it seeks is relevant to the issue of materiality. The False Claims Act defines material to mean having "a natural tendency

the payment or receipt of money." 31 U.S.C. §3729(b)(4). In this case, based on the risk-adjusted payment structure of the MA program, certain medical diagnoses directly affect payment amounts and, thus, are inherently material. As the United States has discussed on several occasions, and as the Ninth Circuit recognized in *Swoben*, "diagnoses codes contribute to an enrollee's risk score, which is used to adjust a base payment rate." *Id*. at 1167-68. Thus, there is an automatic causation between the invalid diagnoses submitted by defendants and the risk-adjusted payments made by Medicare.

Critically, United's discovery requests ignore the automated payment structure of the MA program. The materiality of the codes that United used to inflate its payments in this case derives from CMS' decision to implement electronic processing of codes submitted by MAOs. The system is hard-wired, by design, to use codes to expedite payment of risk-adjusted claims. Simply put, payment amounts are determined based on inputs from an MAO which are exclusively within the control of the party submitting the codes. The same is true with respect to deleted codes, in that those inputs to the system also come from the MAOs, and overpayment amounts are determined and recouped based on those submissions.

In *Silingo* the Ninth Circuit recognized that "diagnosis codes . . . [are] the key to calculation of capitation rates." 895 F.3d at 624. Thus, the appellate court also recognized the direct link between invalid codes and Medicare payments: "if enrollee diagnoses are overstated, *the capitation payments to [MAOs] will be improperly inflated.*" *Id*. at 625 (emphasis supplied). *Silingo* is particularly instructive because it concerned the very same issue in this case: the inaccuracy of diagnoses submitted for risk-adjusted payments. *Id.* at 626. *Silingo* made clear that the link between diagnosis codes and payment is direct. *Id.* at 632 ("And all of these organizations had an incentive to pass along fraudulent data because, by overstating diagnoses, they could yield more revenue and profit under the capitated payment system—and it was not certain that they would get caught."). The fact that in this case Defendants' scienter concerning the invalidity of the diagnoses derives from chart reviews conducted after they submitted the

claims (thereby giving rise to liability under the "reverse false claim" provision at 31 U.S.C. § 3729(a)(1)(G)), does not affect the directness of the causal link between the invalid diagnoses they failed to correct and the inflated risk adjusted payments they improperly received and retained as a result.

The February 2018 decision by this Court on Defendants' Motion to Dismiss was in accord with the Ninth Circuit's opinions in *Swoben* and *Silingo*. This Court recognized that the diagnosis codes that MAOs submit to CMS directly impact the payments made by CMS. Dkt. 212, 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"). United fails to explain how internal CMS deliberative or law enforcement investigation documents will alter, much less negate, the payment structure of the MA program or the direct connection between invalid diagnosis codes and government payment as a result of that structure.

Moreover, the February 2018 ruling by this Court specifically addressed the type of law enforcement information that is the focus of United's discovery. The Court noted that the government's suspicions about United's compliance with accuracy requirements did not mean CMS had information about which particular diagnoses were unsupported – and, therefore "CMS could not know how it should change the risk adjustment payments." Dkt. 212, at 21. Thus, the Court concluded, CMS' continued payments "despite generalized knowledge of 'one way' Chart Reviews and problematic diagnosis codes" does not negate the "materiality" of United's failure to delete invalid diagnoses. Accordingly, even if there were any factual issue left to probe, there is no remotely plausible expectation that information compiled during a law enforcement investigation of *some other MAO* would yield evidence relating to the materiality of any diagnostic code *submitted by United*, including whether CMS had actual knowledge that any code *submitted by United* was invalid -- which is the subject of this case.

United's request for information related to law enforcement investigations that

occurred after payment by CMS is deficient for another reason. Whatever law enforcement actions did or did not occur do not alter the fact that the MA program is structured to rely on diagnosis codes to determine payment amounts. As explained, the materiality of the diagnosis data is a product of the payment system's automated operation. Because risk-adjusted payments are based on reported diagnoses, if an MAO refrains from submitting an unsupported code, or deletes a code after it has been submitted, there can be no dispute that such an action will have an impact on the size of the risk adjusted payment.

United's contentions regarding any actions by the government subsequent to payment to recover overpayments conflate the separate questions of materiality and estoppel. United's position, generously construed, is that the government should be estopped from enforcing the plain language of the MA regulations and contracts in this case based on how it handled other enforcement matters. This estoppel argument fails as a matter of law, however, as discussed in the United States' and relator's Motion to Strike Defendants' affirmative defenses (Dkt. 235-1, at 9-11), as well as the Motion to Dismiss Defendants' counterclaim (Dkt 236-1, at 23).

2. Non-Public Information is Not Relevant to Defendants' Scienter

Finally, United contends that CMS's non-public documents may be relevant to the issue of scienter – notwithstanding the fact that United has never seen the documents. Scienter in this case involves whether United "knew," as that term is defined in the FCA, that submitted diagnosis codes were unsupported by patient charts. None of the discovery sought by United of internal government deliberations or actions will shed light on or affect what *the defendants knew* about the diagnosis codes and whether they should have been deleted. *See, e.g., United States v. Tenet*, No. CV-03-206, Memorandum and Order at 9 (C.D. Cal. filed Sept. 7, 2005) (Exhibit 23) ("Evidence of other's confusion over the coding standards does not tend to establish whether [defendant] itself was confused by those coding standards, nor does it tend to show that [defendant's] interpretations of those standards was 'reasonable'.").

By contrast, some guidance communicated by the government publicly may be relevant to United's state of mind, and there are plenty of public pronouncements made by the agency setting forth the agency's view of whether an MAO should delete diagnosis codes. This guidance is already available to United, and is consistent with the governing contractual and regulatory requirements which both the Ninth Circuit and this Court have already determined required United to delete diagnosis codes that it knew were invalid. For example, in 2013, the agency stated in the Medicare Managed Care Manual that MAOs must delete erroneous diagnosis codes, and United expressly agreed in its MA Contract to comply with this document. *See* Dkt. 234-1, Exhibit 5 at § 40 ("If upon conducting an internal review of submitted diagnosis codes, the plan sponsor [or MAO] determines that any ICD-9-CM diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor [or MAO] is responsible for deleting the submitted ICD-9-CM diagnosis codes as soon as possible"); Section A of Article II and Section A(1) of Article IX of the Part C contract (Exhibit 1) (expressly requiring MAOs to operate "in compliance with… [the] Medicare Managed Care Manual"). CMS's view has been reflected in other public guidance dating back to 2003. *See, e.g.*, 2003 Regional Risk Adjustment Training For Medicare+Choice Organizations, Participant Guide, at § 6.12.3 (Exhibit 16) (stating that M+C organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in the RAPS Database); 2004 Regional Risk Adjustment Training For Medicare Advantage Organizations, Participant Guide, at § 4.16 (Exhibit 17) ("M+C organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in RAS."); 2006 Risk Adjustment Data Basic Training For Medicare Advantage Organizations, Participant Guide, at § 4.16 (Exhibit 18) ("MA organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in the RAPS database."); 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide, at § 4.16 (Exhibit 19) (same). The above-cited Participant Guides and Manual Section are only examples;

they do not come close to representing the full universe of information and guidance publicly issued by the government since the inception of the MA program.

CMS has also published extensive information on the system it uses to process MAO-submitted diagnosis codes and issue risk adjusted payments. *See, e.g.,* 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide (Exhibit 19), Module 2 - "Risk Adjustment Submission Process Overview" and Module 4 - "Data Submission"; EDI Agreement (Dkt. 234-1, Exhibit 2). As discussed, this payment system is inexorably based on diagnosis codes submitted by Defendants.

Moreover, since the beginning of the MA program, CMS has issued extensive information on steps it has implemented to promote compliance with the requirement that diagnoses must be substantiated by the beneficiaries' medical records in order to be valid for payment purposes. As early as 1999, CMS announced that it was undertaking "payment validation activity" that was "intended to improve the accuracy of the risk adjustment data . . . submitted to CMS for payment." Policy and Technical Changes to the Medicare Advantage Program, 74 Fed. Reg. 54,634, 54,674 (Oct. 22, 2009). These "risk adjustment data validation (RADV) audits" sought "to confirm the presence of risk adjustment conditions (that is, diagnoses [relevant to risk adjustment]) as reported by MA organizations for their enrollees and confirmed via medical record documentation." *Id*. These audits were "aimed at validating that a particular Medicare beneficiary indeed has the medical condition for which the MA organization has been paid." 75 Fed. Reg. at 19,748; *see* 42 C.F.R. § 422.310(e) (requiring insurers "to submit a sample of medical records for the validation of risk adjustment data"); 2009 Proposed Rule, 74 Fed. Reg. at 54,674 (RADV audits are "intended to improve the accuracy of the risk adjustment data . . . submitted to CMS for payment").

Unlike the information that HHS has publicly issued, which may be relevant to United's knowledge of its obligation to delete diagnosis codes, United does not contend that any of the discovery it seeks involves information that was disclosed to United. If

United did not receive or could not have obtained the requested information publicly as a participant in the MA program, then there is no way that that information could have shaped its knowledge about invalid diagnosis codes and its obligation to delete them. Under these circumstances, United has failed to establish that this information has any probative value that justifies the burdensome discovery it seeks.

IV. CONCLUSION

The government estimates at this juncture that there are over 675,000 documents that agency personnel and DOJ attorneys must review for privilege. This number will expand considerably as electronic searches yield more potentially responsive documents. This number also does not include all of the law enforcement files that would require close review. The identification and review of material potentially covered by the deliberative process privilege is inordinately time consuming because of the nature of such material, which can include drafts, internal comments, handwritten notes, and meeting minutes. Unlike attorney-client communications or attorney work-product, which are more easily identified based on the custodians and search terms, deliberative material is interspersed throughout agency records and distinguishable only by its timing and context. If discovery in this case is not subject to appropriate limits based on relevancy, the identification, review, and logging of irrelevant deliberative process material will continue to consume an unwarranted and unnecessary amount of agency resources and government funds. For these reasons, the United States respectfully requests that the Court set appropriate limits on the discovery demanded by United and hold that no further discovery is permitted with respect to issues that have been resolved by the Ninth Circuit or decisions by this Court, and in any event are not relevant to any issues in this case.

Respectfully submitted,

Dated: August 6, 2018

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

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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)

DECLARATION OF MARTHA GLOVER IN SUPPORT OF NOTICE OF MOTION AND MOTION PURSUANT TO RULE 16(b)(3) FOR ISSUANCE OF A SCHEDULING ORDER

Date: September 17, 2018
Time: 10:00 a.m.
Court: 5A. Hon. Michael W. Fitzgerald

DECLARATION OF MARTHA GLOVER

I, Martha Glover, declare:

1. I am an attorney and a Civil Law Clerk II (contractor) for the United States Department of Justice, Civil Division, in Washington, D.C. I have been so employed for nearly 6 years. I have personal knowledge of the matters set forth herein and, if called to testify, could and would testify competently thereto.

2. Attached hereto as Exhibit 16 is a true and correct copy of portions of the Center for Medicare and Medicaid Services' ("CMS'") 2003 Regional Risk Adjustment Training For Medicare+Choice Organizations, Participant Guide, at § 6.12.3. The complete version of this document is available publicly at the following CMS website address: https://csscoperations.com/internet/Cssc.nsf/files/participant-guide102703-revb_112403.pdf/$FIle/participant-guide102703-revb_112403.pdf.

3. Attached hereto as Exhibit 17 is a true and correct copy of portions of CMS' 2004 Regional Risk Adjustment Training For Medicare Advantage Organizations, Participant Guide, at § 4.16. The complete version of this document is available publicly at the following CMS website address: https://csscoperations.com/internet/Cssc.nsf/files/partguide-revisions-1a_030205.pdf/$FIle/partguide-revisions-1a_030205.pdf.

4. Attached hereto as Exhibit 18 is a true and correct copy of portions of CMS' 2006 Risk Adjustment Data Basic Training For Medicare Advantage Organizations, Participant Guide, at § 4.16. The complete version of this document is available publicly at the following CMS website address: https://csscoperations.com/internet/Cssc.nsf/files/raps-participant-guide_081606.pdf/$FIle/raps-participant-guide_081606.pdf.

5. Attached hereto as Exhibit 19 is a true and correct copy of portions of CMS' 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide, Module 2 - "Risk Adjustment Submission Process Overview," Module 4 - "Data Submission," and § 4.16. The complete version of this

document is available publicly at the following CMS website address: https://csscoperations.com/Internet/Cssc3.Nsf/files/participant-guide-publish_052909.pdf/$File/participant-guide-publish_052909.pdf.

6. Attached hereto as Exhibit 20 is a true and correct copy of a letter dated June 15, 2018 from David W. Rowe, Esq., of Latham & Watkins LLP, to Paul Perkins, Esq., Civil Division, Fraud Section, United States Department of Justice.

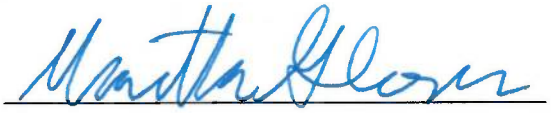
7. Attached hereto as Exhibit 21 is a true and correct copy of Defendant UHC of California's Request for Production to the Government (Set No. One).

8. Attached hereto as Exhibit 22 is a true and correct copy of relevant excerpts of Transcript of Record before the Hon. Suzanne Segal, United States Magistrate Judge, dated July 12, 2018.

9. Attached hereto as Exhibit 23 is a true and correct copy of a memorandum decision in *United States v. Tenet*, No. CV-03-206, Memorandum and Order at 9 (C.D. Cal. filed Sept. 7, 2005).

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

Executed on August 6, 2018 at Washington, D.C.



MARTHA GLOVER

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6.12.3 M+C Organization Responsibilities Regarding Deletions

- M+C organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in the RAPS Database.
- If a diagnosis cluster is deleted for the purpose of correcting data, the M+C organization is responsible for submitting the correct diagnosis cluster. Conversely, if the M+C organization submits corrected data, the M+C organization must submit the appropriate deletion records. That is, if the correct diagnosis cluster is submitted, the erroneous diagnosis cluster cannot be ignored.
- If a correction applies to the same beneficiary as the deletion, the correction may be included in the same CCC record as the deletion (do not exceed 10 diagnosis clusters per CCC record).
- If the corrected diagnosis cluster belongs to a different beneficiary than the deleted diagnosis cluster, the correct diagnosis cluster may be submitted in the same file as the deletion.

6.12.4 2003 Reconciliation Data

After September 27, 2002, payment year 2003 reconciliation hospital inpatient data (discharge dates: July 1, 2001 through June 30, 2002) must be submitted as a 111 or 11Z bill type. The most recent information will be stored. This is similar to the overlay process used prior to the automated *encounter data* adjustment process described above. The "From" and "Through" dates will be checked to identify duplicate transactions and determine which of the duplicate transactions was submitted most recently. The latest version will be utilized in the risk adjustment model, and the remaining submissions will be discarded.

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4.16 M+C Organization Responsibilities Regarding Deletions (Slide 21)

- M+C organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in RAS.
- If a diagnosis cluster is deleted for the purpose of correcting data, the M+C organization is responsible for submitting the correct diagnosis cluster. Conversely, if the M+C organization submits corrected data, the M+C organization must submit the appropriate deletion record. That is, if the correct diagnosis cluster is submitted, the erroneous diagnosis cluster cannot be ignored.
- If a correction applies to the same beneficiary as the deletion, the correction may be included in the same "CCC" record as the deletion (Do not exceed 10 diagnosis clusters per "CCC" record).
- If the corrected diagnosis cluster belongs to a different beneficiary than the deleted diagnosis cluster, the correct diagnosis cluster may be submitted in the same file as the deletion.

M+C organizations should not delete a diagnosis code or record repeatedly on the same day and on the same record. M+C organizations should implement a process to ensure that only one instance of a specific diagnosis cluster (either add or delete) is submitted on a given day.

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4.16 MA Organization Responsibilities Regarding Deletions (Slide 22)

- MA organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in the RAPS database.
- If a diagnosis cluster is deleted for the purpose of correcting data, the MA organization is responsible for submitting the correct diagnosis cluster. Conversely, if the MA organization submits corrected data, the MA organization must submit the appropriate deletion record. That is, if the correct diagnosis cluster is submitted, the erroneous diagnosis cluster cannot be ignored.
- If a correction applies to the same beneficiary as the deletion, the correction may be included in the same "CCC" record as the deletion. (Do not exceed 10 diagnosis clusters per "CCC" record.)
- If the corrected diagnosis cluster belongs to a different beneficiary than the deleted diagnosis cluster, the correct diagnosis cluster may be submitted in the same file as the deletion.

MA organizations should not delete a diagnosis code or record repeatedly on the same day and on the same record. MA organizations should implement a process to ensure that only one instance of a specific diagnosis cluster (either add or delete) is submitted on a given day.

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MODULE 2 – RISK ADJUSTMENT SUBMISSION PROCESS OVERVIEW

Purpose

The success of Medicare Advantage (MA) risk adjustment is dependent upon organizations understanding the process of collecting and submitting accurate risk adjustment data. The purpose of this module is to provide participants with important terms, key resources, and schedule information that will provide the foundation for this training.

Learning Objectives

At the completion of this module, participants will be able to:

- Define common risk adjustment terminology.
- Demonstrate knowledge in interpreting key components of the risk adjustment process.
- Interpret the risk adjustment schedule.
- Identify the Centers for Medicare & Medicaid Services (CMS) outreach efforts available to organizations.

ICON KEY

Example

Reminder

Resource

2.1 Common Risk Adjustment Terms (Slide 7)

Table 2A provides descriptions of common risk adjustment terminology.

TABLE 2A – RISK ADJUSTMENT COMMON TERMS

TERM	DESCRIPTION
FERAS	Risk adjustment submitters send data to Palmetto through the **Front End Risk Adjustment System**.
RAPS	Risk adjustment data are processed by the **Risk Adjustment Processing System.**
RAS	The **Risk Adjustment System** calculates the risk score.
MAR	The **Medicare Advantage Prescription Drug System** calculates the risk payment.
Common UI	The **Common UI** maintains Medicare beneficiary eligibility data.
HPMS	The **Health Plan Management System** is a CMS MA information system that contains health plan-level data.
Re uired Diagnosis	ICD- -CM diagnosis codes required to be submitted for the CMS-Hierarchical Condition Category (HCC) model and for future model development.

2.2 Risk Adjustment Process Overview

Hospital inpatient, hospital outpatient, and physician risk adjustment data must be submitted at least quarterly. Risk adjustment data are processed through RAPS.

