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**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 MWF(SSx)

**UNITED'S OPPOSITION TO
PLAINTIFFS' JOINT MOTION
PURSUANT TO RULE 16(b)(3)
FOR ISSUANCE OF
SCHEDULING ORDER
MODIFYING EXTENT OF
DISCOVERY**

*[Declarations of Abid R. Qureshi,
Rebecca Martin, and MaryBeth Meyer
filed concurrently herewith]*

Hon. Michael W. Fitzgerald
Courtroom: 5A

Date: September 17, 2018
Time: 10:00 a.m.

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1 **I. INTRODUCTION**

2 The government's Motion for a Scheduling Order Modifying Discovery
3 ("Motion") is *at least the fifth time* the government has sought to prevent United
4 from obtaining discovery at the heart of this case. This latest attempt is no more
5 persuasive than the rest of the handful. The Motion should be denied.

6 *First*, the Motion flouts this Court's standing order, runs afoul of this
7 Court's comments during the scheduling conference, and ignores repeated
8 statements from Magistrate Judge Segal that the government cannot unilaterally
9 control the flow of discovery. Despite these directives, the government continues
10 to withhold relevant information and then seek judicial approval of its ongoing
11 "pocket veto" strategy. The government's persistent recalcitrance must end.

12 *Second*, the evidence the government seeks to withhold easily passes the low
13 bar required for discovery, particularly this early and in a case of this magnitude.
14 The government's contrary position (at 1) is that because its Amended Complaint
15 asserts only that United had a duty to delete codes it allegedly *knew* from its chart
16 review program were unsupported, any evidence about a "general duty to verify
17 diagnosis codes" cannot be relevant in this case. That is incorrect.

18 To begin, the government errs in describing the Amended Complaint as
19 limited to an attack on United's chart review program. The Amended Complaint
20 contains more than 20 pages of allegations about supposed deficiencies in the
21 design and scope of a *different program*, called the "Risk Adjustment Coding and
22 Compliance Review" Program ("RACCR"). And *those* allegations absolutely are
23 based on the assertion that United had a "general duty" to search affirmatively for
24 unsupported codes. In seeking to preclude discovery into whether such a duty
25 existed—and, if so, the nature and extent of that duty—the government ignores
26 RACCR *entirely*.

27 The government also ignores its two common law claims. As explained in
28 United's Oppositions to the Government's Motion to Strike and Motion for Partial

Summary Judgment, the discovery the government seeks to preclude here goes directly to the elements of those two common law claims. *See, e.g.*, Mot. to Strike Opp’n at 4, 16; Mot. for Partial Summ. J. Opp’n at 19. In light of the extensive focus on the importance of those two claims in United’s pending Oppositions, it is difficult to explain the government’s failure even to acknowledge those claims in this later-filed Motion.

The discovery the government seeks to foreclose also is relevant to numerous issues concerning the government’s sole remaining False Claims Act count. That count alleges United retained monies to which it was not entitled by failing to conduct so-called “two-way looks” during chart review. The discovery the government seeks to preclude is relevant to that claim for many reasons, including to show that: (1) CMS officials themselves believe that conducting one-way reviews is proper; (2) United did not receive an overpayment; (3) United did not improperly retain an overpayment; and (4) United’s failure to delete codes did not materially impact the government’s decision to continue paying and contracting with United. More generally, the discovery will shed light on the contractual and regulatory provisions on which the government bases this claim.

Third, the government is wrong that this Court and the Ninth Circuit already have decided as a matter of law that Medicare Advantage (“MA”) plans have an obligation to delete codes they purportedly know though their chart review programs are unsupported, and that such codes are material, thus rendering discovery on those points unnecessary. All of the decisions on which the government relies—this Court’s Order on United’s Motion to Dismiss, as well as *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)—involved motions to dismiss, and the courts thus accepted as true the allegations in the complaint and drew all inferences in favor of the government. A holding that a plaintiff has stated a cognizable claim at the pleading stage is hardly

1 the same as a holding that a defendant has violated the False Claims Act as a
2 matter of law. Moreover, neither Ninth Circuit decision addressed Reverse False
3 Claims Act counts (the only remaining False Claims Act claim left in this case),
4 and neither purported to analyze any of the factual or legal issues in this case (such
5 as materiality or the validity of the contractual and regulatory provisions at issue
6 here). And in fact, the allegations here veer far afield from the allegations in
7 *Silingo* of deliberate fabrication of complex diagnosis codes and forging of medical
8 records by the MA plan. Certainly, no decision has held that *United's* chart review
9 program is unlawful, and United contests the notion that chart review gives an MA
10 plan "knowledge" that codes separately submitted by the providers who saw the
11 actual patients are unsupported. United is entitled to discovery in the
12 government's possession that tests the veracity of the government's allegations and
13 demonstrates that the government cannot sustain its burden of proof on any of its
14 remaining claims.

15 *Fourth*, the government has not demonstrated that the discovery United
16 seeks is unduly burdensome. Nor could it. The government investigated this case
17 for more than five years before choosing to bring this action. The government
18 determined the size, scope, and nature of the case, and it cannot now complain that
19 United is defending itself. Any burden on agency resources is a direct
20 consequence of the case the government decided to bring.

21 In reality, the government's assertions about discovery burdens reflect
22 concerns about litigation strategy, not agency resources. As United explains
23 further below, the limited discovery United has conducted to date has confirmed
24 the validity of United's defenses, including on issues at the core of this case. *See*,
25 *e.g., infra* at 10 n.7, 12 n.9. The government should not be permitted to force
26 United to litigate those issues with one arm tied behind its back.

27 The government's arguments are especially unpersuasive given the
28 asymmetrical discovery burdens the parties have faced to date. United has

1 produced more than *22 times* as many documents, and more than *10 times* as many
 2 witnesses, as the government. United has collected more than 70 million
 3 documents amounting to over 14 terabytes of data throughout the course of this
 4 litigation alone. The government's claimed burden pales in comparison and does
 5 not justify refusing to provide United the discovery it needs to defend itself.