2.2.1 Risk Adjustment Data Re uirements (Slide 8)

- The data required under the risk adjustment process include:
  - Health Insurance Claim (HIC) number.
  - Diagnosis code.
  - Service from date.
  - Service through date.
  - Provider type (hospital inpatient, hospital outpatient, physician).
- MA organizations must submit data at least quarterly to CMS.
- Each quarterly submission should represent approximately one-fourth of the data that the MA organization will submit during a data collection year. MA organizations will be monitored to ensure compliance.
- All beneficiary ICD- -CM diagnosis codes required for the CMS-HCC risk adjustment model must be reported at least once per enrollee in the data collection period.

2.2.2 Risk Adjustment Data Collection (Slide)

- MA organizations may choose to collect data from providers in a variety of formats:
  - Standard fee-for-service claim or encounter formats
    - Uniform Billing Form (UB- 4)
    - HCFA 15
    - National Standard Format (NSF) v3. 1
    - American National Standards Institute (ANSI) 12 837 v3 .51 or v4 .1 . Health Insurance Portability and Accountability Act (HIPAA) mandated transactions must use v4 .1 .
  - Superbill
  - RAPS format
    - HIC number
    - Provider type
    - Diagnosis code
    - Service from date
    - Service through date

2.2.3 Risk Adjustment Data Submission (Slide 10)

- MA organizations must submit data to CMS through FERAS (Palmetto GBA) utilizing the following formats:

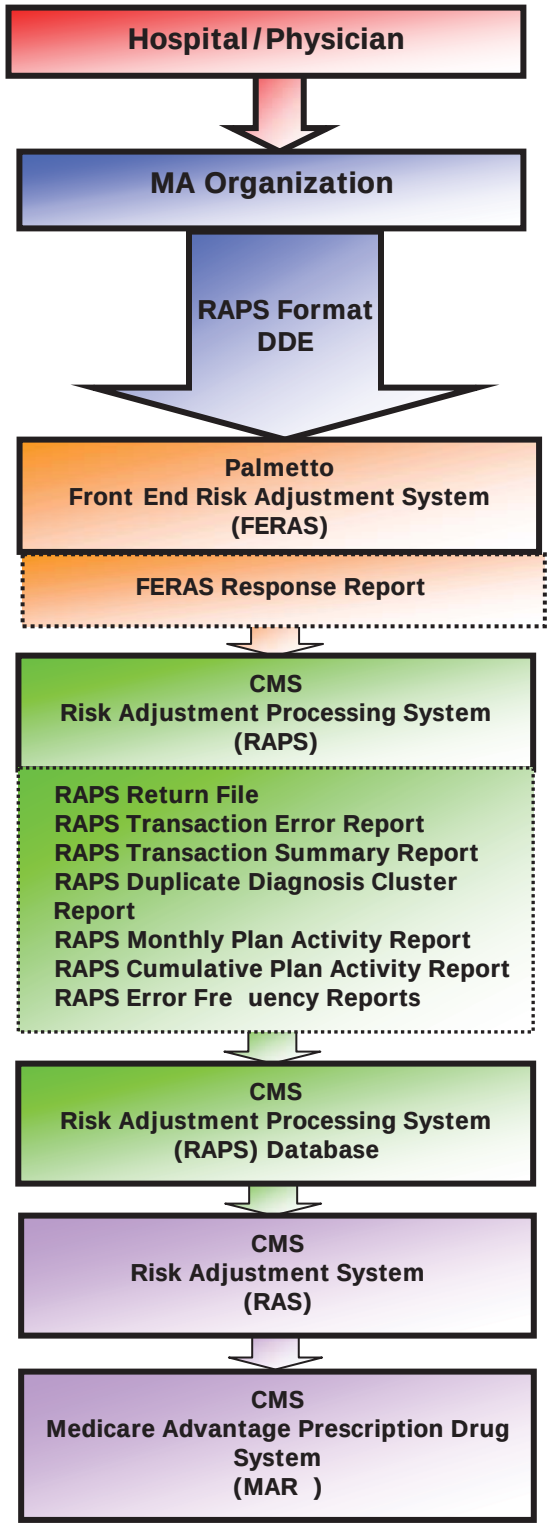
  - RAPS format (all types of data)
  - Direct Data Entry Screen (all types of data)

Figure 2A illustrates the risk adjustment dataflow.

2.2.4 Risk Adjustment Dataflow (Slide 11)

- Hospital/physician submits data to MA organization via:
  - Full or abbreviated UB- 4, HCFA 15 , NSF v3. 1, ANSI x837 v3 .51 or v4 .1 , Superbill or RAPS format.
- The MA organization submits these data at least quarterly to Palmetto GBA.
- The MA organization submits the data via Direct Data Entry or in the RAPS format.
- The data are sent to FERAS for processing where the file-level data, batch-level data, and first and last detail records are checked.
- If any data are rejected, then data are reported on the FERAS Response Report.
- After passing the FERAS checks, the file is submitted to RAPS where detail editing is performed.
- The RAPS Return File is returned daily and shows all records approved and where errors occurred.
- The RAPS Transaction Error Report displays records on which errors occurred.
- The RAPS Transaction Summary Report is sent to the MA organization daily and identifies data that have been finalized in RAPS database.
- The Duplicate Diagnosis Cluster Report identifies diagnosis clusters submitted with information that duplicates a stored cluster.
- The RAPS Monthly Plan Activity Report and Cumulative Plan Activity Report provides a summary of all diagnoses stored for a given time period.
- Distributed monthly and quarterly, the Error Frequency Report provides an overview of all errors associated with files submitted in test and production.
- RAPS database stores all finalized diagnosis clusters.
- RAS calculates the Risk Adjuster Factors by executing the CMS-HCC model.
- MARx is used in the calculation of payments and determination of plan payments. MARx replaced Medicare Managed Care System (MMCS) on November 15, 2 5.

Figure 2A – Risk Adjustment Dataflow



2.2.5 Important Information About Risk Adjustment Processing

- MA organizations transmit data to FERAS at Palmetto GBA.
- FERAS performs format and face validity checks on the file- and batch- level as well as formatting verification on the first and last detail record (CCC) in the file.
- If the data fail the front-end checks, the complete file is rejected at the front end.
- The FERAS Response Report identifies whether the file is accepted or rejected up front.
- Once the file has passed front-end checks, it moves to RAPS. All validity edits on detail-level data are performed in this system.
- Processing time from beginning to end should take approximately 1 to 2 days.
- After the file has processed through RAPS, the MA organization will receive a RAPS Return File and RAPS Transaction Error Report identifying any errors.
- All ICD- -CM diagnoses that pass validity edits are stored in the RAPS database.
- The MA organization will also receive a RAPS Transaction Summary Report reflecting all finalized data sent to the RAPS database along with all rejected data.
- The MA organization also receives two monthly risk adjustment management reports: 1) the RAPS Monthly Plan Activity Report and 2) the RAPS Cumulative Plan Activity Report.
- All data are converted to the RAPS format and returned in the RAPS Return File.
- Interim bills (112 and 113 bill types) are not accepted. If a MA organization receives interim bills, do not submit the hospital inpatient diagnoses on receipt of the final bill (114 bill type).

2.3 Submission Schedule (Slide 12)

The elimination of the payment lag changes the submission schedule. This requires MA organizations to meet three submission deadlines the first Friday in September, the first Friday in March of each year, and a reconciliation (final submission) deadline of January 31. The schedule is illustrated in Table 2B.

TABLE 2B – SUBMISSION TIMETABLE

CY	DATES OF SERVICE	INITIAL SUBMISSION DEADLINE	FIRST PAYMENT DATE	FINAL SUBMISSION DEADLINE
2 8	July 1, 2 6 through June 3 , 2 7	September 7, 2 7	January 1, 2 8	NA
2 8	January 1, 2 7 through December 31, 2 7	March 7, 2 8	July 1, 2 8	January 31, 2
2	July 1, 2 7 through June 3 , 2 8	September 5, 2 8	January 1, 2	NA
2	January 1, 2 8 through December 31, 2 8	March 6, 2	July 1, 2	January 31, 2 1
2 1	July 1, 2 8 through June 3 , 2	September 4, 2	January 1, 2 1	N/A
2 1	January 1, 2 through December 31, 2	March 5, 2 1	July 1, 2 1	January 31, 2 11

2.4 Training and Support (Slide 13)

To ensure that participating organizations have the necessary tools and information to be successful with the risk adjustment process, CMS has planned the following outreach efforts, as described in Table 2C.

TABLE 2C – TRAINING AND SUPPORT

INITIATIVE	DESCRIPTION
Customer Service & Support Center (CSSC)	This toll free help line (1-877-534-2772) is available Monday – Friday, : a.m. to 7: p.m. Eastern Time (ET) (with the exception of corporate observed holidays) to provide assistance. The support center provides ongoing assistance. The FERAS system is available to submit risk adjustment data 24 hours a day, 7 days a week regardless of holidays. The only exception is from 5: PM EST - 1 : PM EST on Sunday when systems and equipment undergo routine maintenance.
www.csscoperations.com	The CSSC website, www.csscoperations.com is the gateway to RAPS. isitors to the site can access information about RAPS/FERAS, including opportunities to register for service, enroll to submit risk adjustment data, and obtain comprehensive information about data entry and report layouts. In addition, the site provides valuable links to CMS instructions and other official resources. Monthly User Group and other training information are regularly posted. Finally, the site provides up-to-date system status alerts and answers to frequently asked questions (FA s) about risk adjustment. To register for email updates, go to www.csscoperations.com, click on Risk Adjustment Processing System (RAPS), and then click on Register for Medicare Advantage . Afterwards, click on new registrations only and complete the registration form.
User Groups	Conducted once each month from 1:3 – 2:3 p.m. ET. The purpose of the User Group meeting is to share information among participants, distribute new information, and identify issues for future resolution. Meeting notes and &As are provided. To register online for User Groups, go to ugregistration@tarsc.info.
Onsite Consultation	On-site consultation visits provide MA organizations with the opportunity to gain valuable information about risk adjustment data submission and data validation processes. These consultations generally occur between April and May. Each visit includes a review of the MA organization's system.
www.tarsc.info	The website, www.tarsc.info is the website for risk adjustment training and User Group information. The website includes information about trainings and user groups, training dates, locations, online registration, and training FA s.

MODULE 4 – DATA SUBMISSION

Purpose (Slide 2)

Medicare Advantage (MA) organizations must submit accurate diagnostic data when submitting risk adjustment data. This module describes the file layout for risk adjustment process submissions.

Learning Objectives (Slides 3 4)

At the completion of this module, participants will be able to:

- Understand the submission process requirements, connectivity options, and Risk Adjustment Processing System (RAPS) file layout.
- Identify the data elements required to submit risk adjustment data.
- Locate and describe the diagnosis clusters in the RAPS format.
- Understand the Direct Data Entry (DDE) process.
- Describe the filtering process.
- Describe the diagnoses deletion process.

ICON KEY

Example 

Reminder 

Resource 

4.1 Submission Process Re uirements (Slide 6)

New MA organizations must complete an Electronic Data Interchange (EDI) Agreement with the Centers for Medicare & Medicaid Services (CMS) and submit that Agreement to the Customer Service and Support Center (CSSC) prior to submitting risk adjustment data. The EDI Agreement is a contract between the MA organization and CMS attesting to the accuracy of the data submitted. An officer (e.g., CEO) that represents the MA organization must sign this document. New Plans must submit the EDI Agreement within 1 month of the HPMS effective date.

MA organizations must make special arrangements to use a third party submitter. If the submitter is an entity other than an MA organization, the submitter must complete the Submitter ID Application Form, and an EDI Agreement form. MA organization must complete, sign, and return the EDI Agreement for each plan number submitting data. CMS holds the MA organization accountable for the content of submissions regardless of who submits the data.

New MA organizations must submit test data within 3 months of the HPMS effective date and a production file must be submitted within 4 months of the effective date.

If a new contract number is assigned, the MA organization must submit a new EDI agreement. If the submitter's system successfully submitted test data previously, CMS does not require additional testing.

MA organizations must submit during each calendar quarter, at a minimum, approximately one-fourth of their total risk adjustment data submission for the collection period. More frequent submissions are recommended and may benefit MA organizations in identifying data collection and submission issues early.

4.2 Connectivity Options (Slide 7)

Connectivity refers to the electronic connection between the MA organization and CMS. MA organizations use the electronic connection to submit risk adjustment data to CMS and receive information in return. All third party submitters and large plans that submit their own data must establish a connection to the Front End Risk Adjustment System (FERAS) through the Medicare Data Communication Network (MCDN) that AT&T Global Network Services (AGNS) provides. The MCDN is the secure network linking RAPS data processing entries. Table 4A describes the three connectivity options.

TABLE 4A – CONNECTIVITY OPTIONS

Connect Direct (formerly Network Data Mover)	Formerly Network Data Mover (NDM). Mainframe-to-mainframe connection. Next day receipt of FERAS response.
File Transfer Protocol (FTP)	Modem-to-modem (dial-up) or lease line connection. Requires password and phone line. Same day receipt of FERAS response.
Gentran (Sterling Enterprise Integrator)	Two connectivity options: -Secure File Transfer Protocol (SFTP) standards based protocol via a vendor. -Secure Hyper Text Transfer Protocol (HTTPS), secure web interface.

Small plans with less then or equal to 1 , members may submit data using the Gentran Mailbox. For technical support questions regarding Gentran mailbox, users may contact the Customer Support for Medicare Modernization (CSMM) by calling (8) 27-8 6 , emailing mmahelp@cms.hhs.gov, or viewing the website at http://www.cms.hhs.gov/mmahelp.

4.3 Re uired Diagnosis (Slide 8)

alid diagnosis codes are ICD- -CM codes that CMS accepts as valid, but may not be included in the CMS-HCC Model. Required diagnosis codes are ICD- -CM codes that CMS accepts as valid, and are included in the current or future CMS HCC Models.

MA organizations must submit each required diagnosis at least once during a reporting period for each enrolled beneficiary.

For payments beginning on January 1, 2 , the initial submission deadline is September 5, 2 8 for the reporting period July 1, 2 7 through June 3 , 2 8. For payments beginning on July 1, 2 , March 6, 2 is the submission deadline for reporting data with dates of service January 1, 2 8 through December 31, 2 8. **Refer to the Risk Adjustment Process Overview module, Table 2B.**

A required (model) diagnosis must meet the following criteria:

- The diagnosis is included in the current or future CMS-Hierarchical Condition Category (CMS-HCC), Prescription Drug (RxHCC) or End Stage Renal Disease (ESRD) risk adjustment models.
- The diagnosis must be received from one of the three provider types (hospital inpatient, hospital outpatient, and physician) covered by the risk adjustment requirements.
- The diagnosis must be collected according to the risk adjustment data collection instructions.

MA organizations may elect to submit a diagnosis more than once during a data collection period for any given beneficiary, as long as that recorded diagnosis was from a face-to-face visit with one of the three provider types covered under risk adjustment. MA organizations may submit any diagnoses received from the three covered provider types, including diagnoses that are not in the CMS-HCC risk adjustment model. Diagnoses that are in the model, but not collected from one of the three provider types cannot be submitted as risk adjustment data.

A list of valid ICD- -CM codes for the risk adjustment models for any given payment year includes a list of published NCHS/CMS codes that are valid for the payment year. The list is posted on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/ 6 Risk adjustment.asp TopOfPage, listed under Risk Model Diagnosis Codes (IP, 34 D) – Updated 1 / 4/2 8 for current model codes, and future model codes are listed under Future Model Diagnoses. Please be aware that both models (i.e., **Current Model** and **Future Model**) are required.

Do not submit risk adjustment diagnoses based on any diagnostic radiology services, regardless of the type of diagnostic radiology bill (outpatient department or physician component). Diagnostic radiologists typically do not document confirmed diagnoses. Confirmed diagnoses come from referring physician or physician extenders.

4.4 Submission Formats (Slide)

Effective October 1, 2 7, MA organizations must submit data electronically using one of two formats:

- RAPS format (all provider types)
- DDE screen (all provider types)

4.5 Submission File Layout Logic (Slide 10)

Submissions are organized into three levels of data:

- File-level information—identifies the submitter
- Batch-level information—identifies the MA organization
- Detail-level information—identifies the beneficiary

Figure 4A illustrates a summary of the RAPS file structure.

Figure 4A – RAPS File Structure Summary

RT AAA – FILE HEADER (Submitter Info)
Always the first record on the file, and must be followed by Record Type (RT) BBB.

- Record ID
- Submitter ID
- File ID
- Transaction Date
- Production/Test Indicator
- Filler

RT BBB – BATCH HEADER (MA Organization Info)
Must follow RT AAA or RT and must be followed by RT CCC.

- Record ID
- Sequence Number
- Plan Number
- Filler

RT CCC – DETAIL RECORD (Beneficiary Info)
Must follow RT BBB or RT CCC and may be followed by another RT CCC.

- Record ID
- Sequence Number
- Sequence Number Error
- Patient Control Number (optional)
- HIC Number
- HIC Error Code
- Patient Date of Birth (optional)
- Date of Birth Error Code
- Diagnosis Cluster (1 Occurrences)
  - Provider Type
  - From Date
  - Through Date
  - Delete Indicator
  - Diagnosis Code
  - Diagnosis Code – Filler
  - Diagnosis Cluster – Error 1
  - Diagnosis Cluster – Error 2
- Corrected HIC Number
- Filler

RT YYY – BATCH TRAILER
Must follow RT CCC and may be followed by another RT BBB or RT .

- Record ID
- Sequence Number
- Plan Number
- CCC Record Total
- Filler

RT ZZZ – FILE TRAILER
Must follow RT , and must be the last record on the file.

- Record ID
- Submitter ID
- File ID
- BBB Record Total
- Filler

DETAIL LEVEL
BATCH LEVEL
FILE LEVEL

4.6 Diagnosis Cluster

The diagnosis cluster contains the core information used to calculate a risk adjustment factor. The following components are included in the cluster:

- Provider Type
- From Date
- Through Date
- Diagnosis Code

A maximum of 1 diagnosis clusters are allowed per CCC record. Each cluster must include the items identified above. If any of these attributes are submitted more than once for the same HIC number, a duplicate diagnosis cluster error will occur.

4.7 Provider Type

MA organizations must submit risk adjustment data for hospital inpatient, hospital outpatient, and physician services. MA organizations may submit all provider types in the same CCC record. The provider type must be coded accurately. There is one provider type per diagnosis cluster. Table 4B shows the provider types and their codes.

Type of Bill (TOB), which is coded on the UB- 4 during the collection of hospital data, may be used to assist in translating the correct provider type. Table 4B also shows the TOB and provider type correlation.