6 In sum, this Motion is meritless for many reasons. United describes those
 7 reasons in further detail below not because the Motion raises serious questions, but
 8 because United and the government both know how *important* the information is
 9 that the government is trying so desperately to withhold.

10 **II. PROCEDURAL & FACTUAL BACKGROUND**

11 Before filing its Complaint-in-Intervention on May 17, 2017, the
 12 government conducted a five-year investigation during which United produced
 13 over 600,000 documents, compiled detailed responses (including over 125,000
 14 lines of data) to dozens of complex interrogatories, and produced more than 20
 15 witnesses for oral examinations.

16 On November 17, 2017, the government filed a 166-page, 364-paragraph
 17 Amended Complaint-In-Intervention, which alleged violations of the False Claims
 18 Act and two common law claims for Payment By Mistake and Unjust Enrichment,
 19 and which sought substantial damages and other remedies. On February 12, 2018,
 20 this Court dismissed the government's three affirmative False Claims Act counts,
 21 leaving only a Reverse False Claims Act count and the two common law claims.

22 United served its first document requests on the government in August 2017.
 23 More than a year later, the government has produced only about 44,000
 24 documents. Meanwhile, United has produced over 376,000 documents¹ since
 25 receiving the government's first document requests in October 2017, in addition to
 26

27 ¹ This figure includes United's upcoming monthly production, which includes over
 28 100,000 documents.

1 the over 600,000 documents produced during the course of the investigation.
 2 Including the parties' productions in the *Swoben* case, United has produced more
 3 than 22 *times* as many documents as the government.

4 Ever since this lawsuit was unsealed, the government has sought to prevent
 5 United from "catching up" to the discovery the government obtained during its
 6 five-year investigation. The government's recurring attempts to deprive United of
 7 discovery have required United to seek judicial intervention on multiple occasions.
 8 On each occasion to date, United's requests have been successful.

9 United first sought judicial intervention after the government refused to
 10 make two CMS officials available for depositions, arguing that depositions should
 11 be delayed because of the possibility that motion practice might alter the scope of
 12 discovery. *See* Ex. 1, Tr. of Dec. 18, 2017 Conf. at 5:1–4.² Magistrate Judge Segal
 13 rejected this argument, stating that United was entitled to proceed with the
 14 depositions. *Id.* at 10:12–11:15. These depositions confirmed United's positions
 15 on several critical issues. *See, e.g., infra* at 10 n.7, 12 n.9.

16 The government next asked this Court to enter a phased discovery order,
 17 arguing that United should be barred from taking further depositions until after
 18 resolution of the government's anticipated motions. This Court rejected that
 19 request and made clear that the government could not unilaterally dictate the pace
 20 of discovery. *See, e.g.,* Ex. 2, Tr. of Apr. 9, 2018 Scheduling Conf. at 21:7–9.

21 In February 2018, United again was forced to seek judicial assistance after
 22 the government had failed to produce a single document *more than five months*
 23 after United served document requests. Magistrate Judge Segal made clear that
 24 United "has a right to . . . vigorously and quickly defend itself," that she "wouldn't
 25 want to delay the case and delay [United's] ability to defend themselves," and that,

27 ² Citations to "Ex." materials refer to exhibits to the Declaration of Abid R.
 28 Qureshi filed concurrently herewith.

1 “given the complexity of this case, . . . I don’t think it’s inappropriate for a
 2 defendant to be moving quickly to try and gather information and prepare its
 3 defenses.” *See* Ex. 3, Tr. of Feb. 8, 2018 Conf. at 25:14–15, 27:8–10, 32:3–4.

4 United next sought and received judicial assistance earlier this month, after
 5 the government informed United that it had unilaterally decided it would no longer
 6 produce privilege logs until the Court ruled on this Motion and the government’s
 7 Motion to Strike Affirmative Defenses and Motion for Partial Summary Judgment,
 8 all of which are designed to prevent United from obtaining discovery related to the
 9 government’s and other MA plans’ understanding and interpretations of the factual
 10 issues and legal obligations squarely at issue in this case. Magistrate Judge Segal
 11 noted that “we’re back to a place that we were previously at with the United
 12 States.” She then captured the fundamental issue with the government’s position:
 13 “[Y]ou initiated this case; you knew the volume of the case; you knew the response
 14 that you would likely get from United; you are not new to this kind of
 15 litigation. . . . [T]he volume of work involved in responding to discovery requests
 16 and participating in this case was something the Government needed to kind of
 17 assess before they filed the complaint in this action.” *See* Ex. 4, Tr. of Aug. 16,
 18 2018 Conf. at 20:9–15.

19 This Motion is more of the same. It should be denied for many reasons.

20 **III. ARGUMENT**

21 The government faces a heavy burden to prevail on this Motion, which seeks
 22 to curtail discovery at an early stage of a significant lawsuit. *See, e.g., In re*
 23 *Allergan, Inc. Sec. Litig.*, No. 14-CV-02004, 2016 WL 5929250, at *2 (C.D. Cal.
 24 Oct. 5, 2016) (“The Federal Rules of Civil Procedure provide for broad factual
 25 discovery. A party ‘may obtain discovery regarding any non-privileged matter that
 26 is relevant to any party’s claim or defense and proportional to the needs of the
 27 case’” (citing Fed. R. Civ. P. 26(b)(1)). As discussed below and in United’s
 28 Partial Summary Judgment and Motion to Strike Oppositions, the evidence the

1 government seeks to preclude is directly relevant to the claims and defenses in this
 2 case, and United is entitled to a full and fair opportunity to explore these issues.