TABLE 4B – PROVIDER TYPES

PROVIDER TYPE	CODE	TYPE OF BILL
Principal Hospital Inpatient (principal diagnosis)	1	111 or 11
Hospital Inpatient Other (other diagnosis)	2	111 or 11
Hospital Outpatient	1	131, 13 , 141 or 14
Physician	2	N/A

Interim bills (112 and 113 bill types) are not accepted. If an MA organization receives interim bills, do not submit the hospital inpatient diagnoses until the receipt of the final interim bill (114 bill type).

4.8 From and Through Dates

- CC MMDD is the correct submission format for the From and Through dates of service.
- The Through Date defines the data used in the data collection year for risk adjustment purposes.

June 3 , 2 6 is submitted as 2 6 63 .

Table 4C shows the From and Through Dates for each provider type.

TABLE 4C – FROM AND THROUGH DATES

PROVIDER TYPE	FROM DATE	THROUGH DATE
Hospital Inpatient	Admission Date	Must have a through date and must be the discharge date
Hospital Outpatient	Exact date of patient visit or the first date service began for a series of services	Exact date of patient visit or the last date of service for a series of services
Physician		

When a submitter submits a From Date that does not include a Through Date for physician or hospital outpatient services, RAPS automatically copies the From Date into the Through Date field.

4. Diagnosis Code

- Each required diagnosis code must be submitted at least once during a reporting period.
- The decimal is implied in the format.

4.10 RAPS Format

Table 4D describes each field of the RAPS file layout.

- The shaded fields in the table represent where the RAPS Return File provides new information after data processes through RAPS.
- There are two diagnosis cluster error fields because MA organizations can receive up to two errors on any diagnosis cluster.

TABLE 4D – RAPS FILE LAYOUT

RAPS RECORD AAA – FILE HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**E PLANATION**
1	1-3	Required	Record ID	File-level information that identifies the submitter. This field should always be populated with AAA.
2	4-	Required	Submitter ID	Identifies the submitter and should be populated with the six-digit alphanumeric SH assigned by CSSC.
3	1 -1	Required	File ID	1 -digit alphanumeric character identifying the specific file submitted. This file name may not be repeated within a 12-month period.
4	2 -27	Required	Transaction Date	Specifies the date that the file was submitted to Palmetto and formatted as CC MMDD.
5	28-31	Required	Production Test Indicator	Must be populated with PROD or TEST. Submission test data proceeds through the entire process.
6	32-512	Spaces	Filler	Must be populated with 481 spaces. The Filler field allows for additional fields in the future.

RAPS RECORD BBB – BATCH HEADER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**E PLANATION**
1	1-3	Required	Record ID	Batch-level information that identifies the MA organization is populated with BBB.
2	4-1	Required	Sequence Number	This field identifies the batch submitted. The first batch in a file must begin with 1. All successive batch sequence numbers in the file must be incremented by one. This is a numeric field.
3	11-15	Required	Plan Number	Identifies the MA organization and should be populated with the five-digit alphanumeric contract assigned by CMS. (H , R , etc.)
4	16-512	Spaces	Filler	Must be populated with 4 7 spaces. The Filler field allows for additional fields in the future.

TABLE 4D – RAPS FILE LAYOUT (CONTINUED)

RAPS RECORD CCC – DETAIL LEVEL				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**E PLANATION**
1	1-3	Required	Record ID	Detail-level information that identifies the beneficiary information. This field should always be populated with CCC.
2	4-1	Required	Sequence Number	This field identifies the detail record submitted. The first detail record in a batch must begin with 1. All successive detail sequence numbers in the batch must be incremented by one. This is a numeric field. Limited to 1, , per day.
3	11-13	RAPS RETURN	Sequence Number Error Code	This field must be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error in the sequence number, or will remain blank if no errors were detected in the sequence number.
4	14-53	Optional	Patient Control Number	This optional field may be used by the MA organization to identify the claim submitted. The field allows up to 4 alphanumeric characters.
5	54-78	Required	HIC	The Health Insurance Claim number for the beneficiary. This is a 25-digit alphanumeric field. Enter spaces, not zeros, in unused spaces.
6	7 -81	RAPS RETURN	HIC Error Code	This should be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error in the HIC number, or remains blank if no errors were detected in the HIC number.
7	82-8	Optional	Patient DOB	This optional field may be populated with the patient's date of birth and is used to verify that the correct beneficiary identification was submitted. If the field is populated, it must be formatted as CC MMDD, and CMS edits this field against the information on file at the MBD. If no DOB is submitted, fill with spaces.
8	- 2	RAPS RETURN	DOB Error Code	This field must be submitted with spaces. Upon return, this field is populated with an error code if RAPS finds an error with DOB, or remains blank if no errors were detected in the DOB.

TABLE 4D – RAPS FILE LAYOUT (CONTINUED)

RAPS RECORD CCC – DETAIL LEVEL (CONTINUED)				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**E PLANATION**
	3-412	DIAGNOSIS-CLUSTER (1 occurrences)		The following 8 fields (. - .7) may be repeated 1 times in the same CCC record with one diagnosis per cluster. Each diagnosis cluster must contain 32 characters or spaces. Plans must not skip clusters when submitting active diagnosis codes. If there are less than 1 diagnosis clusters the remaining clusters are space filled. If there are more than 1 diagnoses, a new CCC record must be established.
.		Required	Provider Type	This 2-digit alphanumeric field identifies the site of service provided (1, 2,1 ,2).
.1		Required	From Date	For hospital inpatient this describes the admission date. For physician and hospital outpatient this describes the date of service. Must be formatted as CC MMDD.
.2		Required	Through Date	For hospital inpatient this describes the discharge date. For physician and hospital outpatient this may be left blank and the system will fill with the From Date. Must be formatted as CC MMDD.
.3		Conditional	Delete Indicator	This field allows the MA organization to delete a diagnosis, for correction purposes, that has been stored in the RAPS database. Enter a D or space.
.4		Required	Diagnosis Code	This field is populated with the three-to five-digit ICD- -CM diagnosis code. The decimal is implied and should not be included (e.g., 42732).
.5		SPACE	Diagnosis Code Filler	This field is designed to allow space for future ICD-1 -CM codes and any other growth in the diagnosis cluster. This field must be populated with spaces.
.6		RAPS RETURN	Diagnosis Cluster Error 1	This field must be submitted with spaces. Upon return, this field is populated with one error code if RAPS finds an error in the diagnosis cluster, or remains blank if no errors were detected in the diagnosis cluster.
.7		RAPS RETURN	Diagnosis Cluster Error 2	This field must be submitted with spaces. Upon return, this field is populated with one error code if RAPS finds an error in the diagnosis cluster, or remains blank if no errors were detected in the diagnosis cluster.
1	413-437	RAPS RETURN	Corrected HIC number	This field must be submitted with spaces. If the MA organization has submitted an outdated HIC, upon return, this field is populated with the most current HIC number and the HIC Error field contains an information error code.
2	438-512	Spaces	Filler	Must be populated with 75 spaces. The Filler field allows for additional fields in the future.

TABLE 4D – RAPS FILE LAYOUT (CONTINUED)

RAPS RECORD YYY – BATCH TRAILER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**E PLANATION**
1	1-3	Required	Record ID	Batch trailer information should be populated with .
2	4-1	Required	Sequence Number	A 7-digit numeric character identifying the batch submitted. Must match the BBB record.
3	11-15	Required	H Number	H number assigned by CMS to identify the MA organization. Must match the H number in the corresponding BBB record (i.e., the BBB record with the same sequence number).
4	16-22	Required	CCC Record Total	This field should total the number of CCC records in the batch. This field is numeric and should be filled with leading zeroes (e.g., 1). Limited to 1, , per day.
5	23-512	Spaces	Filler	Must be populated with 4 spaces. The Filler field allows for additional fields in the future.

RAPS RECORD ZZZ – FILE TRAILER				
FIELD NO	**POSITION**	**SUBMISSION STATUS**	**FIELD NAME**	**E PLANATION**
1	1-3	Required	Record ID	File Trailer Information should be populated with .
2	4-	Required	Submitter ID	Identifies the submitter and must match the 6-digit alphanumeric SH in the AAA records.
3	1 -1	Required	File ID	1 -digit alphanumeric character identifying the specific file submitted. Must match the File ID in the AAA record.
4	2 -26	Required	BBB Record Total	This field should total the number of batches in the file. This field is numeric and should be filled with leading zeros (e.g., 1).
5	27-512	Required	Filler	Must be populated with 486 spaces. The Filler field allows for additional fields in the future.

4.11 Filtering Risk Adjustment Data (Slides 13 14)

MA organizations are required to filter risk adjustment data to ensure that they submit data from only appropriate data sources (e.g., hospital inpatient, hospital outpatient, and physician provider types). A filtering process is used to identify the correct provider types in claims and encounter data. CMS further recommends the following filtering guidelines:

- Hospital inpatient data require admission and discharge dates of service from appropriate facilities. **Refer to the Data Collection module** for examples of covered facilities.
- Physician data require face-to-face visits with a professional listed on the CMS specialty list. **Refer to the Data Collection module** for the list of acceptable physician data sources.
- Hospital outpatient data require the most demanding or accurate filtering. Data requirements include diagnoses from appropriate facilities and covered services contained on the CMS covered outpatient listings. **Refer to the Data Collection module** for examples of covered facilities and non-covered services/facilities.

The following over-filtering and under-filtering examples may be useful:

a) Hospital Inpatient:
   - Over-filtering - Failing to submit data from specialized facilities (e.g., Rehabilitation and Psychiatric Hospitals).
   - Under-filtering - Submitting data from interim bills or from non-covered institutional stays (e.g., nursing facility data).

b) Hospital Outpatient:
   - Over-filtering - Failing to submit data from specialized facilities, particularly those that do not appear on the inpatient provider list (e.g., Rural Health Clinics, Federally ualified Health Centers) excluding bills with both covered and non-covered procedure codes.
   - Under-filtering - Submitting data from non-covered facilities or submitting non-covered services from covered facilities (e.g., laboratory only or radiology only claims).

c) Physicians:
   - Over-filtering - Failing to capture data from non-physician practitioners that appear on the physician specialty list (e.g., nurse practitioners, physician assistants, etc.).
   - Under-filtering - Submitting all paid claims from the claims database, including laboratory, Durable Medical Equipment (DME), ambulance, etc.

For those plans that use CPT codes to screen diagnosis codes that are submitted to CMS, please note that the CPT range for radiology is 7 through 7 . The following CPT codes indicate diagnostic radiology and other diagnoses that should not be submitted as risk adjustment data: 7 1 through 76 and 78 through 78 . Plans should update these codes annually.

4.12 Modifying Risk Adjustment Data (Slide 15)

RAPS allows for the correction of risk adjustment data submitted to CMS. This correction process is based on the concept that the incorrect cluster must be deleted from the system before the correct cluster is added. For this reason, data correction is at least a two-step process.

4.13 Deleting Diagnosis Clusters (Slide 16)

Each diagnosis cluster (Diagnosis Code, From Date, Through Date, and Provider Type) is stored separately as a unique cluster associated with a beneficiary's HIC number. If a diagnosis was submitted in error and needs to be corrected, the original diagnosis cluster must be resubmitted with a delete indicator in the appropriate field. **Delete transactions may only be submitted using the RAPS format or the DDE function.** When a delete record is received, CMS maintains the original diagnosis cluster on file and adds a delete indicator to it and the date of the deletion.

4.14 Reasons to Delete a Diagnosis Cluster (Slide 17)

There are three reasons MA organizations may delete a diagnosis cluster:

- Diagnosis cluster submitted erroneously (e.g., data from an interim bill was submitted for hospital inpatient).
- Incorrect HIC number used for submission of a beneficiary's diagnostic information.
- An error in a diagnosis cluster field (i.e., Provider Type, Dates of Service, Diagnosis Code).

MA organizations submit deletions within a file, batch, or record containing previously submitted risk adjustment data.

4.15 Steps for Deleting a Diagnosis Cluster (Slides 18 20)

Before deleting an error, verify that the diagnosis cluster appears on the RAPS Return File. Only diagnosis clusters accepted by RAPS and stored in the RAPS database may be deleted.

There are two methods for deleting diagnosis clusters:

Method 1 for Deleting Clusters

1. Submit RAPS format using normal submission process with appropriate HIC number included.
2. Enter information in the diagnosis cluster fields (. , .1, .2, .4, .5) exactly as it appeared in the original submission.
3. In field .3 enter a D for delete.
4. Enter the appropriate information in all other records to ensure the submission file is complete.
5. Transmit the file to FERAS. (See www.csscoperations.com for details.)

Method 2 for Deleting Clusters

1. Create a file using the DDE screens available through FERAS at Palmetto (detailed information about the DDE process is located in Section 4.2).
2. Enter information exactly as it appeared in the original submission.
3. In the DDE CCC record screen, hit the down arrow key and select D.
4. Proceed with entering all appropriate information.
5. Upload the file created in DDE to FERAS at Palmetto.

4.16 MA Organization Responsibilities Regarding Deletions (Slide 21)

- MA organizations must submit delete records when an erroneous diagnosis cluster has been accepted by RAPS and stored in the RAPS database.
- If a diagnosis cluster is deleted for the purpose of correcting data, the MA organization is responsible for submitting the correct diagnosis cluster. Conversely, if the MA organization submits corrected data, the MA organization must submit the appropriate deletion record. That is, if the correct diagnosis cluster is submitted, the erroneous diagnosis cluster cannot be ignored.
- If a correction applies to the same beneficiary as the deletion, the correction may be included in the same CCC record as the deletion. (Do not exceed 1 diagnosis clusters per CCC record.)
- If only one of several clusters within the CCC record requires modification, do not resubmit all other associated clusters. If clusters are resubmitted exactly the same without the delete indicator, the plans will generate a duplicate cluster error.
- If the corrected diagnosis cluster belongs to a different beneficiary than the deleted diagnosis cluster, the correct diagnosis cluster may be submitted in the same file as the deletion.

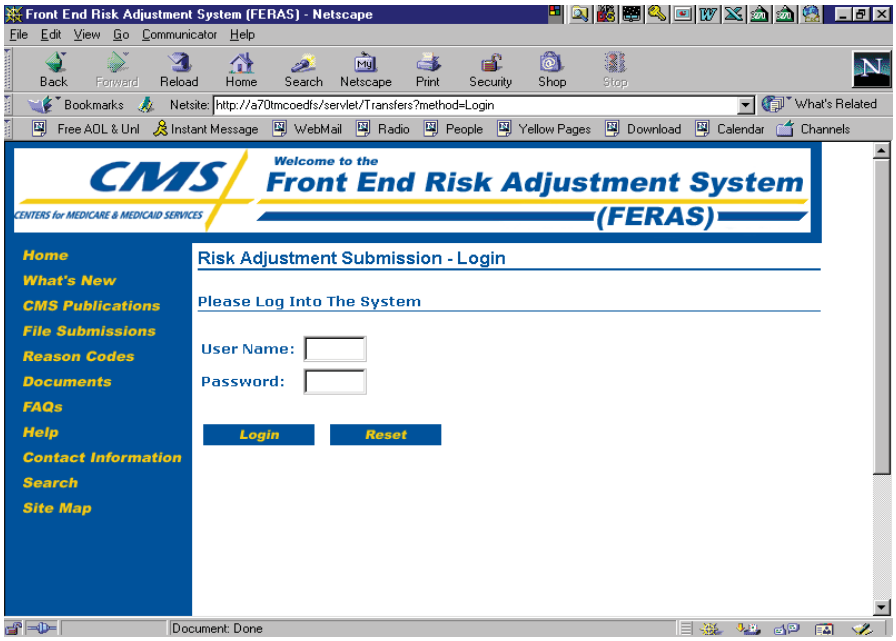
MA organizations should not delete a diagnosis code or record repeatedly on the same day and on the same record. MA organizations should implement a process to ensure that only one instance of a specific diagnosis cluster (either add or delete) is submitted on a given day.

4.17 Direct Data Entry (Slide 22)

MA organizations have the option of manually entering diagnostic information via the DDE application offered by Palmetto. DDE instructions are illustrated in the screen shots below. DDE is available in FERAS at Palmetto via the Medicare Data Communications Network (MDCN).

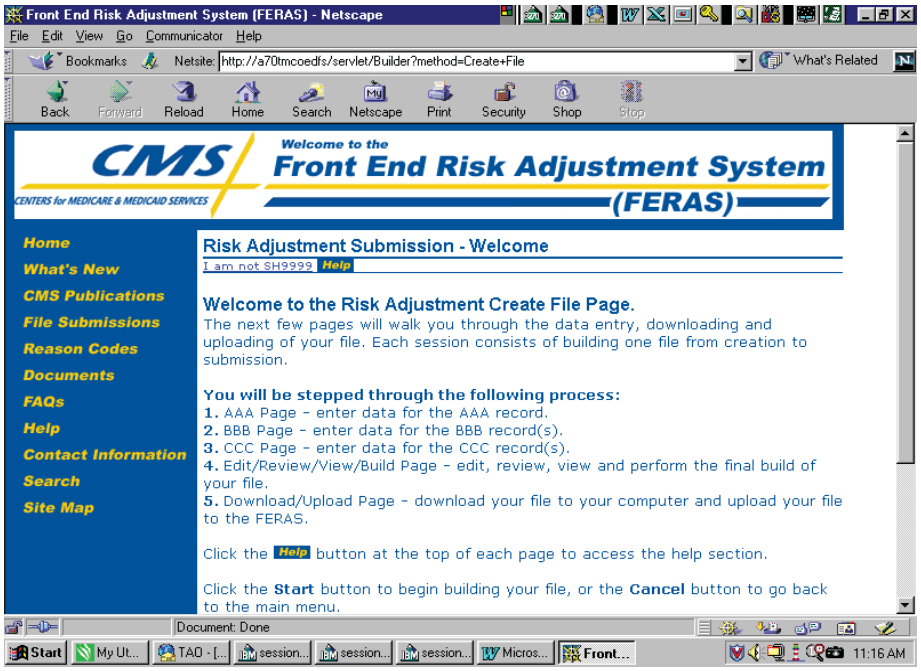
- DDE entries allow for deletion of records for corrections even if another submission format was used.
- The DDE screens, as shown in Figures 4B through 4G, automatically prevent the placement of incorrect data characters (e.g., alpha characters will not be accepted in the From or Through Date fields).
- After the user has entered all relevant data, the user will click on the Create File button in FERAS. This will create a file on the user's local PC.
- After the file is created on the local PC, the user must upload the file to FERAS in order to complete the process.
- Files created in DDE and uploaded to FERAS will receive a FERAS Response Report, which may be downloaded from the MA organization's electronic mailbox.

Figure 4B – DDE 1



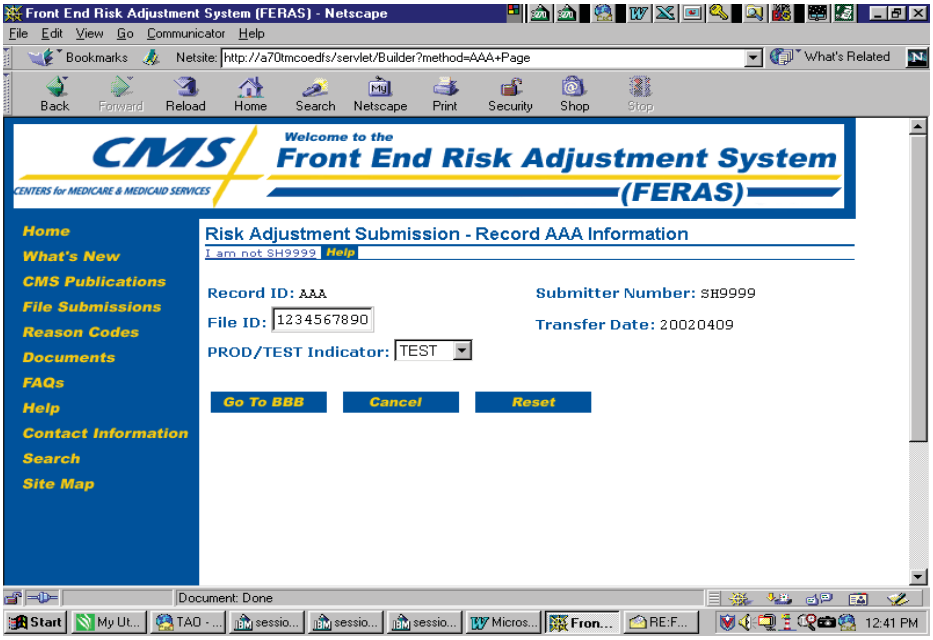
LOGIN PAGE – Submitters are assigned a User Name and Password to access the DDE application.

Figure 4C – DDE 2



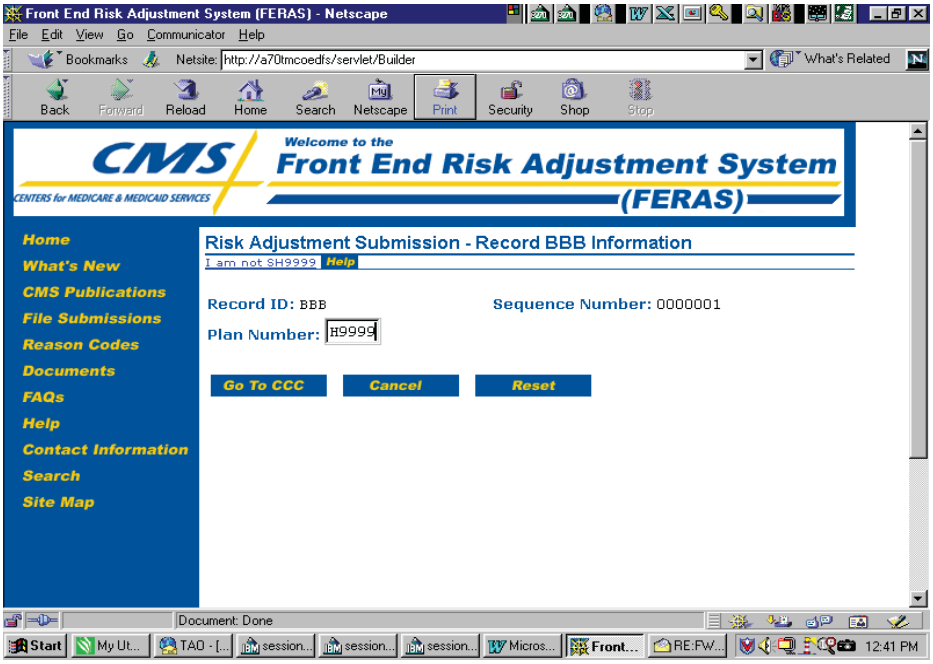
WELCOME PAGE – Submitters are provided instructions on the use of the DDE.

Figure 4D – DDE 3



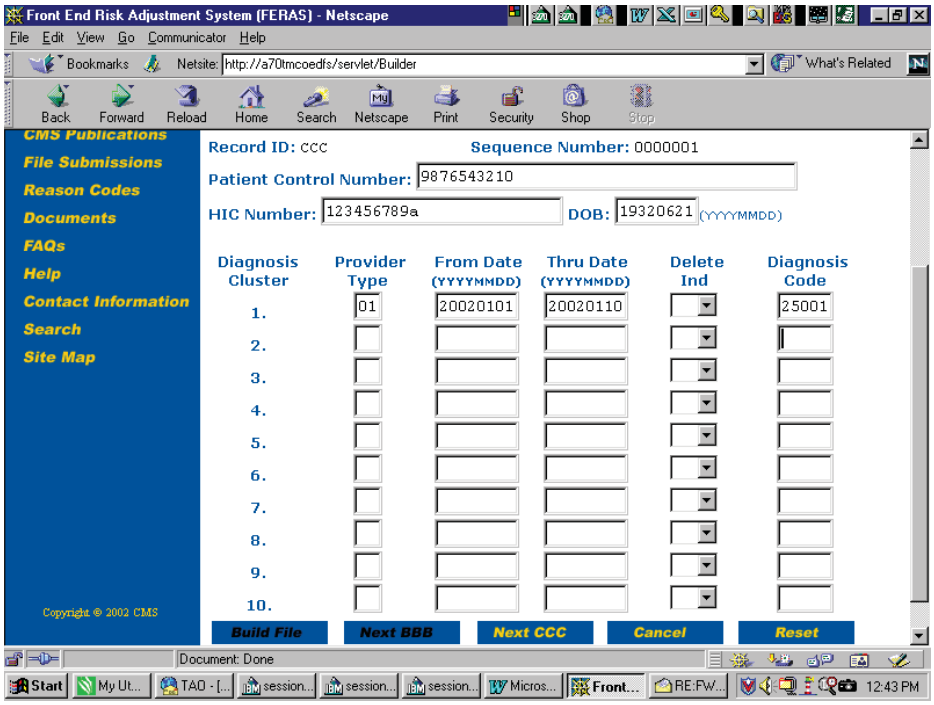
The file level information is entered and must begin with RT AAA.

Figure 4E – DDE 4



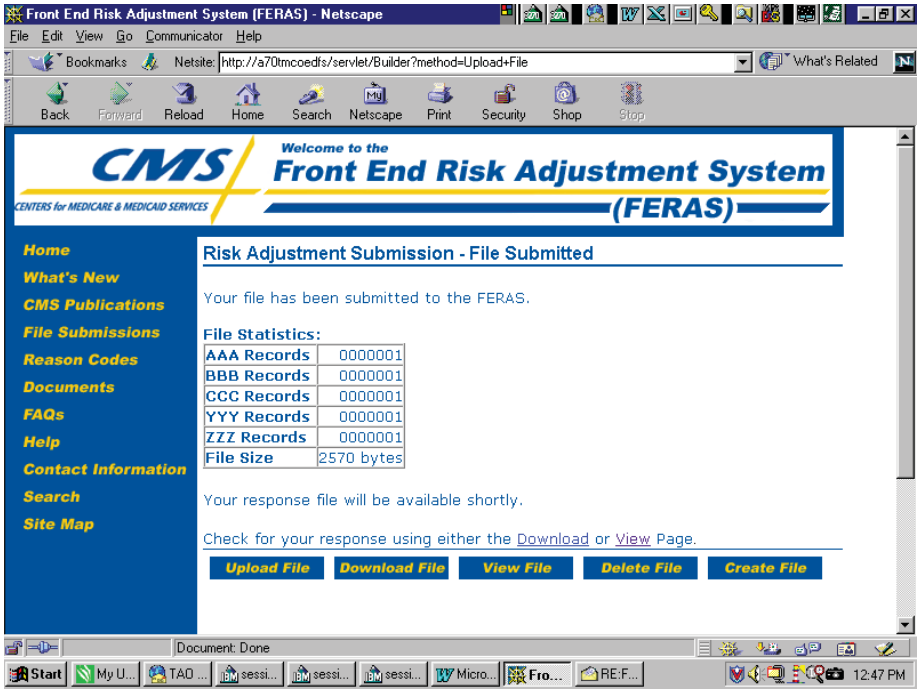
The batch level information is entered and must begin with RT BBB.

Figure 4F – DDE 5



The CCC Record allows up to 10 diagnostic clusters.

Figure 4G – DDE 6



The file has been uploaded to FERAS.

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LATHAM & WATKINS LLP

June 15, 2018

VIA EMAIL

Paul Perkins
Civil Division, Fraud Section
United States Department of Justice
175 N. St. N.E.
Washington, DC 20002

Re: Government's Unsupported Assertions of the Deliberative Process Privilege

Dear Paul:

UnitedHealth is concerned that the government is improperly invoking the deliberative process privilege to shield highly relevant documents from discovery. As discussed below, the deliberative process privilege is a narrow, qualified privilege that the government cannot invoke to prevent discovery of documents critical to UnitedHealth's ability to defend itself. Please let us know by June 22 if you will reconsider your position or, if necessary, your availability for a meet and confer.

The government's reliance on the deliberative process privilege is improper in at least three respects. *First*, the government is refusing even to collect documents from certain sources it believes may contain a high percentage of documents protected by the deliberative process privilege. Such an approach ignores the qualified and limited nature of the deliberative process privilege. *Second*, the government is taking an overly broad view of the privilege, and its privilege logs do not provide the requisite support for an assertion of the deliberative process privilege. *Third*, even if the government properly asserted the deliberative process privilege, UnitedHealth's need for the requested information far outweighs the government's interest in non-disclosure.

A. The Government's Refusal To Collect Documents Based On The Deliberative Process Privilege

The deliberative process privilege is a qualified privilege that is narrowly construed and applies only in limited circumstances. *See FTC v. Warner Commc'ns. Inc.*, 742 F.2d 1156, 1161 (9th Cir. 1984) (holding that the deliberative process privilege applies only to documents that are "predecisional" and "deliberative in nature" and stating that "[p]urely factual material . . . is not protected"); *N. Pacifica, LLC v. City of Pacifica*, 274 F. Supp. 2d 1118, 1121 (N.D. Cal. 2002) (stating that "the privilege is strictly confined within the narrowest possible limits consistent with the logic of its principles") (internal quotation and citation omitted). The government has the burden of establishing that the deliberative process privilege protects the material at issue. *N.*

Pacifica, LLC, 274 F. Supp. 2d at 1121. As discussed below, an appropriate agency official must personally consider each document, detail the information over which the privilege is asserted, and explain why such information properly falls within the scope of the deliberative process privilege. By refusing even to collect various categories of documents, *see, e.g.*, United States' Apr. 20, 2018 Ltr. at 3, the government cannot satisfy its obligations for asserting this narrow, qualified privilege. We believe that the government's refusal to collect documents and undertake an individualized review of each document is improper and fails to comply with relevant law. If you have any relevant authority that would support the government's blanket refusal to collect responsive documents, please forward to us immediately.

B. The Government's Expansive And Unsupported Assertions Of The Deliberative Process Privilege

The government has produced approximately 30,300 documents and logged approximately 6,700 documents in this litigation. Remarkably, the government is asserting privilege over about 5,900 of these documents solely on the basis of the deliberative process privilege—about 19.5% of the documents produced by the government and over 88% of all documents on the government's privilege logs. When including privileges asserted simultaneously with this privilege, this number rises to over 6,300—nearly 21% of the documents produced by the government and nearly 95% of the documents on the government's privilege log. These staggering statistics suggest that the government is taking an inappropriately expansive view of the deliberative process privilege.

The government's privilege logs do not provide adequate support for its expansive assertions of the deliberative process privilege. A proper assertion of the privilege requires: "(1) a formal claim of privilege by the head of the department possessing control over the requested information; (2) an assertion of the privilege based on actual personal consideration by that official; and (3) a detailed specification of the information for which the privilege is claimed, along with an explanation of why it properly falls within the scope of the privilege." *Coleman v. Schwarzenegger*, 2008 WL 2237046, at *4 (E.D. Cal. May 29, 2008) (internal quotation and citation omitted).

Additionally, to qualify for protection under the deliberative process privilege, materials must be both "predecisional" and "deliberative." *Hongsermeier v. Comm'r of Internal Revenue*, 621 F.3d 890, 904 (9th Cir. 2010) (quoting *N.L.R.B. v. Sears, Roebuck & Co.*, 421 U.S. 132, 150 (1975)). A document will be considered "predecisional" if it was "prepared in order to assist an agency decisionmaker in arriving at his decision." *Carter v. U.S. Dep't of Commerce*, 307 F.3d 1084, 1089 (9th Cir. 2002) (holding that adjusted census data held back based on accuracy concerns was not "predecisional" because it was originally prepared for the purpose of dissemination to the public) (quotations and citation omitted). To be deemed deliberative, the statement or document must have been a direct part of the deliberative process in that it makes recommendations or expresses opinions on legal or policy matters. *See Vaughn v. Rosen*, 523 F.2d 1136, 1144 (D.C. Cir. 1975) ("[P]redecisional materials are not exempt merely because they are predecisional; they must also be a part of the agency give-and-take of the deliberative process by which the decision itself is made."); *see also Allen v. Woodford*, No. CV-F-05-1104, 2007 WL 309945, at *5, *9 (E.D. Cal. Jan. 30, 2007) (stating that, to qualify for the deliberative process privilege, the document must relate to a larger policy formulation, not a single, trivial decision,

such as whether to fire a single employee). Additionally, the "privilege only applies to significant policy decisions, rather than factual material," *Dominguez v. Schwarzenegger*, 2010 WL 3341038, at *5 (N.D. Cal. Aug. 25, 2010) (internal quotation and citation omitted) (ordering production of all documents for which government invoked solely deliberative process privilege where government failed to identify specific policy decisions at issue).[1] For example, discussions about CMS's own error rates and what impact the underlying errors had on CMS's calculations of risk adjustment coefficients would not qualify for the deliberative process privilege because these discussions would involve purely factual information, not questions of policy.

The government has not properly satisfied the requirements to assert the deliberative process privilege. The government has not identified a formal claim of privilege by any official of any relevant agency, let alone a high-ranking official. There also does not appear to be any indication that an appropriate agency official asserted the privilege based on his or her actual personal consideration of the documents. Rather, it appears that the privilege assertions to date have been made by lawyers at the Department of Justice.

Furthermore, the basic descriptions provided by the government fail to satisfy the requirement that the government provide a "detailed specification of the information for which the privilege is claimed, along with an explanation of why it properly falls within the scope of the privilege." *Id.* Nor do the government's privilege log descriptions even detail whether or how each document is both pre-decisional and deliberative.

For example:

- Document "reflecting internal agency deliberations regarding RADV audit methodology." *See, e.g.*, USBPPRIV00000239. The government has used this description for approximately 1,742 documents that span from September 2003 to July 2017.

- Document "reflecting calculation of RA error rate." *See, e.g.*, USBPPRIV00001566. The government has used this description for approximately 743 documents that span from September 2004 to November 2016.

- Document "reflecting internal agency deliberations regarding Advance Notice and/or Announcement and Call Letter." *See, e.g.*, USBPPRIV00000410. The government has used this description for approximately 429 documents that span from March 2005 to April 2017.

[1] The government should not be withholding in full documents that contain factual (or other) materials that do not qualify for this narrow privilege. This does not appear to be the case, however, considering the government is withholding in full approximately 95% of documents over which it is asserting solely the deliberative process privilege and is only redacting approximately 5% of these documents.

- Document "reflecting internal agency deliberations regarding RA supporting documentation requirements." *See, e.g.*, USBPPRIV00002198. The government has used this description for approximately 413 documents that span from August 2004 to May 2017.

- Document "reflecting internal agency deliberations regarding medical coding in support of RA payments." *See, e.g.*, USBPRIV00005095. The government has used this description for approximately 315 documents that span from March 2004 to May 2017.

- Document "reflecting internal agency deliberations regarding FFS adjuster." *See, e.g.*, USBPPRIV00001545. The government has used this description for approximately 214 documents that span from June 2005 to March 2017.

These generic, widely used descriptions do not adequately describe the content of the purported deliberations and do not provide the requisite level of detail for UnitedHealth to determine whether such documents properly fall within the scope of the deliberative process privilege. And, as noted above, the government has not indicated that any high-ranking agency official reviewed any of these documents before including them on the logs.

Because the government has not provided the requisite level of detail about the exact agency decisions at issue and how each document contributed to those decisions, UnitedHealth cannot properly assess whether any purported deliberations were ultimately adopted by the agency. *See Nat'l Resources Def. Council v. U.S. Dep't of Defense*, 388 F. Supp. 2d 1086, 1098 (C.D. Cal. 2005) ("Even if the document is predecisional at the time it is prepared, it can lose that status if it is adopted, formally or informally, as the agency position on an issue or is used by the agency in its dealings with the public." (quoting *United States v. Rozet*, 183 F.R.D. 662, 666 (N.D. Cal. 1998)); *Assembly of State of Cal. v. U.S. Dept. of Commerce*, 968 F. 2d 916, 920 (9th Cir. 1992) (noting that a "predecisional" document is one "prepared in order to assist in an agency decisionmaker in arriving at his decision" and that "documents deemed 'postdecisional' do not enjoy the protection of the deliberative process privilege") (quoting *Sears, Roebuck & Co.*, 421 U.S. at 153).

The government has also logged documents that were circulated to numerous individuals—far more than one would expect from a document that properly fell within the deliberative process privilege. For example, USBPPRIV00000183 is purportedly an "[e]mail reflecting internal agency deliberations regarding RADV audit methodology." The privilege log lists approximately 114 individuals in the "To" field and another approximately 64 in the "cc" field. It is doubtful that this type of mass email, which was sent to around 180 people, would properly fall under the deliberative process privilege. *See also* USBPPRIV00000177 ("Email reflecting internal agency deliberations regarding RADV audit methodology" sent to approximately 125 recipients); USBPPRIV00000288 ("Email, with attachments, reflecting internal agency deliberations regarding calculation of RA error rate" sent to approximately 108 recipients).