3 **A. The Government Misrepresents Its Own Allegations and Ignores**
 4 **Its Common Law Claims**

5 The government seeks to foreclose discovery on “any obligation or
 6 requirement that MA plans validate the accuracy of diagnosis codes submitted on
 7 claims data” by arguing that this “issue . . . is not presented by this case.” (Mot. at
 8 1.) In support, the government argues (at 1) that it “has not alleged that United had
 9 a general duty to verify diagnosis codes, but rather that where, as here, it undertook
 10 reviews of those codes, it had a duty to delete any unsupported codes it found.”
 11 The government goes so far as to assert (at 7) that allegations that “United was
 12 required to look for errors *beyond those* revealed by the chart reviews it
 13 indisputably conducted” form “no part of this case” (emphasis in original).

14 This assertion is astonishing. The Amended Complaint expressly alleges
 15 that “Defendants engaged in other conduct (*unrelated to their Chart Review*
 16 *Program*) that violated the FCA,” Am. Compl. ¶ 15 (emphasis added), and is
 17 replete with allegations that United did not do enough affirmatively to audit and
 18 review unsupported diagnosis codes through its RACCR Program—a voluntary
 19 compliance program that served as a safeguard against potential up-coding by
 20 capitated provider groups. For example, the Amended Complaint alleges that:

- 21 • “[Defendants’] effort to identify the invalid codes submitted by these
 22 incentivized providers was limited to the RACCR Program. Moreover,
 23 [Defendants] designed and implemented the RACCR Program to limit its
 24 scope and to minimize the number of invalid diagnoses for which
 25 [Defendants] would have to return overpayments to CMS,” *id.* ¶ 239;
- 26 • “[Defendants] knew they had an obligation to review diagnoses reported
 27 by incentivized providers to determine their validity,” *id.* ¶ 244;
- 28 • “Despite [Defendants’] understanding that the RACCR Program was part
 of UHG’s effort to comply with CMS’s accuracy requirements, they
 structured the RACCR Program to limit its utility in identifying invalid

1 diagnosis codes. There were various fundamental limitations on the
2 RACCR Program,” *id.* ¶ 245

3 None of these allegations relate in any way to unsupported codes allegedly
4 “revealed” (at 7) by United’s chart reviews.

5 It is wholly disingenuous for the government to ignore more than 20 pages
6 of allegations in its own pleading against United regarding the supposed
7 inadequacy of its efforts to validate provider-submitted diagnosis codes, *see* Am.
8 Compl. at ¶¶ 15–18, 239–92, and then complain about United’s request for
9 documents related to whether any such obligation or requirement existed in the
10 first place.³ The government’s allegations are not limited to United’s alleged
11 failure to delete unsupported codes “revealed” through chart reviews, and extend to
12 allegations that United should have done more to *discover* unsupported codes.

13 The government also ignores its common law claims. United’s Partial
14 Summary Judgment and Motion to Strike Oppositions—which the government had
15 for two weeks before filing its Motion—detail why the discovery the government
16 seeks to foreclose goes to the very elements of these common law claims. *See*,
17 *e.g.*, Mot. to Strike Opp’n at 2 (“The government wholly ignores . . . its pending
18 claim for Payment by Mistake, but that claim requires the government to prove
19 what it knew and what it would have done differently if it had the knowledge it
20 claims it lacked.”); Partial Summ. J. Opp’n at 19 (“[A]s with its Motion to Strike,
21 the government’s brief completely ignores the remaining two common law
22 claims.”). This Motion suffers the same problem. It seeks to prevent United from
23 obtaining discovery relevant to the government’s own knowledge of unsupported
24

25 ³ For example, United is seeking discovery “regarding any obligation or
26 requirement that MA Plans validate the accuracy of diagnosis codes submitted on
27 claims data before they submit claims data to CMS,” United’s Request for
28 Production (“RFP”) No. 39, and “relating to CMS guidance to MA Plans regarding
oversight of Providers, including Documents relating to MA Plans’ obligations to
oversee Providers’ submission of accurate risk adjustment data.” *Id.* No. 2-17.

codes and the steps it took in response to that knowledge,⁴ for example, but never even attempts to explain how that evidence could *not* be relevant to its claim for Payment By Mistake. *See, e.g.*, Mot. to Strike Opp’n at 2, 16; Mot. for Partial Summ. J. at 19. Having seen United’s Oppositions to its other motions, if the government had an argument on that score, it was required to offer it up front—not wait to address it until reply, at which point United will have no ability to respond.

B. The Discovery Sought By United Is Critical To The Claims and Defenses Related To The Only Remaining False Claims Act Count

The information the government seeks to shield also is relevant to the only remaining False Claims Act count and United’s defenses. Such discovery is relevant to whether United received an overpayment; whether United believed it received an overpayment and, thereafter, improperly retained that overpayment; whether CMS officials themselves believe that conducting one-way reviews is improper or allegedly violates any general duty to delete codes allegedly known to be unsupported; and whether United’s purported actions materially impacted the government’s decisions to continue paying and contracting with United.

1. The Discovery the Government Seeks to Foreclose is Relevant to Whether United Received an Overpayment

To prevail on its Reverse False Claims Act count, the government must prove that United “knowingly conceal[ed] or knowingly and improperly avoid[ed] or decrease[d] an obligation to pay or transmit money or property to the Government.” 31 U.S.C. § 3729(a)(1)(G); *see id.* § 3729(b)(3) (an “obligation” is “an established duty, whether or not fixed, arising from . . . the retention of any overpayment”); Partial Summ. J. Opp’n at 19–20; Mot. to Strike Opp’n at 4–5. The Amended Complaint contains numerous references to alleged overpayments to

⁴ For example, United seeks discovery related to the government’s knowledge as to whether MA Plans were (1) validating the accuracy of diagnosis codes, (2) deleting unsupported diagnosis codes, and (3) looking both ways. RFP Nos. 17–19.

1 United, *see, e.g.*, Am. Compl. ¶¶ 267–70, and the theory that United improperly
 2 retained overpayments is central to the government’s remaining statutory claim.