In sum, the government has not properly invoked the deliberative process privilege for the approximately 6,300 responsive documents it seeks to shield from production in this matter based on that privilege. The government chose to bring this lawsuit. It cannot now hide behind the deliberative process privilege to skirt its discovery obligations and deprive UnitedHealth of highly relevant documents to which it is entitled.

II. UnitedHealth's Need For The Requested Information Outweighs The Government's Interest In Non-Disclosure

Even if the government had properly invoked the deliberative process privilege—which it has not—the privilege is qualified and can be overcome by a sufficient showing of need outweighing the harm that might result from disclosure. *Warner Commc'ns Inc.*, 742 F. 2d at 1161 ("A litigant may obtain deliberative materials if his or her need for the materials and the need for accurate fact-finding override the government's interest in non-disclosure.") (citations omitted). Here, the government is alleging over a billion dollars in damages; UnitedHealth's need for arguably privileged documents far outweighs the government's interest in non-disclosure.

The Ninth Circuit has set forth four non-exclusive factors that may be considered in balancing of the competing interests: "(1) the relevance of the evidence; (2) the availability of other evidence; (3) the government's role in the litigation; and (4) the extent to which disclosure would hinder frank and independent discussion regarding contemplated policies and decisions." *Id.* (citations omitted). These factors overwhelming weigh in favor of overcoming any assertion of deliberative process privilege in this case.

First, as UnitedHealth has explained in numerous letters and meet and confers, the requested documents are crucial for its defenses to the misconduct charges made by the government in this case. For example, under *United Health Services, Inc. v. United States ex rel. Escobar*, 136 S.Ct. 1989 (2016), documents related to the government's interpretations of the requirements imposed on MA plans by CMS statutes, rules, regulations, and guidance—requirements the government now claims UnitedHealth violated—are directly relevant to UnitedHealth's defenses. Thus, documents related to, among other things, the government's understanding of whether MA plans were required to "look both ways," whether other MA plans were conducting "one-way looks," and how the government responded to any allegations of non-compliance are all relevant to whether any alleged misconduct by UnitedHealth satisfies *Escobar*'s demanding materiality standard. These documents—as well as documents such as those relating to the government's views on how to measure overpayments—are also relevant to whether UnitedHealth's interpretation of relevant statutes, guidelines, and communications with CMS officials was reasonable. *See, e.g.*, *United States v. Pac. Gas & Elec. Co.*, 178 F. Supp. 3d 927, 963 (N.D. Cal. 2016) (holding that evidence of government's or other regulated entities' interpretation of regulations was relevant to reasonableness of defendant's interpretation). Furthermore, documents related to the government's own error rates are relevant to UnitedHealth's theory of the proper calculation of any potential damages.

The government appears to be asserting the deliberative process privilege over these types of documents and depriving UnitedHealth of these crucial documents. For example, the government is asserting privilege over approximately 743 documents related to the "calculation of RA error rate," approximately 278 documents related to the "calculation of coding intensity adjuster," approximately 257 documents related to "non-UHG MAO RA activities," and approximately 214 documents related to the "FFS adjuster."

Second, UnitedHealth cannot obtain this crucial evidence related to government knowledge and interpretations of MA requirements from other sources—the government is the sole custodian of this information.

Third, the government chose to bring this lawsuit, so its role in the litigation weighs heavily toward disclosure of these documents.

Fourth, because there is a protective order in place, the risk that disclosure of these documents will have a chilling effect on future deliberations by government employees is minimal. *See, e.g.*, *In re McKesson Governmental Entities Average Wholesale Price Litig.*, 264 F.R.D. 595, 602–03 (N.D. Cal. 2009) (holding that the protective order in place would sufficiently protect the government's interest); *Noble v. City of Fresno*, No. 1:16-cv-01690, 2018 WL 1381945, at *9 (E.D. Cal. Mar. 19, 2018) (same).

Thus, even if the government had properly invoked the deliberative process privilege (which it has not), the privilege would be overcome in this case because UnitedHealth's need for the documents outweighs the government's interest in non-disclosure.

* * *

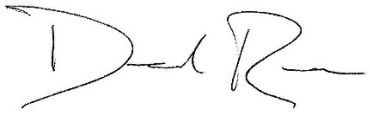
Please let us know by June 22 if you will reconsider your position or, if necessary, your availability the following week for a meet and confer.

If the government continues to assert the deliberative process privilege over any documents, UnitedHealth requests that the government (1) collect any documents it has previously refused to collect, produce non-privileged documents, and log any purportedly privileged documents; (2) revise its privilege logs to provide the requisite detail about the information over which the government claims the privilege applies; and (3) provide a formal claim of privilege by an appropriate agency official who has personally reviewed any documents over which the government is asserting the deliberative process privilege.

Please do not hesitate to contact me with any questions. Thank you.

LATHAM & WATKINS LLP

Sincerely yours,



David W. Rowe
of LATHAM & WATKINS LLP

cc: Counsel of Record

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Attorneys for Defendants UnitedHealth Group, Inc.; United Healthcare Services, Inc.; United Healthcare, Inc.; UnitedHealthcare Insurance Company; UHIC Holdings, Inc.; Ovations, Inc.; Optum, Inc.; OptumInsight, Inc.; and Defendant Medicare Advantage Organizations and Plans listed on Exhibit 1 to the United States' Complaint-In-Partial-Intervention and Demand for Jury Trial (collectively "UnitedHealth")

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA *ex rel.* BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC., *et al.*, Defendants.	CASE NO. CV 16-08697 MFW (SSx) DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. ONE) Assigned to Hon. Michael W. Fitzgerald DISCOVERY MATTER

PROPOUNDING PARTY: Defendant UHC of California

RESPONDING PARTY: Plaintiff United States Government

SET NO.: ONE (1)

TO THE RESPONDING PARTY AND TO ITS ATTORNEYS OF RECORD:

Please take notice that pursuant to Rules 26(b)(1) and 34 of the Federal Rules of Civil Procedure and Rule 34-1 of the Local Civil Rules of the United States District Court for the Central District of California, Defendant UHC of California, by and through its undersigned attorneys, submits the following Request for the Production of Documents to the United States Government ("Government"). On or before the thirtieth (30th) day after service of this Request, Plaintiff shall produce and permit the inspection and copying of the documents or things described below at Latham & Watkins, 555 Eleventh Street, Northwest, Suite 1000, Washington, DC 20004. The Definitions and Instructions set forth below shall govern all of the following Requests, as well as responses to the Requests.

DEFINITIONS

As used herein, the following terms and phrases shall have the following meanings:

1. The applicable definitions and rules of construction set forth in the Federal Rules of Civil Procedure and the local rules are incorporated herein by reference.

2. **"Bid(s)"** shall mean and refer to bids and supporting documentation submitted to CMS pursuant to 42 U.S.C. § 1395w-24(a).

3. **"Claim"** shall mean and refer to the definition set forth in the False Claims Act at 31 U.S.C. § 3729(b)(2).

4. **"CMS"** shall mean the United States Centers for Medicare and Medicaid Services, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

5. "**Complaint**" shall mean the complaint filed by the Government in this case on May 16, 2017, and any forthcoming amended complaints filed by the Government in this case.

6. **"Concerning"** shall mean and refer to relating to, referring to, received from, addressed to, sent to, alluding to, responding to, announcing, identifying, explaining, evaluating, discussing, showing, supporting, describing, studying, reflecting, analyzing, or consulting.

7. "**Document**" shall have the full meaning ascribed to it in Federal Rule of Civil Procedure 34 and shall include every writing or record (including Electronically Stored Information) of every type and description such as communications, correspondence, speech, writings, memoranda, stenographic or handwritten notes, language (machine, foreign, or otherwise), studies, publications, books, pamphlets, reports, financial statements, calculations, analyses, films, video tape, photographs, graphs, symbols, signs, voice recordings, sound, radio and/or video signal, telephone, teletype, telecommunication, telegram, facsimile transmission, microfilm, microfiche, photographic film of any type, e-mail, computer electronics of any kind, computer files or all other data compilations from which information can be obtained including electromagnetically sensitive stored media such as floppy discs, hard discs, magnetic disks, and magnetic tapes, any preliminary versions, drafts or revisions of any of the foregoing, and all copies of every such writing or record (or a draft thereof) whenever a copy of a Document is not an identical copy of the original or where such copy contains any commentary, notes or markings whatsoever that do not appear on the original.

8. "**Electronically Stored Information**" or "**ESI**" refers to any designated documents or electronically stored information - including writings, drawings, graphs, charts, photographs, sound recordings, images, e-mails and other data or data compilations stored in any medium (hard drives, disc drives, servers,

lap tops) from which information can be obtained, including all data which may have been deleted, but which can be recovered or retrieved from a back-up system or such other method translated, if necessary, by the party into reasonably usable form. For the avoidance of doubt, any electronic Documents or data shall include its associated metadata.

9. "**Each**" includes the word "every" and "**every**" includes the word "each," "**any**" includes the word "all" and "**all**" includes the word "any," "**and**" includes the word "or" and "**or**" includes the word "and," as necessary to bring within the scope of each Request information which might otherwise be construed to be outside its scope.

10. "**False**" shall mean and refer to "false" or "fraudulent" as those terms are used in the False Claims Act, at 31 U.S.C. §§ 3729(a)(1)(A)-(B).

11. **"Gainshare Arrangements"** refers to agreements whereby Medicare Advantage Plans pay fee-for-service providers additional payments based on revenue, including risk adjustment payments, which Medicare Advantage Plans receive from CMS.

12. "**Government**" shall mean the United States, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf, including but not limited to any component of the United States Department of Justice, the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services and all subdivisions and components thereof.

13. **"HCC"** means a hierarchical condition category associated with one or more diagnosis codes (ICD-9-CM or ICD-10-CM codes) that represent the disease component of the beneficiary risk scores that are applied to Medicare Advantage payments. "RxHCC" means an HCC used for Medicare Part D.

14. **"ICE"** means and refers to the Industry Collaborative Effort for Healthcare, an association of MA Organizations and their Plans as well as provider

groups that service beneficiaries in Plans.

15. **"Identify"** means and refers to the following:

a. when used in reference to a natural person, it means that individual's full name, present or last known residence address and telephone number, business/government affiliation and business/government address and telephone number and e-mail address;

b. when used in reference to an organization, it means to state the organization's full name and, if it is a corporation, partnership or other business entity, the address of its principal place of business;

c. when used in connection with a Document or other recording (written, electronic, or otherwise), it means to state the following, as applicable: the type of document, its date (or approximate date), author, addressee, title, present location, the form in which it is maintained (e.g., written document, computer file, posting on the Internet or World Wide Web, audio or video recording or any other form), the name and address of its custodian, and the substance of the contents thereof. In lieu of identifying any document, copies thereof may be furnished;

d. when used in reference to a communication (whether written, oral, electronic, or otherwise), shall mean to state the form of the communication (e.g., telephone conversation, letter, telegram, teletype, telecopy, electronic mail, posting on the Internet or World Wide Web, facsimile, written memorandum, face-to-face conversation, or any other form), the date (or approximate date) of the communication or the dates (or approximate dates) on which the communication was sent, posted, and/or received (if not the same), the parties to the communication, the party who initiated it, the substance of the communication, and the present location and the name and

address of the custodian if the communication was non-verbal, and/or any written memorialization of the communication; and

e. when used in connection with a location, it means the name of the establishment, the street address, the suite or apartment number if any, the city, state and zip code, and, if applicable, the telephone number.

16. "**Including**" shall be construed as broadly as possible and shall mean "without limitation."

17. **"Limited Data Set Files"** and **"LDS Files"** shall mean and refer to publically available data files containing both institutional and non-institutional Medicare claims and provider information as well as beneficiary level health information.

18. **"Medicare Advantage Plan"** and **"MA Plan"** shall mean and refer to a Medicare Advantage Organization with a contract to provide health benefits coverage that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries in residing in the service area of the MA Plan, in exchange for capitated (i.e., set or fixed), per-member-per-month payments from the federal government, under Parts C and D of the Medicare Program. *See* 42 U.S.C. §§ 1395w-22(a)(1) and 23(a)(1); *see also* 42 U.S.C. § 1395w-28(b)(1).

19. "**Medicare Advantage Organization**" and **"MAO**" shall mean and refer to a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage contract requirements. *See* 42 U.S.C. § 1395w-28(a)(1).

20. "**Person**" shall mean natural persons, proprietorships, corporations, public corporations, municipal corporations, the federal government and all departments and agencies thereof, state governments, local governments, other governmental agencies, political subdivisions, partnerships, groups, associations or organizations.

21. **"RADAR"** shall mean and refer to the Risk Adjustment Data Acquisition and Reporting team within ICE.

22. "**Relating to**" and "**regarding**" or any derivative thereof, in addition to their customary and usual meanings, shall mean concerning, referring to, containing, identifying, monitoring, constituting, reflecting, discussing, pertaining to, assessing, recording, supporting, negating, refuting, touching upon and/or summarizing.

23. "**Relator**" shall mean Benjamin Poehling and all Persons acting on his behalf.

24. "**Risk Adjustment**" shall mean and refer to the method by which CMS adjusts capitation payments to Medicare Advantage Organizations and their health Plans based on enrollees' demographic factors and health status to ensure actuarial equivalence under Parts C and Part D of the Medicare Program, as described in 42 U.S.C. § 1395w-23 and 42 C.F.R. § 422.308(c)(1).

25. **"Risk Adjustment Attestations"** shall mean and refer to the requirement defined in 42 C.F.R. § 422.504(l) that Medicare Advantage organizations must request payment under their contract with CMS on a document that certifies the accuracy, completeness, and truthfulness of relevant data that CMS requests.

26. **"Risk Adjustment Error"** or **"RAE"** shall mean and refer to the estimate that captures error in risk adjustment data (clinical diagnosis data) submitted to CMS by MA plans for risk adjustment payments, based on a national sample of MA beneficiaries. *See* CMS "2011 Medicare Advantage (Part C) Improper Payment Error Rate" Fact Sheet, *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2011-Fact-sheets-items/2011-11-157.html.

27. "***Swoben* Investigation**" shall mean and refer to the Government's investigation related to the case captioned *United States of America ex rel. James*

M. Swoben v. SCAN Health Plan, et al., CV 09-5013 JFW (JEMx), originally filed in the United States District Court for the Central Division of California on July 13, 2009.

28. **"UnitedHealth"** shall mean UnitedHealth Group, Inc.; United Healthcare Services, Inc.; United Healthcare, Inc.; UnitedHealthcare Insurance Company; UHIC Holdings, Inc.; Ovations, Inc.; Optum, Inc.; OptumInsight, Inc.; and Defendant Medicare Advantage Organizations and Plans listed on Exhibit 1 to the United States' Complaint-In-Partial-Intervention and Demand for Jury Trial.

29. "**You**" and "**Your**" shall mean the Government and all Persons acting on its behalf.

INSTRUCTIONS

1. You are to produce all documents, as defined above, that are in the possession, custody or control of You, or in the possession, custody or control of any attorney or agent for You. Without limiting the term "control," a document is deemed to be within Your control if you have ownership, possession or custody of the document, or the right to secure the document or copy thereof from any person or public or private entity having physical possession thereof.

2. Whenever appropriate, the singular form of a word shall be interpreted as plural, and vice versa. Similarly, the use of the present tense of a verb shall be considered to include within its meaning the future and past tense, and vice versa.

3. Each Request should be construed to include the time period from January 1, 2004 through May 16, 2017 (unless stated differently by a specific document request).

4. You are under a duty to supplement Your response to these requests for documents pursuant to Federal Rule of Civil Procedure 26(e)(1).

5. If You know of documents responsive to a particular request that You cannot locate after a reasonable search, describe the documents in Your response to

the particular request and explain the reason for being unable to locate the documents. If a document has been lost or destroyed, state when the document was lost or destroyed and explain the circumstances under which it was lost or destroyed.

6. The documents produced in response to the document requests shall be produced as they are kept in the ordinary course of business and shall be organized so that Defendant can ascertain the files in which they were located, their relative order in such files, and how such files were maintained.

7. Production of Electronically Stored Information ("ESI"), as that phrase is understood in Fed. R. Civ. P. 26, should conform to the instructions contained in the agreed upon "Specifications for Production of ESI and Digitized ('Scanned') Images."

8. If the contention is made that any requested documents are not subject to discovery in whole or part by reason of privilege or otherwise, identify each such document in a log consistent with the requirements of Fed. R. Civ. P. 26(b)(5).

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 1:

All Documents regarding the final Risk Adjustment Data Validation ("RADV") methodology discussed in CMS's *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012), as well as any prior RADV methodologies adopted or suggested by CMS and all comments filed on those methodologies.

REQUEST FOR PRODUCTION NO. 2:

All Documents relating to the standard for evaluating the accuracy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data that CMS and the Office of the Inspector General ("OIG") of the Department

of Health and Human Services ("HHS") apply in RADV audits, including but not limited to, all Documents in which CMS and OIG set forth, discuss, review, and/or revise that standard and all Documents upon which CMS relied to set that standard.

REQUEST FOR PRODUCTION NO. 3:

All Documents relating to any regulations, rules, guidance or other public pronouncements setting forth the Government's standards for evaluating the accuracy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data.

REQUEST FOR PRODUCTION NO. 4:

All Documents relating to any CMS analyses and/or reviews of, and reports on, capitation arrangements and Gainshare Arrangements within the Medicare Advantage program, and any other arrangements that align providers' interests with the interests of MA Plans to provide more efficient and effective care to MA Plan members or that pay for value or quality rather than quantity of services, and their impact on patient outcomes, control of healthcare costs and any other impacts that are measured by these analyses, reviews, and reports.

REQUEST FOR PRODUCTION NO. 5:

All Documents relating to the preliminary or final results of any audits or reviews conducted by or on behalf of the Government, including CMS and the HHS OIG, of diagnosis codes submitted to the Medicare Program for Risk Adjustment payments, including, but not limited to, RADV Audits.

REQUEST FOR PRODUCTION NO. 6:

All Documents regarding the RADV Medicare fee-for-service ("FFS") error rate adjuster discussed in CMS's *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012), including but not limited to, Documents describing any effort by the Government to calculate a Medicare FFS error rate and Documents describing any analysis by the Government related to measuring the

accuracy of diagnoses submitted on Medicare FFS claims.

REQUEST FOR PRODUCTION NO. 7:

All Documents regarding the Risk Adjustment Error ("RAE") rate, including Documents sufficient to show the annual RAE rates calculated by the Government over time.

REQUEST FOR PRODUCTION NO. 8:

All data from all fields included in the following Limited Data Set ("LDS") Files: 1) 100% Denominator File, 2) 5% Carrier Standard Analytic File, 3) 100% Inpatient Standard Analytic File, and 4) 100% Outpatient Standard Analytic File. This request seeks data for dates of service years 2005 through 2015.

REQUEST FOR PRODUCTION NO. 9:

All communications between CMS and Signature Consulting Group regarding RADV audits and/or HCC coding criteria and analysis.

REQUEST FOR PRODUCTION NO. 10:

All Documents related to CMS and any other Government involvement in ICE and RADAR activities, meetings, calls, workshops, conferences and other collaborations regarding any Risk Adjustment issues.

REQUEST FOR PRODUCTION NO. 11:

All Documents related to communications between the Government and ICE and RADAR relating to Risk Adjustment.

REQUEST FOR PRODUCTION NO. 12:

A copy of each signed Medicare Advantage contract between CMS and UnitedHealth and any Documents related to such contracts.

REQUEST FOR PRODUCTION NO. 13:

A copy of each Risk Adjustment Attestation that any Medicare Advantage Organization ("MAO") submitted to CMS pursuant to 42 C.F.R. § 422.504(l), and any Documents submitted by Medicare Advantage Organizations to qualify or explain their Risk Adjustment Attestations.

REQUEST FOR PRODUCTION NO. 14:

All Documents relating to the annual Risk Adjustment Attestation of accuracy submitted by MAOs pursuant to 42 C.F.R. § 422.504(l), including Documents relating to the specific data and information MA Plans must certify as accurate, complete, and truthful.

REQUEST FOR PRODUCTION NO. 15:

All Documents relating to the Government's review, analysis, or acceptance of the Risk Adjustment Attestations submitted by any MAO pursuant to 42 C.F.R. § 422.504(l).

REQUEST FOR PRODUCTION NO. 16:

All Documents relating to CMS's issuance or decision to issue risk adjustment payments, including final reconciliation payments, to UnitedHealth after receiving UnitedHealth's Risk Adjustment Attestations.

REQUEST FOR PRODUCTION NO. 17:

All Documents relating to the Government's knowledge as to whether MA Plans were validating the accuracy of diagnosis codes submitted on claims data to CMS for purposes of Risk Adjustment.

REQUEST FOR PRODUCTION NO. 18:

All Documents relating to the Government's knowledge as to whether MA Plans were deleting diagnosis codes submitted on claims data to CMS for purposes of Risk Adjustment that were not supported by a medical record.

REQUEST FOR PRODUCTION NO. 19:

All Documents relating to the Government's knowledge as to whether MA Plans "look both ways."

REQUEST FOR PRODUCTION NO. 20:

All Documents relating to the Government's knowledge of MA Plans' efforts to exercise "reasonable diligence" to report and return overpayments to CMS as described in 79 Fed Reg. 29,844, 29,923.

REQUEST FOR PRODUCTION NO. 21:

All Documents relating to the Government's, review, analysis, or receipt of the Bids submitted by UnitedHealth pursuant to 42 U.S.C. § 1395w-24(a), including but not limited to Documents relating to (a) any actions that the Government took in response to those Bids, (b) questions posed by the Government, (c) any evidence of the Government's concerns with the UnitedHealth Bids, (d) any conclusions reached by the Government in the course of evaluating the UnitedHealth Bids, and (e) any analysis or reviews or conclusions regarding the appropriateness of any of the assumptions set forth or relied by United in its Bids.

REQUEST FOR PRODUCTION NO. 22:

All Documents relating to instructions and guidelines for CMS employees responsible for reviewing MA Plans' bids and associated material.

REQUEST FOR PRODUCTION NO. 23:

All Documents regarding the requirement mandated by 42 U.S.C. § 1395w-23(a)(l)(C)(ii) that CMS apply a coding intensity adjustment to MA Plans, including but not limited to all Documents relating to the calculation of the coding intensity adjustment.

REQUEST FOR PRODUCTION NO. 24:

Documents sufficient to show the methodology by which the Government calculates Risk Adjustment Factors, including but not limited to, all Documents regarding consideration of whether CMS's calculation of Risk Adjustment Factors and development of a risk model from other than inpatient settings should be based on diagnoses from claims data or medical charts. *See* 42 U.S.C. § 1395w-23. This request seeks documents from June 1, 1997 through May 1, 2017.

REQUEST FOR PRODUCTION NO. 25:

All Documents relating to the statement contained in "*Medicare Program; Medicare+Choice Program*" that MA Organizations "undertake 'due diligence' to

ensure the accuracy, completeness, and truthfulness of encounter data" they submit to CMS, and make "good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted" to CMS, 65 Fed. Reg. 40,170, 40,268 (June 29, 2000), including, but not limited to, any Documents discussing or describing any obligations created by this statement. This request seeks documents from June 1, 1997 through May 1, 2017.

REQUEST FOR PRODUCTION NO. 26:

All Documents regarding CMS's proposal in proposed rule "*Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" to add 42 C.F.R. § 422.310(e)(1) requiring that "[a]ny medical record reviews conducted by a MA organization ... be designed to determine the accuracy of diagnoses submitted under § 422.308(c) and § 422.310(g)," 79 Fed. Reg. 1918,2053 (Jan. 10, 2014), including, but not limited to, any and all reasons, analyses, or considerations regarding why CMS did not adopt this proposal in the final rule. 79 Fed. Reg. 29,844, 29,921; 29,926 (May 23, 2014).

REQUEST FOR PRODUCTION NO. 27:

All Documents regarding CMS's "*Reporting and Returning of Overpayments*" proposal in its proposed rule "*Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" to add 42 C.F.R. § 422.326 to "clarify the statutory definition of overpayment" 79 Fed. Reg. 1918, 2055-56 (Jan. 10, 2014), including, but not limited to, any comments submitted to CMS about the proposed rule.

REQUEST FOR PRODUCTION NO. 28:

All Documents regarding CMS's "*Reporting and Returning of Overpayments"* final rule in *"Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" 79 Fed. Reg. 29,844, 29,921; 29,926 (May 23, 2014).

REQUEST FOR PRODUCTION NO. 29:

All Documents containing unique versions of Chapter 7 and Chapter 21 of CMS's "*Medicare Managed Care Manual*" dating from 1999 to the present.

REQUEST FOR PRODUCTION NO. 30:

All Documents related to internal discussions, analyses and/or calculations regarding the preparation of the Regulatory Impact Statement for HCFA, Medicare Program: Medicare + Choice Program Final Rule, 65 Fed. Reg. 40170 (June 29, 2000).

REQUEST FOR PRODUCTION NO. 31:

All Documents regarding whether Section 6.4.1 of CMS's *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide* requires MAOs to delete unsupported codes.

REQUEST FOR PRODUCTION NO. 32:

All Documents regarding whether Section 7.2.4.1 of CMS's *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide* applies to contexts other than CMS's RADV audits.

REQUEST FOR PRODUCTION NO. 33:

All Documents reflecting discussion or analysis of CMS's overpayment standard, requiring Plans to exercise "reasonable diligence" in reporting and returning overpayments, including but not limited to Documents explaining or analyzing the "reasonable diligence" standard. *See* 79 Fed Reg. 29,844, 29,923.

REQUEST FOR PRODUCTION NO. 34:

All Documents regarding CMS's "*Guidance for Reporting and Returning Medicare Advantage Organization and/or Sponsor Identified Overpayments to the Centers for Medicare & Medicaid Services (CMS)*" (February 18, 2015).

REQUEST FOR PRODUCTION NO. 35:

All Documents regarding any Government efforts to review, validate or otherwise evaluate the accuracy of Medicare FFS diagnosis codes that it received

on claims data as part of its process of calculating risk-adjusted reimbursement rates or calculating annual risk scores, including, but not limited to, any Documents related to whether the Government reviews or otherwise evaluates corresponding medical records as part of any such validation activities.

REQUEST FOR PRODUCTION NO. 36:

All Documents regarding the Government's forecasting, budgeting and/or appropriating payments or funds to CMS related to insuring the Medicare FFS population.

REQUEST FOR PRODUCTION NO. 37:

All Documents relating to the methodology CMS used to calculate its annual county-level average risk score and per capita costs for Calendar Years 2005 through 2015. *See, e.g.*, County Fee-for-Service Expenditure Data for Calendar Year 2012, *available at* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html.

REQUEST FOR PRODUCTION NO. 38:

All Documents reflecting or relating to whether MA Plans validate or validated the accuracy of diagnosis codes submitted on claims data to CMS for purposes of Risk Adjustment and whether MA Plans "look both ways" when reviewing medical charts.

REQUEST FOR PRODUCTION NO. 39:

All Documents regarding any obligation or requirement that MA Plans validate the accuracy of diagnosis codes submitted on claims data before they submit claims data to CMS for purposes of Risk Adjustment, including but not limited to any such obligation or requirement that appears in CMS's *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide*.

REQUEST FOR PRODUCTION NO. 40

All Documents relating to discussions between the Government and MA Plans regarding the voluntary retention or return of potential or actual overpayments as a result of MA Plan review of Risk Adjustment data.

REQUEST FOR PRODUCTION NO. 41:

All Documents relating to discussions between the Government and MA Plans regarding Chart Reviews, compliance obligations with respect to Risk Adjustment, diagnosis coding and medical record document as those issues pertain to Risk Adjustment, and RADV Audits, including but not limited to Documents relating to discussions with UnitedHealth in 2014.

REQUEST FOR PRODUCTION NO. 42:

All training-related Documents that the Government provided coders (or contractors coding on behalf of the Government) to instruct them on evaluating the accuracy and adequacy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data.

REQUEST FOR PRODUCTION NO. 43:

All Documents regarding coding for purposes of evaluating the accuracy and adequacy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data, including but not limited to coding chronic conditions.

REQUEST FOR PRODUCTION NO. 44:

All Documents related to instructions and guidelines CMS has issued regarding coding and reporting using Revisions 9 and 10 of the International Classification of Diseases ("ICD"), including all Documents related to the creation and development of any such instructions and guidelines.

REQUEST FOR PRODUCTION NO. 45:

All Documents related to the coding convention that "[t]he assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists." *See* "ICD-10-CM Official Guidelines for Coding and Reporting FY 2017 (October 1, 2016 – September 30, 2017)," *available at*

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf.

REQUEST FOR PRODUCTION NO. 46:

All Documents related to the response to the question from the Coding Clinic Fourth Quarter 2016 that reads in part: "Please explain the intent of the new ICD-10-CM guideline regarding code assignment and clinical criteria that reads as follows: 'The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists.'" *See* AHA Coding Clinic for ICD-10-CM and ICD-10-PCS at 147 (Fourth Quarter 2016), *available at* www.CodingClinicAdvisor.com.

REQUEST FOR PRODUCTION NO. 47:

Documents sufficient to show the dollar value of diagnosis codes deleted by all MA Plans including, but not limited to, UnitedHealth.

REQUEST FOR PRODUCTION NO. 48:

All Documents related to the deletion of emails from any email accounts maintained by Ms. Marilyn Tavenner or to her use of a private email address to correspond regarding Risk Adjustment.

REQUEST FOR PRODUCTION NO. 49:

All Documents relating to any March and/or April 2014 meetings or discussions involving Mr. Larry Renfro and Mr. Jonathan Blum and/or Ms. Marilyn Tavenner.

REQUEST FOR PRODUCTION NO. 50:

All Documents relating to the April 29, 2014 meeting between Mr. Sean Cavanaugh, Ms. Cynthia Tudor, Ms. Cheri Rice, Mr. Dan Farmer, and Ms. Julie Grover from CMS and UnitedHealth executives Mr. Dan Schumacher, Mr. Steve Nelson, Ms. Karen Erickson, and Mr. Thad Johnson. This request includes any Documents relating to the preparation for and follow-up from this meeting.

REQUEST FOR PRODUCTION NO. 51:

All Documents relating to the May 2, 2014 email from Ms. Cheri Rice to Mr. Steve Nelson regarding "[UnitedHealth's] 2012 Attestation and follow-up from yesterday's meeting."

REQUEST FOR PRODUCTION NO. 52:

All Documents relating to the July 30, 2015 email from Ms. Cheri Rice to Mr. Steve Nelson regarding "[UnitedHealth's] 2013 CMS RAF Attestation."

REQUEST FOR PRODUCTION NO. 53:

All Documents relating to the June 15, 2016 email from Ms. Cheri Rice to Mr. Steve Nelson regarding "[UnitedHealth's] 2014 CMS RAF Attestation."

REQUEST FOR PRODUCTION NO. 54:

All Documents regarding any interviews or depositions of current and/or former CMS officials related to any matter (litigation or investigation) involving Risk Adjustment and MA Plans.

REQUEST FOR PRODUCTION NO. 55

All Documents relating to Your Complaint's allegations that UnitedHealth submitted false and fraudulent claims to the Government.

REQUEST FOR PRODUCTION NO. 56:

All Documents relating to Your Complaint's allegations that UnitedHealth received payments from the Government based on allegedly false HCC or RxHCC diagnoses.

REQUEST FOR PRODUCTION NO. 57:

All Documents provided by the Relator to the Government that the Government has not already provided to UnitedHealth.

REQUEST FOR PRODUCTION NO. 58:

All Documents relating to meetings between the Relator and the Government.

REQUEST FOR PRODUCTION NO. 59:

All Documents relating to Government litigation hold(s) related to this case and/or the *Swoben* Investigation, including but not limited to copies of the litigation hold(s) and documents sufficient to show who received the hold, what the hold covers, and when it was issued.

REQUEST FOR PRODUCTION NO. 60:

All Documents relating to Government document retention policies, including but not limited to its policies for retaining data, electronic documents and emails, as well as copies of the document retention policies and documents sufficient to show what the policy covers, and to what timeframe it applies.

REQUEST FOR PRODUCTION NO. 61:

Documents sufficient to show what steps the Government took to preserve ESI, including email and any other information created or maintained by former Government personnel (including but not limited to CMS employees) related to this case and/or the *Swoben* Investigation.

REQUEST FOR PRODUCTION NO. 62:

All Documents that are facially marked with any claim of privilege or as to which UnitedHealth has asserted a claim of privilege in connection with Your *Poehling* Investigation to the extent any of the Documents were read, reviewed, analyzed or shared with any individual at the Department of Justice ("DOJ"), OIG or CMS, or any non-governmental individual, who was or is involved in any way in the litigation or investigation of allegations in this matter.

REQUEST FOR PRODUCTION NO. 63:

All Documents relating to any efforts the Government undertook in connection with receiving, reviewing, or analyzing UnitedHealth Documents that are facially marked with any claim of privilege or to which UnitedHealth has asserted a claim of privilege in connection with Your *Poehling* Investigation, to the extent any of the Documents were read, reviewed, analyzed, or shared with any

individual at DOJ, OIG, or CMS, or any non-governmental individual, who was or is involved in any way in the litigation or investigation of allegations in this matter.

REQUEST FOR PRODUCTION NO. 64:

All Documents relating to whether any representative of the Government (including any investigator) reviewed, analyzed, or discussed any privileged UnitedHealth information, including UnitedHealth Documents that are facially marked with any claim of privilege or as to which UnitedHealth has asserted a claim of privilege in connection with Your Poehling Investigation, including UnitedHealth Documents provided to the Government by Mr. Poehling or his counsel, to the extent any of the Documents were read, reviewed, analyzed or shared with any individual at DOJ, OIG or CMS, or any non-governmental individual, who was or is involved in any way in the litigation or investigation of the allegations in this case.

REQUEST FOR PRODUCTION NO. 65:

All Documents relating to the Government's handling of UnitedHealth's clawback requests, including confirmation that Documents that were clawed back were, in fact, deleted from all Government computers and other data recording devices.

REQUEST FOR PRODUCTION NO. 66:

All Documents relating to any efforts the Government undertook in connection with receiving, reviewing, or analyzing potentially privileged UnitedHealth documents in this case to the extent Your Complaint is based in any part on the *Poehling* Investigation, including any Documents designated privileged on their face.

REQUEST FOR PRODUCTION NO. 67:

All Documents relating to whether any representative of the Government (including any investigator) reviewed, analyzed, or discussed any privileged

UnitedHealth information, including privileged UnitedHealth Documents provided to the Government by Mr. Poehling or his counsel.

REQUEST FOR PRODUCTION NO. 68:

All Documents relating to any steps the Government took to prevent any individual at DOJ, OIG or CMS, or any non-governmental individual, who was or is involved in any way in the litigation or investigation of the allegations in this case and who had or has access to UnitedHealth Documents that are facially marked with any claim of privilege or as to which UnitedHealth has asserted a claim of privilege in connection with Your *Poehling* Investigation, including UnitedHealth Documents provided to the Government by Mr. Poehling or his counsel, from revealing, using, or otherwise conveying privileged UnitedHealth information to any Person.

REQUEST FOR PRODUCTION NO. 69:

All Documents on which You intend to rely to support the claims that UnitedHealth knew that many provider-reported diagnosis codes were invalid, as alleged in paragraphs 81 through 120 of Your Complaint.

REQUEST FOR PRODUCTION NO. 70:

All Documents on which You intend to rely to support the claims that UnitedHealth knew that it was obligated to undertake good faith efforts to identify and delete invalid provider-reported diagnosis codes, as alleged in paragraphs 81 through 120 of Your Complaint.

REQUEST FOR PRODUCTION NO. 71:

All Documents on which You intend to rely to support the claim that UnitedHealth is not entitled to a significant amount of Risk Adjustment payments it has received from Medicare, as alleged in paragraph 115 of Your Complaint.

REQUEST FOR PRODUCTION NO. 72:

All Documents on which You intend to rely to support the claim that UnitedHealth avoided "looking both ways," as alleged in paragraphs 121 through 134 of Your Complaint.

REQUEST FOR PRODUCTION NO. 73:

All Documents on which You intend to rely to support the claims that UnitedHealth engaged in a "Recode Project" designed to "liberalize[] its coding policies to enable the coders to identify more diagnosis codes purportedly supported by the beneficiaries' medical records" as alleged in paragraph 133 of Your Complaint.

REQUEST FOR PRODUCTION NO. 74:

All Documents on which You intend to rely to support the claims that UnitedHealth knew it was obligated to "look both ways" at the results of its Chart Reviews and to delete invalid diagnoses as alleged in paragraphs 135 through 152 of Your Complaint.

REQUEST FOR PRODUCTION NO. 75:

All Documents on which You intend to rely to support the claims that UnitedHealth's "look both way" Claims Verification program was insufficient and short-lived, as alleged in paragraphs 153 through 193 of Your Complaint.

REQUEST FOR PRODUCTION NO. 76:

All Documents on which You intend to rely to support the claims that UnitedHealth failed to delete at least over one billion dollars of invalid diagnoses, as alleged in paragraphs 194 through 197 of Your Complaint.