3 Among other things, the government seeks to foreclose discovery showing
 4 the error rate in CMS’s own data,⁵ which CMS formally has acknowledged in the
 5 audit context must be taken into account before determining whether the existence
 6 of unsupported codes in MA plans’ data equates to an overpayment. *See* Partial
 7 Summ. J. Opp’n at 11–13; Schindler Decl. Ex. 18, 2010 RADV Rule (Dkt. 254-
 8 1).⁶ Evidence about the presence and extent of unsupported codes in CMS’s own
 9 data will help United show that requiring United to delete unsupported codes
 10 without CMS doing the same in its data would result in a systematic *underpayment*
 11 and violate the statutory (and contractual) requirement of actuarial equivalence.
 12 *See, e.g.*, Partial Summ. J. Opp’n at 22–23, 44–46. The government seeks to avoid
 13 discovery into such evidence because it knows the evidence United has to date
 14 supports United’s arguments and undermines the government’s theories.⁷ United
 15 is entitled to obtain evidence to show that, contrary to the government’s core

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 18 ⁵ United seeks documents “regarding the RADV Medicare fee-for-service (‘FFS’)
 19 error rate adjuster,” including documents describing the government’s efforts to
 20 calculate a Medicare FFS error rate and analyses related to measuring the accuracy
 21 of diagnoses submitted on FFS claims. RFP No. 6.

22 ⁶ Citations to “Schindler Decl.” refer to exhibits to the Declaration of David J.
 23 Schindler in Support of United’s Opposition to Plaintiffs’ Motion for Partial
 24 Summary Judgment (Dkt. 254).

25 ⁷ The government produced a document in response to a FOIA request—though it
 26 attempted to shield that document in this litigation—that contains notes from an
 27 internal CMS presentation about the need to account for CMS’s own error rate in
 28 determining overpayments and states that adopting an FFS adjuster “from a
 technical point of view is the right thing to do” and would “put[] us in the best
 position to withstand litigation challenges.” Schindler Decl. Ex. 16, Agenda (Dkt.
 254-1). As another example, Jeffrey Grant (one of only two CMS officials
 26 deposed in this case to date) testified that, assuming the coding intensity
 27 adjustment fully offsets any activities that an MA plan undertakes to code more
 28 completely, if a plan were to audit twenty-five percent or fewer of its members’
 charts and delete unsupported codes it found, without CMS deleting such codes in
 the FFS data, the MA plan would be underpaid. *See* Schindler Decl. Ex. 7, Grant
 Dep. 208:15–17 (Dkt. 254-1); Partial Summ. J. Opp’n at 44–45.

1 contention, United was not overpaid merely because it may have received
2 payments based on some unsupported codes.⁸

3 As the Court is aware, United argued this actuarial equivalence point in its
4 Partial Summary Judgment Opposition, and this issue goes to the heart of United's
5 APA challenge—the extensive briefing for which United previously submitted to
6 this Court. *See, e.g.*, Partial Summ. J. Opp'n at 20–26, Schindler Decl. Exs. 37–40.
7 (Dkt. 254-2). The government's Motion here is one last desperate attempt to get in
8 front of the APA case and prevent United from fully defending itself by refusing to
9 produce relevant discovery. Judge Collyer held oral argument in the APA case on
10 August 8, 2018, and a decision on United's substantial challenge is forthcoming.
11 *See* Ex. 5, Tr. of Aug. 8, 2018 Mots. Hr'g; *see, e.g., id.* at 40:8–12 (Judge Collyer:
12 “[H]ow can you impose on Medicare Advantage insurers compliance requirements
13 that CMS itself does not follow? Because as a program, it comes out not
14 actuarially equivalent, and it's predictable and intended to come out that way.”). If
15 United prevails in the APA case, that will confirm *by law* the presence of
16 unsupported codes does not result, without more, in an overpayment. And if the
17 presence of unsupported codes does not result in overpayments, then those codes
18 are not material, either, because the government *could not* have reduced its
19 payment based on them without violating statutory and contractual obligations.
20 United is entitled to discovery showing the government's awareness of that
21 limitation.

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27 ⁸ For example, United seeks discovery “relating to CMS policies, guidance, or
28 procedures relating to the requirement . . . that CMS pay MA plans in a manner
that ‘ensures actuarial equivalence.’” RFP No. 2-19.

1 **2. *The Discovery the Government Seeks to Foreclose is Relevant to***
 2 ***Scienter***

3 The government argues (at 11) that “[s]cienter in this case involves whether
 4 United ‘knew,’ as that term is defined in the FCA, that submitted diagnosis codes
 5 were unsupported by patient charts.” Such a circumscribed view of scienter is
 6 unfounded. Proving that United improperly retained overpayments requires the
 7 government to show that United knew about unsupported codes simply by virtue of
 8 its one-way looks and that United knew that unsupported codes necessarily
 9 resulted in overpayments. *See* 31 U.S.C. § 3729(a)(1)(G). That, in turn, requires
 10 the government to prove United knew that there was something improper or
 11 fraudulent in conducting one-way chart reviews and that United was objectively
 12 unreasonable in its belief that there was no overpayment so long as the rate of its
 13 unsupported codes did not exceed CMS’s. *See* Mot. to Strike Opp’n at 17–18.