REQUEST FOR PRODUCTION NO. 77:

All Documents on which You intend to rely to support the claims that UnitedHealth avoided repaying Medicare for invalid diagnoses reported by its financially-incentivized providers, as alleged in paragraphs 198 through 229 of Your Complaint.

REQUEST FOR PRODUCTION NO. 78:

All Documents on which You intend to rely to support the claims related to UnitedHealth's Risk Adjustment Attestations, as alleged in paragraphs 230 through 233 of Your Complaint.

Dated: August 24, 2017

LATHAM & WATKINS LLP
DAVID J. SCHINDLER
DANIEL MERON
ABID R. QURESHI

By _____
Daniel Meron
Attorneys for UnitedHealth Defendants

PROOF OF SERVICE

I am employed in the County of Los Angeles, State of California. I am over the age of 18 years and not a party to this action. My business address is Latham & Watkins LLP, 355 South Grand Avenue, Suite 100, Los Angeles, CA 90071-1560.

On **August 24, 2017**, I served the following document described as:

DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. ONE)

by serving a true copy of the above-described document in the following manner:

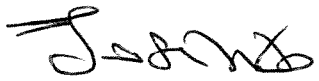
BY ELECTRONIC MAIL

The above-described document was transmitted via electronic mail to the following party pursuant to written consent under Federal Rule of Civil Procedure 5(b)(2)(E) on **August 24, 2017**:

SEE ATTACHED SERVICE LIST

I declare that I am employed in the office of a member of the Bar of, or permitted to practice before, this Court at whose direction the service was made and declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on **August 24, 2017**, at Los Angeles, California.



Josephine Osei-Tutu

SERVICE LIST

United States District Court
Case No. CV 09-5013 JFW(JEMx)

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA,	)	**CASE NO: 2:16-CV-08697-MWF-SS**
	)	
Plaintiff,	)	**CIVIL**
	)	
vs.	)	**Los Angeles, California**
	)	
UNITED HEALTH GROUP, INC, ET AL,	)	**Thursday, July 12, 2018**
	)	
	)	
Defendants.	)	

TELEPHONIC CONFERENCE RE DISCOVERY

BEFORE THE HONORABLE SUZANNE H. SEGAL,
UNITED STATES MAGISTRATE JUDGE

APPEARANCES:	**SEE PAGE 2**
Court Reporter:	**Recorded; XTR**
Courtroom Deputy:	**Marlene Ramirez**
Transcribed by:	**Exceptional Reporting Services, Inc.** **P.O. Box 18668** **Corpus Christi, TX 78480-8668** **361 949-2988**

Proceedings recorded by electronic sound recording; transcript produced by transcription service.

APPEARANCES FOR:

United States of America:	**PAUL G. FREEBORNE, ESQ.** **MARK J. DRAYCOTT, ESQ.** **EDWARD CROOKE, ESQ.** **CAROL L. WALLACK, ESQ.** **U.S. Department of Justice** **601 D Street NW, Suite 9934** **Washington, DC 20004** **JOHN E. LEE, ESQ.** **Office of the U.S. Attorney** **300 N. Los Angeles, Room 7516** **Los Angeles, CA 90012**
Relator:	**MAX VOLDMAN, ESQ.** **HENRY C. SU, ESQ.** **Constantine Cannon** **1001 Pennsylvania Ave. NW, Suite 1300N** **Washington, DC 20004** **TAEVA SHEFLER, ESQ.** **Phillips & Cohen** **100 The Embarcadero, Suite 300** **San Francisco, CA 94105** **JOHN P. LAHAD, ESQ.** **GENG CHEN, ESQ.** **Susman Godfrey** **1000 Louisiana St., Suite 5100** **Houston, TX 77002**
United Health:	**DAVID J. SCHINDLER, ESQ.** **Latham & Watkins** **355 S. Grand Ave., Suite 100** **Los Angeles, CA 90071**

Los Angeles, California; Thursday, July 12, 2018

(Call to Order)

(Telephonic Appearances)

THE COURT: Good morning. We are here today on the record on Case CV-16-8697, *United States of America versus United Health Group, Inc. et al.*

Counsel, please state your appearance for the record.

MR. FREEBORNE: Paul Freeborne from the Department of Justice.

THE COURT: Good morning.

MR. DRAYCOTT: Justin Draycott from the Department of Justice.

THE COURT: Good morning.

MR. VOLDMAN: Max Voldman for relator from Constantine Cannon.

THE COURT: Good morning.

MR. CROOKE: Edward Crooke for the Department of Justice.

THE COURT: Good morning.

MS. WALLACK: Carol Wallack from the Department of Justice.

THE COURT: Good morning.

MR. SU: Henry Su for the relator from Constantine Cannon.

THE COURT: (indisc.)

be saying in response to the -- in response to the motion that we're going to put before Judge Fitzgerald.

(Voices overlapping)

THE COURT: I appreciate it and I don't disagree with you that it would be more efficient to have these issues resolved before the discovery motions are filed. And you know, there's a part of me that would love to agree with you and say you're right, I'm just going to delay all the work you've put in front of me until Judge Fitzgerald decides what we're going to do here; I'm going to delay and wait until September, October, November. Trust me, there's a part of me that would really like to do that. But I honestly don't think I'm permitted to do that until the district judge who sets the schedule in this case tells me I'm permitted to do that. I can't --

MR. SPEAKER: Your Honor, if I --

(Voices overlapping)

THE COURT: -- find myself and if -- no, I really would like us to move on. Because I'm not going to resolve this now. You certainly can make the motion to stay the discovery motion, then I can consider it and Judge Fitzgerald can consider it. But I'm not going to be able to resolve this now.

What I can tell you is that typically in this district we don't save things like discovery motions until the

district judge issues a scheduling order, says okay, I'm going to do it in phases; no discovery on this issue until this date. If the trial judge, whether it's Magistrate Judge (indisc.) or the district judge, sets the schedule. And so Judge Fitzgerald will set the schedule in this case. And until he does I'm operating as I would ordinarily operate, which is you file a motion according to the local rules, you set a hearing date and I try to adjudicate it in a timely fashion. So believe me, I'd much prefer to put these motions off.

All right, so let's move on if we can to the production of documents in the files of the OIG custodian. Mr. Schindler.

MR. SCHINDLER: Well, in many respects, your Honor, these things go hand in hand, right. Because what we're really saying are tethered together. They effectively said they should not have to produce any documents that are in the files of the OIG. And those are the same kinds of documents when the day is done. They've advanced essentially a law enforcement privilege to protect the documents, but it really ignores the qualified nature of the privilege, especially in this context. You can't make a blanket assertion as privilege on the OIG even before collecting responsive documents.

But more importantly, in this case the question of the non-materiality of these records or these decisions, if you will, or the information, the notion that somehow United was

obligated to perform two-way looks, clearly outweighs any assertion of the qualified privilege that might otherwise attach to records belonging to OIG custodians.

But that issue is really subsumed in the overarching point I made earlier, which is we're entitled to documents that demonstrate that lack of materiality under *Escobar* goes to the heart of our defense and documents in the possession of the OIG are exactly that.

THE COURT: All right. And who is going to respond for the Plaintiff?

MR. FREEBORNE: Your Honor, this is Paul Freeborne. And I agree with Mr. Schindler. I think the issues are subsumed. From our perspective United has the obligation under 26(b) to show relevancy. We think materiality has been resolved as a matter of law. There is no factual issue to probe. Simply stated, Judge Fitzgerald and the Ninth Circuit have recognized that the materiality of accurate diagnosis codes. And what OIG did or did not do cannot do that. And so it's a completely irrelevant inquiry. Moreover, they're seeking privileged information, investigated information, not of United but of other third party plans. And in that rubric they have the obligation to show good cause.

And just to understand the argument we're making about the motion to stay, again, it's not a motion to stay discovery. What it is is seeking a threshold ruling on

relevancy to avoid a showdown on privilege. Mr. Schindler has stated prior to the agenda that the Court is likely to face not only motions to compel with respect to the Office of the Inspector General and its activities but they're also seeking to probe agency deliberations on the same grounds. And it behooves -- and there is case authority that's -- at least in the DC Circuit that supports the proposition that there has to be some good cause shown to go down that road. And that's all we're proposing to do. And the parties are in fundamental disagreement with respect to the relevancy and the good cause found by United. And so we think whatever motion they're going to file should be denied.

THE COURT: So let me ask you this. In getting back to the stay issue -- and I do feel it's really an issue for Judge Fitzgerald. I know you have a hearing before him on September 17th. But I do think you could, you know, do a short motion and ask for it to be heard perhaps at a certain time on the issue of, you know, a stay of discovery or a stay of the discovery motion under the theories you've put forward.

Because again, I don't think it's up for me unless Judge Fitzgerald then referred that motion to me, which he could. But until that happens, at the moment he is the decision maker about the schedule of this case. So I just don't feel like I have the freedom to say, you know, yes, I would stay discovery; or no, I wouldn't. It's just not within

my authority. So, you know, for your consideration it may be something you want to do, you know, before Judge Fitzgerald.

MR. SPEAKER: Thank you, your Honor.

THE COURT: All right. So I think on the OIG custodians and -- I'll hear Mr. Schindler in a minute on part two of that item in the agenda. But it doesn't seem like that's something that the parties could reach an agreement on. And it's a sufficiently fact driven type of analysis to apply the law enforcement privilege, you know, that I don't think I can even give you a preliminary idea of my thoughts on that because it's just going to turn a lot on the declarations and the facts you've put before the Court.

What about the production of documents concerning investigations of other MA plans?

MR. FREEBORNE: Well, that is -- this is Paul Freeborne, your Honor. That is the issue that we were just discussing.

THE COURT: Okay, all right.

MR. FREEBORNE: There were other requests that go to the specific program activities where we removed OIG as a custodian because OIG doesn't have any role in program responsibilities. But the other issues really pertain to the materiality issue that Mr. Schindler identified earlier.

THE COURT: All right. And then on the deliberative process privilege, you know, I mean it's a -- it applies to

things that are pre-decisional, it applies to things that, you know, really reflect deliberation as opposed to a factual finding. I guess that's -- I'm just sharing that with the parties that I would look to the Ninth Circuit law and other circuits' law on the application of that to decide. You know, it sometimes shields documents, it sometimes doesn't. I mean again, a very fact driven analysis. So I can't really tell you, you know, what I would do. It would depend on what was put before me.

MR. SPEAKER: And the parties have not met and conferred on the deliberative process privilege motion to compel that's contemplated by United.

THE COURT: And to some degree, you know, you can resolve it on a declaration to the Court sometimes. But often that does require in camera review that I need to look at the document and decide if it's sufficiently deliberative or if it's not deliberative and factual.

MR. SCHINDLER: Yeah. I think, your Honor, just in -- and Mr. Freeborne is right. We've not had the opportunity yet to meet and confer with them and we alert you more to the fact that it isn't just one document. What we have is a wholesale assertion by the Government to cross a broad swamp of documents. And you are right, we're going to have to present you with appropriate record to show you that this is being used inappropriately to shield relevant documents.

Moreover, the deliberative process privilege is not absolute. It can be overcome by the need -- in this case the need is demonstrable. Because these are, in fact, documents that demonstrate exactly what we've said all along as part of our defense, that CMS not only knew about what we were doing but that CMS and its internal people agree with the positions that we have taken. But we need to key that up for you in a way that will allow you to rule, so we simply wanted to flag that point.

The only other thing I would say with respect to the OIG is the information pertaining to other MA plans pertain solely to the concept of what OIG did or did not do in the face of information that demonstrates specifically that other plans were engaged in the same behavior and OIG likewise failed to take action against them, which goes directly to the defense we have raised here. And that's the issue. It isn't an effort on our part to seek information about other MA plans. Rather it's our effort to seek information about what the Government did or did not do based upon information it had that demonstrates that it, too, did not lead at the time -- that amounted to an overpayment. That's all.

THE COURT: All right. Well, thank you very much. And I just want to throw out for the parties' consideration. I recognize you're in the early stages of your case and you're vigorously litigating it and there are a lot of issues that

remain unresolved. And Judge Fitzgerald's rulings are going to be very important to the parties.

I did want to let you know that Judge Ed Infante, who sat in the Northern District for many years and also worked as a private mediator who handled billion-dollar cases with some regularity in his post-judicial life, has returned to our bench. He is sitting now as a magistrate judge in the Central District and he is available to do settlement conferences. So I just put that out there for the parties' consideration, because he would be, I think, an individual who could take on a case of this magnitude and maybe help you find a path to a resolution. So if you decide that's something you're interested in, you can let my courtroom deputy know. All right.

MR. SPEAKER: Thank you.

THE COURT: Anything further at this time?

MR. SPEAKER: No, your Honor. I suspect we are all late to our respective meetings, so thank you for your time.

THE COURT: All right, thank you.

MS. SPEAKER: We appreciate your time, your Honor.

THE COURT: Thank you.

MR. SPEAKER: Thank you, your Honor.

THE COURT: Thank you.

(This proceeding was adjourned at 4:43 p.m.)

CERTIFICATION

I certify that the foregoing is a correct transcript from the electronic sound recording of the proceedings in the above-entitled matter.

July 16, 2018

Signed **Dated**

TONI HUDSON, TRANSCRIBER

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SEP - 8 2005
CENTRAL DISTRICT OF CALIFORNIA
BY DEPUTY

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CLERK, U.S. DISTRICT COURT
SEP - 7 2005
CENTRAL DISTRICT OF CALIFORNIA
BY DEPUTY

THIS CONSTITUTES NOTICE OF ENTRY AS REQUIRED BY FRCP, RULE 77(d).

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. TENET HEALTHCARE CORP., et al., Defendants.	NO. CV 03-206-GAF (JTLx) **MEMORANDUM AND ORDER RE: DEFENDANTS' MOTION FOR REVIEW OF MAGISTRATE JUDGE'S ORDER**

I.

INTRODUCTION

In the present lawsuit, the United States of America ("United States" or "the Government") sues several hospitals and their corporate owners, Tenet Healthcare Corp. and Tenet HealthSystems Medical, Inc. (collectively, "Tenet") to recover overpayments of Medicare reimbursements resulting from the submission by Tenet of allegedly inflated billing information. Presently before the Court is Tenet's motion for review of Magistrate Judge Lum's order of June 29, 2005, which denied, in part, Tenet's motion to compel the production of certain documents. Tenet's motion to compel concerned 14 requests for production of documents. (Order dated June 29, 2005 [Docket No. 121]). Judge Lum granted Tenet's motion as to ten of the requests, and denied the motion as to four requests. (Id.). Tenet now seeks review with respect to

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EXHIBIT 23

two of the denied requests – Requests No. 57 and 66. The Court concludes that Tenet has not demonstrated any basis for disturbing Judge Lum's ruling, and the Court therefore **DENIES** Tenet's motion to overturn the order.

II.

BACKGROUND

A. THE GOVERNMENT'S INVESTIGATION AND THE BROOKWOOD LITIGATION

As noted above, the United States seeks recovery in this suit for overpayments to Tenet based on allegedly "miscoded" Medicare claims for reimbursement. The Government asserts that Tenet "upcoded" claims for pneumonia treatment from a lower-paying diagnosis code to a higher-paying code without medical justification. The Government's investigation of these allegations dates back more than seven years before the present suit was filed in January 2003. (Order dated Oct. 18, 2004 [Docket No. 89] at 2).

The roots of the Government's investigation can be traced to February 1996, when an employee of a company called Health Outcomes Technologies ("HOT") filed a False Claims Act qui tam action in the United States District Court for the Eastern District of Pennsylvania. (Id.; Mot. at 3). The *qui tam* suit alleged that over 100 hospitals across the country, including approximately eight facilities owned by Tenet subsidiaries in Florida, Alabama, Indiana, Tennessee, and Missouri, had violated the False Claims Act ("FCA") by upcoding pneumonia claims submitted to the federal government for reimbursement (the "HOT Litigation"). (Order dated Oct. 18, 2004 [Docket No. 89] at 2).

Among the Tenet hospitals named in the original HOT Litigation was Brookwood Medical Center ("Brookwood"). (Shea Decl., Ex. F at 157). In July 2001, the Pennsylvania District Court transferred the action against Brookwood to the Northern District of Alabama where it became known as United States of America ex rel. Health Outcomes Technologies v. Brookwood Medical Center, Case No. 01-J-1925-S (N.D. Ala.) (the "Brookwood Litigation"). (Id.). As part of the Government's investigation in

that case, the Alabama Quality Assurance Foundation ("AQAF"), a Quality Improvement Organization ("QIO"),[1] compared a sample of Brookwood's medical records with its Medicare claims to determine the number of claims "upcoded" to higher-paying pneumonia diagnoses that were not supported by physician or clinical documentation. (Id., Ex. G). The AQAF's determination of Brookwood's pneumonia coding "error rates" ultimately provided the basis for the calculation of damages Brookwood agreed to pay in settlement of the litigation. (Compare id., Ex. G at 159 (¶ 1) with id., Ex. H at 184).

B. REQUEST NO. 66 – TENET'S REQUEST FOR AQAF'S BROOKWOOD RECORDS

Pursuant to its Request for Production No. 66 ("Request No. 66"), Tenet sought "all documents" relating to the AQAF's "review of pneumonia coding claims" in connection with the Brookwood Litigation, including "worksheets, audit results, checklists, review criteria and protocols, physician reviews or evaluations, and correspondence." (Shea Decl., Ex. A at 18 [Request No. 66]). The United States objected to the request on a number of grounds, including attorney work product and confidentiality, noting that the Government was "prohibited from disclosing certain documents in the possession of QIOs [such as the AQAF] by statutes and regulations." (Id., Ex. B at 38 [Specific Objections to No. 66]).[2]

After some negotiation, the parties agreed that, in response to Request No. 66, the United States would produce protocols, guidelines, tip sheets, instructions and/or policies developed or used by the AQAF in evaluating the Brookwood pneumonia coding claims. (Verelli Decl., Ex. I at 67). The Government subsequently produced the

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[1] QIOs operate under the direction of the Centers for Medicare and Medicaid Services ("CMS") and are responsible for "promoting the effective, efficient, and economical delivery of health care services, and [] promoting the quality of services" (42 U.S.C. § 1395y(g)) by reviewing Medicare "services furnished by physicians, other health care professionals, providers and suppliers." 42 C.F.R. § 476.70. Among other things, QIOs provide "DRG validation," reviewing "the validity of diagnostic and procedural information supplied by the hospital." 42 C.F.R. § 476.71(a)(4).