14 Thus, evidence related to both the objective reasonableness of United’s
 15 interpretations of its obligations and the subjective beliefs held by United is
 16 relevant to scienter. *See id.*; *Safeco Ins. Co. v. Burr*, 551 U.S. 47, 69–71 & n.20
 17 (2007) (stating that where multiple “objectively reasonable” interpretations of a
 18 provision exist, “it would defy history and current thinking to treat a defendant
 19 who merely adopts one such [objectively reasonable] interpretation as a knowing
 20 or reckless violator”); *United States ex rel. McGrath v. Microsemi Corp.*, 690 F.
 21 App’x 551, 552 (9th Cir. 2017) (applying *Safeco* to scienter requirement of False
 22 Claims Act). For example, evidence of CMS’s error rate and other witnesses like
 23 Jeffrey Grant would support United’s argument that its interpretations were
 24 objectively reasonable and, therefore, not a willful violation of its legal
 25 obligations.⁹ *See, e.g., United States v. Pac. Gas & Elec. Co.*, 178 F. Supp. 3d 927,

26 _____
 27 ⁹ Jeffrey Grant—a CMS official who oversaw the creation of the risk adjustment
 28 program—testified that he believed an MA plan’s submission of an unsupported
 code would be improper only if it was making the “very specific submission of a

1 963 (N.D. Cal. 2016) (holding that evidence of government’s or other regulated
 2 entities’ interpretation of regulations was relevant to reasonableness of defendant’s
 3 interpretation, regardless of whether defendant actually knew of that evidence);
 4 Mot. to Strike Opp’n at 17–18; *see also* Partial Summ. J. Opp’n at 19–20.

5 United has every reason to believe that discovery will continue to support its
 6 theory that its interpretations were objectively reasonable. *See, e.g.*, Mot. to Strike
 7 Opp’n at 17–18; Partial Summ. J. Opp’n at 2–3, 19–20, 40–42. The government’s
 8 motive for attempting to suppress relevant evidence is clear: the limited amount of
 9 evidence in United’s possession to date directly supports United’s theory that CMS
 10 officials shared its views. Evidence that government officials did not believe one-
 11 way looks were problematic or improper is plainly relevant and, at a minimum,
 12 demonstrates that United’s interpretations were reasonable.

13 The lone contrary case cited by the government—a pre-*Safeco* district court
 14 decision—is inapposite. In *United States v. Tenet*, No. CV-03-206 (C.D. Cal. Sept.
 15 7, 2005), the defendants moved to compel documents relating to “complaints or
 16 confusion by or amongst the general public” regarding coding-related issues. *Id.*
 17 at 4. Although the district court upheld the magistrate judge’s denial of the motion
 18 to compel, it acknowledged that the Ninth Circuit previously held that the
 19 “‘reasonableness of [a defendant’s] interpretation of the applicable . . . standards
 20 may be relevant to whether it knowingly submitted a false claim,’ i.e., to the third
 21 element of FCA claims—scienter.” *Id.* at 7 (emphasis in original). Here, United is
 22 not seeking discovery about the general public’s confusion about risk adjustment.
 23 United is seeking discovery into the knowledge and interpretations of the very
 24 agency officials tasked with administering the MA program. Similarly, United is

25 very specific data element . . . that [it] know[s] is wrong.” Schindler Decl. Ex. 7,
 26 Grant Dep. at 321:21–23 (Dkt. 254-1). He stated that performing one-way reviews
 27 that add diagnosis codes, without looking at whether previously-submitted codes
 28 lack such support, would not create the requisite knowledge. *Id.* at 322:18–323:15.
 He further testified that he did not believe it was “improper” or “fraud” for an MA
 plan to perform such one-way reviews. *Id.* at 307:11–310:16.

1 seeking discovery into the knowledge and interpretations of other MA plans—not
 2 the general public—because such evidence will support United’s argument (among
 3 others) that its interpretations were objectively reasonable. *See* Mot. to Strike
 4 Opp’n at 17–18; *United States v. Pac. Gas & Elec. Co.*, 178 F. Supp. 3d at 963.

5 **3. *The Discovery the Government Seeks to Foreclose is Relevant to***
 6 ***Materiality***

7 The government also seeks to foreclose discovery of internal CMS
 8 documents and materials relevant to materiality, including investigations of other
 9 MA plans.¹⁰ (Mot at 8-11.) Evidence of how the government responded to
 10 allegations that MA plans were engaging in conduct similar to the conduct at issue
 11 here goes directly to the materiality of any alleged wrongdoing by United. *See*
 12 *United Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2003
 13 (2016); *United States ex rel. Worthy v. E. Me. Healthcare Sys.*, No. 2:14-cv-00184-
 14 JAW, 2017 WL 211609, at *24 (D. Me. Jan. 18, 2017) (evidence regarding
 15 government’s prior investigations of similar allegations and prior actions to
 16 prevent the same type of conduct at issue relevant for materiality purposes); *see*
 17 *also United States ex rel. Scharff v. Camelot Counseling*, No. 13-cv-3791, 2016
 18 WL 5416494, at *17 (S.D.N.Y. Sept. 28, 2016) (complaint failed to allege
 19 sufficient facts to support materiality where it did not allege whether the
 20 government refused to reimburse clinics that engaged in conduct similar to
 21 defendant’s). For example, if the government investigated or otherwise knew that
 22 other MA plans were performing one-way chart reviews, evidence of the
 23 government’s decision to continue paying and contracting with those MA plans
 24 plainly would be relevant to materiality.

25
 26
 27 ¹⁰ For example, United is seeking discovery relating to the government’s
 28 knowledge of MA plans’ efforts to exercise ‘reasonable diligence’ to report and
 return overpayments to CMS. RFP No. 20; *see also supra* at 9 n.4.

1 Additionally, the government misses the mark when it argues (at 10) that the
 2 discovery United seeks is irrelevant because the “government’s suspicions about
 3 United’s compliance with accuracy requirements did not mean CMS had
 4 information about which particular diagnoses were unsupported.” United is
 5 entitled to discovery showing that CMS did not think there was anything improper
 6 about the common industry practice of performing one-way chart reviews, despite
 7 knowing that unsupported codes previously submitted would not be ferreted out or
 8 deleted as part of this process and would therefore be reflected in the payment to
 9 the MA plan. United is likewise entitled to discovery as to steps that CMS could
 10 have taken to learn which “particular diagnoses were unsupported” and whether
 11 CMS chose not to pursue those steps because it had no concern with one-way
 12 reviews. Such evidence is probative of materiality, regardless of whether CMS
 13 had obtained information about which particular diagnoses were unsupported.

14 Furthermore, the government argues (at 2) that United’s discovery requests
 15 are irrelevant because they ignore certain “facts” about the MA program that
 16 allegedly render the failure to delete diagnostic codes “inexorably” material. But
 17 the so-called facts the government relies on are in reality disputed factual
 18 allegations to which United is entitled to discovery and that cannot form the basis
 19 for foreclosing discovery relevant to *Escobar*’s demanding materiality standard.
 20 See *Escobar*, 136 S. Ct. at 2003. For example, the government argues that the
 21 allegedly automated nature of the Medicare Advantage payment system renders the
 22 codes *automatically* material. See Mot. at 9; Am. Compl. ¶ 333. This is a disputed
 23 allegation that ignores the fact that this case largely is about unsupported codes that
 24 were allegedly “revealed” and should have been deleted after the deadline for
 25 submitting codes (“closed period deletes”),¹¹ and that closed period deletes involve

26
 27 ¹¹ The deletes the government alleges United should have made would be “closed
 28 period deletes” for both legal and factual reasons. Legally, the statute defines
 overpayment as amounts to which a plan is not entitled “after applicable

much more than merely submitting “delete files” electronically to CMS—they involve affirmative decisions by CMS officials to process the deletes and adjust prior payments based on CMS’s reconciliation of the submitted data. *See generally* Martin Decl.; Declaration of MaryBeth Meyer (filed concurrently herewith). United cannot be foreclosed from relevant discovery on the element of materiality based on the government’s incorrect and untested factual allegations about the MA payment processing system.

4. *The Discovery the Government Seeks to Foreclose is Relevant to the Meaning of Contractual Provisions and Regulatory Requirements*

Additionally, the discovery the government seeks to foreclose is relevant to interpreting the meaning of contractual and regulatory provisions on which the government relies in its Amended Complaint, Motion for Partial Summary Judgment, and this Motion (at 12). As United has explained, the regulatory provisions invoked by the government do not state that an MA plan is required to delete all codes it allegedly determines to be unsupported, regardless of the rate of unsupported codes in CMS’s own data on which its payments are based, or that it is overpaid every time it receives a payment associated with an unsupported code. *See, e.g.*, Partial Summ. J. Opp’n at 26–46. At the very least, extrinsic evidence is necessary to determine their meaning. *Id.* United also believes the contractual provisions at issue are ambiguous, and thus extrinsic evidence also is necessary to

reconciliation,” which CMS has defined as being the deadline for submission of data. *See* 42 C.F.R. § 422.326; *see also* Exhibit A to the Declaration of Rebecca Martin (filed concurrently herewith) (“Martin Decl.”), CMS, “CORRECTION—Updated Announcement Regarding Encounter Data Deadlines for Payment Years 2016 and 2017 Final Reconciliation” (Feb. 20, 2018) (deletes submitted within the extended deadlines “are not overpayments as defined in Section 1128J(d) of the Social Security Act and 42 CFR § 422.326”). Thus, as a legal matter, any overpayments that United allegedly identified and failed to delete would necessarily be closed period deletes. Factually, the deletes the government alleges United should have made includes many deletes that would have been made in the closed period because United performs chart reviews on an annual cycle that continues until near the end of the submission deadline—and thus the claims verification process United previously employed often occurred in the closed period.

1 resolve their meaning. *See, e.g., id.* at 43–46. The government cannot plausibly
 2 argue against the relevancy of evidence that its own views mirror United’s.

3 **C. The Government Is Wrong That This Court And The Ninth**
 4 **Circuit Have Decided Contested Issues As A Matter Of Law**

5 The government relies heavily on the claim that certain issues already have
 6 been decided by this and other courts as a matter of law in an attempt to
 7 characterize the discovery United seeks as irrelevant and unnecessary. (*See, e.g.,*
 8 *Mot.* at 7–10.) This reliance on these prior decisions is misplaced, and its
 9 discussion of these cases is flawed. The government argues (at 7) that United is
 10 not entitled to discovery on “the government’s understanding of whether [MAOs]
 11 were required to ‘look both ways’”¹² because (i) the Ninth Circuit “held as a matter
 12 of law that United had an obligation to correct diagnosis codes that it knew to be
 13 invalid,” and (ii) this Court effectively held the same by denying (in part) United’s
 14 motion to dismiss.

15 That assertion is simply wrong. Initially, as explained elsewhere, United
 16 denies the contention that it had knowledge of unsupported codes or that it had
 17 been overpaid, and the discovery United seeks is relevant to that *factual* question.
 18 *See, e.g., supra* at 3. Just as important, neither this Court nor the Ninth Circuit
 19 have conclusively determined issues in favor of the government as a matter of law.
 20 Rather, as the decisions make perfectly clear, these courts—as they were required
 21 to do on a motion to dismiss—“assumed the facts alleged in the Complaint [were]
 22 true and construe[d] any inferences arising from those facts in the light most
 23 favorable to [the plaintiffs].” *United States ex rel. Poehling v. UnitedHealth Grp.,*
 24 *Inc.*, Order re Mot. to Dismiss at 2, Feb. 12, 2018 (Dkt. 212); *Swoben*, 848 F.3d at

26 ¹² For example, United is seeking discovery related to “whether MA Plans validate
 27 or validated the accuracy of diagnosis codes submitted on claims data to CMS for
 28 purposes of Risk Adjustment and whether MA Plans “look both ways” when
 reviewing medical charts.” RFP No. 38.