[2] Medicare regulations restrict a QIO's ability to disclose the information it collects, acquires or analyzes. See generally 42 C.F.R. § 480.101 et seq.

agreed-upon documents to Tenet (in addition to the AQAF documents previously produced in connection with the Brookwood settlement).[3] (Id., Ex. B, Shea Decl., Ex. E at 155 [Younts Decl. ¶ 14]). Then, Tenet, in an apparent change of position, moved to compel any remaining unproduced AQAF documents related to the Brookwood Litigation. Judge Lum denied the motion, finding that the documents sought were not relevant to a claim or defense asserted by a party, or reasonably calculated to lead to admissible eivdence. Tenet now seeks to overturn that denial.

C. REQUEST NO. 57 – DOCUMENTS RELATING TO COMPLAINTS OR CONFUSION REGARDING THE PROPER USE OF PNEUMONIA CODES

In addition, Tenet seeks to overturn Judge Lum's denial of its motion to compel production of documents in response to Request No. 57. Request No. 57 seeks:

> All DOCUMENTS RELATING TO any complaints or confusion by or amongst the general public in regard to in-patient coding of patients with pneumonia or septcemia, the sequencing of diagnosis codes, the coding of patients placed on mechanical ventilators, or the proper use of any ICD-9-CM codes grouping to DRGs 79, 415, 416 or 475.

(Shea Decl., Ex. A at 20 [Request No. 57]). Tenet contends Request No. 57 is directed toward gathering evidence of "confusion by the general public regarding the same codes and DRGs at issue in this action." (Mot. at 11). The Government objected to the request as irrelevant, commenting that the "state of mind of the general public is not at issue." (Shea Decl., Ex. B at 62 [Specific Objections to No. 57]). Judge Lum agreed, and denied the motion to compel as to Request No. 57.

III.

ANALYSIS

A. Legal Standard

A district court will not modify or set aside a Magistrate Judge's order on a

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[3] While Tenet and the United States were negotiating the settlement of the Brookwood Litigation, Tenet received a number of documents related to the AQAF investigation. (Opp. at 15).

non-dispositive matter unless it is "found to be clearly erroneous or contrary to law." 28 U.S.C. § 636(b)(1)(A); Fed. R. Civ. P. 72(a). The "contrary to law" standard applies to the Magistrate Judge's legal conclusions, which are reviewed de novo, while the "clearly erroneous" standard applies to the Magistrate Judge's factual findings. See FDIC v. Fidelity & Deposit Co. of Maryland, 196 F.R.D. 375, 378 (S.D. Cal. 2000); Wolpin v. Philip Morris, Inc., 189 F.R.D. 418, 422 (C.D. Cal. 1999). "[R]eview under the 'clearly erroneous' standard is significantly deferential." Concrete Pipe & Prods. v. Constr. Laborers Pension Trust, 508 U.S. 602, 623 (1993). "To conclude that a magistrate judge's decision is clearly erroneous, the District Court must arrive at a 'definite and firm conviction that a mistake has been.'" Id. (quoting Federal Sav. & Loan Ins. Corp. v. Commonwealth Land Title Ins. Co., 130 F.R.D. 507 (D.D.C. 1990); see also FDIC, 196 F.R.D. at 378. Discovery orders and orders imposing discovery-related sanctions are non-dispositive orders subject to this statutory standard of review. See, e.g., Bhan v. NME Hospitals, Inc., 929 F.2d 1404, 1414 (9th Cir. 1991); Grimes v. City and County of San Francisco, 951 F.2d 236, 240 (9th Cir. 1991); In re Verisign Sec. Litig., 2004 U.S. Dist. LEXIS 22467, at *10 (N.D. Cal. March 10, 2004).

However, because "issues of relevancy . . . are traditionally left to the discretion of the trial court," where the Magistrate Judge's discovery order concerns a question of relevance, "the standard of review in most instances is not the explicit statutory standard [of clearly erroneous or contrary to law], but the clearly implicit standard of abuse of discretion." Geophysical Systems Corp. v. Raytheon Co., 117 F.R.D. 646, 647 (C.D. Cal. 1987); see also Wolpin v. Philip Morris Inc., 189 F.R.D. 418, 422 (C.D. Cal. 1999) (citing Geophysical); Folb v. Motion Picture Indus. Pension & Health Plans, 16 F. Supp. 2d 1164, 1168 n.2 (C.D. Cal. 1998) (citing Geophysical); Application for Assistance in a Foreign Proceeding, 147 F.R.D. 223, 225 (C.D. Calif. 1993) (citing Geophysical).

When reviewing for abuse of discretion, the district court cannot simply substitute its judgment for that of the Magistrate Judge. See United States v. McMullen, 98 F.3d

1155, 1159 (9th Cir. 1996). Rather, the abuse of discretion standard requires that the district court uphold any "determination that falls within a broad range of permissible conclusions." Security Farms v. International Bhd. of Teamsters, 124 F.3d 999, 1016 (9th Cir. 1997) (internal quotation marks omitted). "A judge abuses his [or her] discretion only when his [or her] decision is based on an erroneous conclusion of law or where the record contains no evidence on which he [or she] rationally could have based that decision." Premium Service Corp. v. Sperry & Hutchinson Co., 511 F.2d 225, 229 (9th Cir. 1975); see also Wolpin, 189 F.R.D. at 422 (citing Premium Service); Bogovich v. Sandoval, 189 F.3d 999, 1001 (9th Cir. 1999) ("A district court may abuse its discretion if it does not apply the correct law or if it rests its decision on a clearly erroneous finding of material fact.") (internal quotation marks omitted).

B. THE GRAVAMEN OF TENET'S MOTION

With respect to both Requests Nos. 57 and 66, Judge Lum found that the information sought was "not relevant to a claim or defense asserted by the parties and [was] not reasonably calculated to lead to the discovery of admissible evidence." (Order dated June 29, 2005 [Docket No. 121] at 2-3). The gravamen of Tenet's motion for review of Judge Lum's ruling is that her decision was based on an erroneous legal conclusion, and therefore constitutes a reversible abuse of discretion. In particular, Tenet contends that the Magistrate's ruling regarding the relevance of Requests Nos. 57 and 66 "relied on an incorrect interpretation of United States ex rel. Oliver v. The Parsons Co., 195 F.3d 457, 461 (9th Cir. 1999)." (Reply at 2; see also Mot. 11-14 (concluding that Judge Lum's order "contradicts the holding in Parsons").

Parsons involved an action under the FCA in which the plaintiff qui tam alleged that her employer "knowingly violated the federal Cost Accounting Standards in an effort to overcharge the government, thereby giving rise to a claim under the [FCA]." Parsons, 195 F.3d at 460. To prevail on a FCA claim, the plaintiff must show that: "(1) the defendant made a claim against the United States; (2) the claim was false or fraudulent; and (3) that the defendant knew the claim was false or fraudulent." Id. at

461.

As to the second element, the Ninth Circuit ruled that the district court had "erred in applying a 'reasonable interpretation' approach to determining falsity under the [FCA]." Id. at 460. The district court (erroneously) held, on a motion for summary judgment, that "the 'falsity' element under the [FCA] was not met because [the defendant] demonstrated that it made a reasonable interpretation of an ambiguous accounting standard." Id. at 462. The Ninth Circuit, however, observed that "it is [the defendant's] compliance with these [federal accounting] regulations, *as interpreted by this court*, that determines whether its accounting practices resulted in the submission of a 'false claim' under the [FCA]." Id. at 463 (emphasis added). Accordingly, evidence that the defendant adopted a "reasonable interpretation" of the regulations at issue did not preclude a finding of falsity – and was therefore ultimately irrelevant to the question of falsity. Id.

On the other hand, the Ninth Circuit acknowledged that while "the question of 'falsity' itself is determined by whether [the defendant's] representations were accurate in light of applicable law," the "*reasonableness of [the defendant's] interpretation* of the applicable accounting standards may be relevant to whether it *knowingly* submitted a false claim," i.e., to the third element of FCA claims – scienter. Id. (emphasis added).

Here, Tenet contends that Judge Lum "conflate[d] the knowledge requirement with the falsity requirement," ignoring Parsons' teaching that evidence of "*reasonable interpretations*" of government regulations *can be relevant* to the issue of scienter in a FCA action. (Reply at 3; see also Mot. at 10 ("The Magistrate Judge confused the issues by failing to recognize that while the [requested] information may not be relevant to falsity under the False Claims Act, it is certainly relevant to Tenet's scienter."); id. at 11-12 (stating that Judge Lum's ruling "contradicts the holding in Parsons")). Thus, Tenet concludes that Judge Lum's ruling regarding the relevance of the requested information was based on an "erroneous legal conclusion," and should be overturned as an abuse of discretion. (Reply at 2; Mot. at 14). Tenet's position is without merit.

C. REQUEST NO. 57

With regard to Request No 57, Tenet seeks to compel production of documents related to complaints or confusion by the "general public" regarding the coding of patients with pneumonia or the proper use of the codes at issue in this action. (Shea Decl., Ex. A at 20 [Request No. 57]). Tenet argued in its motion to compel, as it does here, that evidence of "confusion or ambiguity regarding the application of the myriad and complex rules and regulations governing the submission of Medicare claims tends to show a lack of scienter for a claim of fraud." (Id., Ex. C [Jt. Stip.] at 95).

As explained above, Tenet maintains that Judge Lum misread Parsons and confused falsity and scienter, and, as a result, wrongly concluded that evidence of confusion or complaints by the public was not relevant to the issue of scienter. Judge Lum's order states:

> First, defendants argue that . . . information [regarding confusion or complaints] is relevant because it would show a lack of scienter on defendants' part with respect to the fraud claim. But the mere fact that others may have complained about the same type of coding issues does not negate the scienter element on defendants' part. What is at issue is whether defendants had actual knowledge that they submitted a false or fraudulent claim, or alternatively, whether there is evidence that defendants acted in deliberate ignorance or in reckless disregard of the truth. See Oliver v. Parsons Co., 184 F.3d 1101, 1104 (9th Cir. 1999). *But evidence of others' confusion or complaints does not tend to establish whether defendants in this case knew that they were submitting false claims to the government.*

(Order dated June 29, 2005 [Docket No. 121] at 1) (emphasis added).

Tenet asserts that Judge Lum's assessment of the relevancy of "*others' confusion or complaints*" to the issue of Tenet's scienter "contradicts the holding in Parsons which specifically stated that the *reasonableness of defendant's interpretations*

is relevant to scienter." (Mot. at 12) (emphasis added). Tenet bolsters its argument by observing that a Texas court in United States v. Medica-Rents Co., 285 F. Supp. 2d 742 (N.D. Tex. 2003) found evidence of "others' confusion" relevant to the issue of scienter.

The Court is not persuaded by this argument. Contrary to Tenet's suggestion, there is nothing in Judge Lum's order to indicate that she held that Parsons somehow "[b]arred [p]roduction [o]f [t]he [r]equested [d]ocuments" (Reply at 2) or rejected Parsons' holding that "*reasonableness of [the defendant's] interpretation of [government regulations]* may be relevant to whether it knowingly submitted a false claim" (195 F.3d at 463 (emphasis added)) or "conflate[d] the knowledge requirement with the falsity requirement." (Reply at 3). It appears, rather, that Judge Lum simply rejected Tenet's argument that evidence of *others' confusion* was relevant to demonstrate the *reasonableness* of Tenet's own interpretation of the coding regulations, and, in turn, the state of Tenet's mind.

This Court agrees with Judge Lum. Evidence of others' confusion over the coding standards does not tend to establish whether Tenet itself was confused by those coding standards, nor does it tend to show that Tenet's interpretations of those standards was "reasonable." In any case, the Court finds that Judge Lum did not abuse her discretion in denying Tenet's motion to compel. Judge Lum's ruling is not based on an erroneous interpretation of Parsons or a "clearly erroneous finding of material fact" (Bogovichl, 189 F.3d at 1001) nor is this a case where "the record contains no evidence on which [Judge Lum] rationally could have based [her] decision." Premium Service, 511 F.2d at 229. Accordingly, the Court **DENIES** Tenet's motion to set aside Judge Lum's order regarding Request No. 57.[4]

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[4] In addition to debating the question of relevance, the parties debate whether Judge Lum was correct in finding that "the discovery request itself is vague and overbroad." (Order dated June 29, 2005 [Docket No. 121] at 1; see also Mot. at 13; Opp. at 5-7; Reply at 6-7). The parties also disagree whether Request No. 57 seeks information that is either publicly available or already in Tenet's possession. (See Opp. at 6-7; Reply at 7-8). However, the Court does not reach the

D. REQUEST NO. 66

With regard to Request No. 66, Tenet seeks to compel production of those AQAF documents related to the Brookwood Litigation that have not already been produced. Tenet contends that Judge Lum's ruling that these documents are not relevant to the instant litigation was "clearly erroneous and contrary to law." Here, as in its original motion to compel, Tenet argues that the requested information is relevant on a number of grounds. First, Tenet claims that "to the extent the AQAF's coding standard differ from coding standards employed by the Government or other parties, they demonstrate the ambiguity and confusion regarding coding and are thus relevant to Tenet's scienter." (Mot. at 18). Second, Tenet asserts that consistency between AQAF's interpretations and Tenet's interpretations "shows that Tenets' interpretations were reasonable, which is also relevant to Tenet's scienter." (Id.). Third, Tenet argues that the documents may be used for impeachment purposes where the Government's current position regarding proper coding differs from AQAF's interpretation – an estoppel argument of sorts. (Id.).

Indeed, the main thrust of Tenet's argument as to why the AQAF Brookwood Litigation documents are relevant to this action is that they can and should be used prevent the Government from asserting pneumonia coding standards in this action that vary from those used in the settlement of the Brookwood Litigation – a case involving the same parties and issues. (See id. ("There is no reason why the coding standards applied in Brookwood would not be equally applicable to the same codes and conditions in this litigation."); see also Reply at 9).[5] According to Tenet, Judge Lum's ruling is "clearly erroneous and contrary to law" as it fails to recognize the significance

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merits of these disputes because its finds that Judge Lum did not abuse her discretion in concluding that the requested information was not relevant to a claim or defense asserted by the parties or reasonably calculated to lead to the discovery of admissible evidence.

[5] Tenet appears to have abandoned its alternative theory, advanced in the motion to compel, that the AQAF documents are also relevant to its statute of limitations defense. (Order dated June 29, 2005 [Docket No. 121] at 3).

of the close relationship between the instant litigation and the Brookwood suit. (See Mot. at 14 (stating that Judge Lum's "holding that the coding standards applied in Brookwood are not relevant to the instant case is clearly erroneous and contrary to law because the instant litigation involved the same parties, legal theories and DRG codes at issue in this litigation"); Reply at 9 ("In determining that the requested documents were not relevant, the Magistrate held that the Brookwood case was 'a different case and involved different claims.' This is clearly erroneous.") (citation omitted)).

Although Tenet strongly asserts that Judge Lum's decision was "contrary to law," Tenet points to no legal authority that was ignored or contradicted by Judge Lum's ruling. No authority, for example, is cited for Tenet's bald assertion that the Government should be bound by the interpretation of coding standards used in the settlement of a prior litigation, however closely related. Nor does Tenet demonstrate any other basis for finding that Judge Lum abused her discretion in denying its motion to compel.

First, the Court rejects Tenet's alternative claim that the ruling as to Request No. 66 should be overturned because Judge Lum "relied in part on her ruling with respect to Request No. 57 that these documents were not relevant to Tenets' scienter," and "this conclusion is contrary to law." (Mot. at 14). For the reasons explained above, the Court is not persuaded by Tenet's argument that Judge Lum's ruling with respect to scienter was based on an erroneous and confused reading of Parsons. Second, there is no basis for finding that Judge Lum's ruling is based on a "clearly erroneous finding of material fact" (Bogovichl, 189 F.3d at 1001) or irrational. Premium Service, 511 F.2d at 229.

Finally, as Judge Lum noted in her order, the Government "has already turned over information such as the AQAF's protocols, guidelines, tip sheets, instructions, and/or policies for pneumonia coding claims," and Tenet "fail[s] to articulate why the information that has been provided thus far is insufficient" to make whatever estoppel-type arguments it seeks to make regarding the AQAF coding standards. (Order dated

June 29, 2005 [Docket No. 121] at 3). In response, Tenet merely repeats its assertion that the requested documents are "relevant to show how the AQAF's coding standards were applied to Brookwood" where the same codes were at issue. (Mot. at 20). In sum, Tenet has demonstrated no basis for disturbing Judge Lum's ruling as to Request No. 66, and the Court **DENIES** the motion to overturn the order with respect to that request.

IV.

CONCLUSION

For the reasons set forth above, the Court **DENIES** Tenet's motion to overturn Magistrate Lum's order of June 29, 2005 with regard to Requests Nos. 57 and 66.

IT IS SO ORDERED.

DATED: September 7, 2005

Gary Allen Feess
United States District Judge

CHAD A. READLER
Acting Assistant Attorney General, Civil Division
NICOLA T. HANNA
United States Attorney
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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) [PROPOSED] ORDER GRANTING MOTION PURSUANT TO RULE 16(b)(3) FOR ISSUANCE OF A SCHEDULING ORDER Date: September 17, 2018 Time: 10:00 a.m. Court: 5A, Hon. Michael W. Fitzgerald

Upon motion of the United States of America and relator Benjamin Poehling for issuance of a scheduling order modifying the extent of discovery, and good cause appearing, said motion is hereby GRANTED. Certain issues have been decided as a matter of law by the Ninth Circuit in *United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161 (9th Cir. 2016), and *United States ex rel. Silingo v. WellPoint, Inc.*, 895 F.3d 619 (9th Cir. 2018), and this Court in this case, including the issues of the legal obligation of Medicare Advantage Organizations ("MAOs") to delete invalid diagnosis codes submitted to the Medicare Program, as well as the materiality of the Defendants' failure to delete invalid diagnosis codes on risk adjustment amounts paid by the Medicare Program. In addition, any legitimate question concerning the agency's interpretation of the Medicare Program is resolved by official pronouncements, not informal statements or internal deliberations.

Accordingly, IT IS ORDERED that no discovery shall be propounded or, if already propounded, need be responded to relating to such decided issues, including:

1. Discovery relating to the government's internal deliberations, unofficial interpretations, or informal understanding of the legal requirements imposed by statutes, rules, regulations, and guidance materials on MAOs to delete invalid diagnosis codes.

2. Discovery relating to investigations conducted by the Department of Health and Human Service's Office of Inspector General concerning whether MAOs other than United complied with their obligation to delete invalid diagnosis codes.

IT IS SO ORDERED.

Dated: _____

_____
UNITED STATES DISTRICT JUDGE