1 1179 (“Under Rule 8, we assume the veracity of a complaint’s factual
 2 allegations”); *Silingo*, 895 F. 3d at 628 (“We . . . accept[] as true all well-
 3 pleaded allegations of fact in the complaint and constru[e] them in the light most
 4 favorable to [the plaintiff].”) (citation and internal quotation omitted).¹³

5 As one example, in addressing the potential implications of certain one-way
 6 looks on an MA plan’s attestations, the Ninth Circuit did not have before it the
 7 evidence that CMS’s Coding Intensity Adjustment already offsets for the financial
 8 impact of codes added by MA plans through their chart reviews. As another
 9 example, the government argues (at 10) that this Court recognized the automated
 10 nature of the Medicare Advantage payment system and impact of diagnosis codes
 11 on payments to MA plans. Not only does United dispute these allegations (*see*
 12 *supra* at 15–16), but the Court made clear it was only assessing whether the
 13 government’s allegations were sufficient to withstand a motion to dismiss. *See*,
 14 *e.g.*, Order re Mot. to Dismiss at 2 (“[T]he Court accepts the following facts as
 15 true”). Now that the case has moved past the pleading stage, the government
 16 must actually *prove*—and United is entitled to discovery that tests the veracity
 17 of—its allegations. This Motion is an attempt to prevent United from doing just
 18 that. Indeed, what little discovery United has been able to obtain to date directly
 19 corroborates United’s fundamental assertions in this case and directly contradicts
 20 the government’s allegations and undermines the government’s remaining claims.
 21 *See, e.g., supra* at 10 n.7. The government cannot preclude United from obtaining
 22 relevant evidence just by pointing to decisions that, by procedural necessity,
 23 assumed such evidence did not even exist.

24 As United detailed in its Partial Summary Judgment Opposition (at 46–49),
 25 the government also fails to recognize the fundamental differences between the

26
 27 ¹³ The *Silingo* court went so far as to state: “We assuredly do not hold now that
 28 *Silingo* showed enough to get to trial, but rather only that her complaint is adequate
 to proceed to discovery.” *Silingo*, 895 F. 3d at 633.

1 allegations and claims remaining in this case and those at issue in *Swoben*. The
 2 Ninth Circuit expressly stated it was not addressing a Reverse False Claims Act
 3 theory—the only surviving False Claims Act theory in this case. *See Swoben*, 848
 4 F.3d at 1172 n.6 (“*Swoben*, however, did not rely on [the reverse false claims]
 5 provision in his opening and reply briefs. We therefore do not address it here.”).
 6 The Ninth Circuit made clear it was not deciding whether unsupported codes were
 7 false claims. *Id.* at 1183 (“Under *Swoben*’s theory . . . the false claims are the
 8 allegedly false § 422.504(l) certifications, *not the erroneously reported diagnosis*
 9 *codes*” (emphasis added)). Nor did the Ninth Circuit address materiality or
 10 overpayments. *See id.* at 1173 & n.7 (stating that the court was not addressing
 11 whether the allegedly false certifications were “material” or “caus[ed] the
 12 government to pay out money or forfeit moneys due”). The Ninth Circuit thus did
 13 not contemplate, let alone decide, that codes were material. And its motion-to-
 14 dismiss-stage decision certainly did not suggest that the codes would be treated as
 15 material regardless of whether there was evidence showing that the government
 16 knowingly paid MA plans based on unsupported codes—exactly the sort of
 17 evidence that the government is trying so desperately to withhold from United.

18 The government’s reliance on *Silingo* likewise is misplaced. Like *Swoben*,
 19 *Silingo* did not analyze the Reverse False Claims Act or the materiality element of
 20 such a claim. The district court had dismissed with prejudice *Silingo*’s Reverse
 21 False Claims Act count, and the Ninth Circuit held that she could not revive it on
 22 appeal. *Silingo*, 895 F.3d at 632. Thus, the Ninth Circuit did not analyze any
 23 implications of the factual allegations on a Reverse False Claims Act count.
 24 Furthermore, the Ninth Circuit did not address materiality whatsoever—in fact, the
 25 only reference to “material” in the decision is a quotation of the statutory language
 26 related to a false records affirmative False Claims Act claim. *See Silingo*, 895 F.3d
 27 at 627. Moreover, the factual allegations in *Silingo* are fundamentally different
 28 than those at issue here. *Silingo* involved allegations that MA plans themselves

1 fraudulently fabricated complex diagnoses and edited and forged medical records.
 2 *Id.* at 626. In contrast, the government’s theory here is not that United fabricated
 3 codes in conducting chart reviews; it is instead that United’s reviews supposedly
 4 revealed that *other* codes separately submitted by providers in good faith were
 5 inadequately documented. Those are not remotely the same thing.¹⁴

6 Finally, neither *Swoben* nor *Silingo* addressed the validity of the contractual
 7 and regulatory provisions at issue here—which United vigorously disputes, as
 8 detailed above—and thus necessarily did not construe those provisions so as to
 9 render them valid. In sum, neither *Swoben* nor *Silingo* resolved issues—factual or
 10 legal—into which the government seeks to prevent discovery. As Judge Collyer
 11 stated when describing *Swoben*, these cases are “not the droid the [government] is
 12 looking for.” Schindler Decl. Ex. 57, APA Order at 2 (Dkt. 254-3).

13 **D. The Government Has Not Demonstrated Any Undue Burden That**
 14 **Would Warrant Its Avoidance Of Basic Discovery**

15 The government conducted a five-year investigation before deciding to file
 16 this action, during which United produced over 600,000 documents and detailed
 17 responses to dozens of complex interrogatories, and the government conducted oral
 18 examinations of more than 20 witnesses. Armed with the substantial amount of
 19 materials and information it had gathered, the government filed its 166-page, 364-
 20 paragraph Amended Complaint after determining the nature, scope, and size of its
 21 case. Yet, the government continues to balk at the notion of engaging in discovery
 22 and allowing United a fair opportunity to defend itself, asserting that doing so
 23 would be burdensome. But as Magistrate Judge Segal recently told the
 24 government, “[Y]ou initiated this case; you knew the volume of the case; you
 25 knew the response that you would likely get from United; you are not new to this

26 _____
 27 ¹⁴ The Ninth Circuit also stated that *Silingo* was “entitled to continue taking
 28 discovery before her claims are resolved on summary judgment or at trial.” *Id.* at
 633. United similarly is entitled to discovery.

1 kind of litigation. . . . [T]he volume of work involved in responding to discovery
 2 requests and participating in this case was something the Government needed to
 3 kind of assess before they filed the complaint in this action.” Ex. 4, Tr. of Aug. 16,
 4 2018 Conf. at 20:9–15. United should not be prejudiced by limited discovery
 5 simply because the government now regrets the burdens of litigating the case it
 6 chose to bring.

7 Additionally, both this Court and Magistrate Judge Segal have given clear
 8 instructions and guidance that discovery is to proceed in this matter, that there will
 9 be no phased discovery as the government sought, and that pending motions do not
 10 alter a party’s discovery obligations. *See, e.g.*, Order Setting Scheduling Conf. at 2
 11 (Dkt. 219) (“The Court encourages counsel to agree to begin to conduct discovery
 12 actively before the Scheduling Conference. At the very least, the parties shall
 13 comply fully with the letter and spirit of Rule 26(a) and thereby obtain and produce
 14 most of what would be produced in the early stage of discovery, because at the
 15 Scheduling Conference the Court will impose strict deadlines to complete
 16 discovery.”); Ex. 1, Tr. of Dec. 18, 2017 Conf. at 13:16–14:2 (“[W]e tend not to
 17 halt discovery in the anticipation that [a party] may win their motion for partial
 18 summary judgment. . . . [W]e generally let the defendant proceed to address the
 19 allegations in the complaint through discovery and we don’t [] wait.”); Ex. 3, Tr. of
 20 Feb. 8, 2018 Conf. at 25:14–15 (“[United] has a right to [] vigorously and quickly
 21 defend itself.”). Despite express instructions and obligations, however, the
 22 government has consistently tried to dictate the course of discovery and prevent
 23 United from obtaining discovery to which it is entitled.

24 The government claims that United is seeking “burdensome discovery” and
 25 laments that it must collect and review an “inordinate volume of documents.”
 26 (Mot. at 3, 14.) The government’s complaints ring hollow, given that the
 27 government opted to bring this action and knew the scope of this case, the volume
 28 of work it would involve, and that United would defend itself. Furthermore, the

government has made no particularized showing of the burden it allegedly faces, instead relying on broad, conclusory statements. Nor can it. The government cannot plausibly argue that engaging in basic discovery is somehow unduly burdensome or disproportionate to the claims in the case, especially given the amount of damages it seeks (*see* Am. Compl. at ¶ 122)—damages that would be trebled under the False Claims Act. The government’s assertions do not come close to satisfying Rule 26(c)’s standard for a protective order, for which the government has moved in the alternative. *See Indep. Living Ctr. of S. Cal. v. City of Los Angeles*, 296 F.R.D. 632, 637 (C.D. Cal. 2013) (rejecting the government’s burden-related arguments where the government did not submit declarations or make any effort other than providing conclusory statements to establish burden); *see also Phillips ex rel. Estates of Byrd v. Gen. Motors Corp.*, 307 F.3d 1206, 1210–11 (9th Cir. 2002) (“For good cause to exist, the party seeking protection bears the burden of showing specific prejudice or harm will result if no protective order is granted.” (citing *Beckman Indus., Inc. v. Int’l Ins. Co.*, 966 F.2d 470, 476 (9th Cir. 1992) (“[B]road allegations of harm, unsubstantiated by specific examples or articulated reasoning, do not satisfy the Rule 26(c) test”).).

Finally, despite the government’s efforts to prevent United from obtaining discovery, United is expending significant efforts engaging in meaningful discovery:

<u>Discovery by United</u>	<u>Discovery by the Government</u>
Over 70 million documents amounting to 14.3 terabytes of data collected in response to the government’s document requests	Over 7 million documents amounting to 5 terabytes of data collected in response to United’s document requests
Over 376,000 documents produced in this litigation	About 44,000 documents produced in this litigation
Over 600,000 documents produced in the investigation; over 34,000 documents produced in <i>Swoben</i>	About 600 mostly publicly available produced documents in <i>Swoben</i>

7 billion records on 4 2-terabyte hard drives produced in response to the government's data requests	About 3.6 terabytes of pre-packaged data available for sale on CMS's website for research purposes produced in response to United's data requests
5 spreadsheets of over 125,000 lines of data produced in response to the government's interrogatories ¹⁵	<i>N/A. United has not served any Interrogatories to date.</i>
About 2,500 privilege log entries in this litigation; over 26,000 privilege log entries during the investigation ¹⁶	About 19,760 privilege log entries, about 16,400 of which are being withheld <i>solely</i> on the basis of the deliberative process privilege

United's significant discovery efforts reflect the case the government chose to bring. The government must undertake reciprocal efforts.

The government claims (at 3) it has over 675,000 documents that must be reviewed for privilege, which implies the government has determined that it will produce those documents absent an assertion of privilege. Despite claiming to have identified over 675,000 for potential production, however, the government has produced only about 44,000 documents since receiving United's first document requests over a year ago. Given the volume of documents that the government forced United to review and produce in the course of the investigation and during the course of this litigation, it is sheer hypocrisy for the government to complain that it is being forced to engage in discovery that is a standard part of any litigation. Furthermore, much of any purported burden facing the government stems from its inappropriate and overly broad assertions of the deliberative process privilege.

¹⁵ The interrogatories focused on United's RACCR Program, which the government omits from its discussion about the nature of its case. *See supra* Section III.A.

¹⁶ The government demanded that United revise its privilege logs from both the litigation and investigation. Despite the government's refusal to revise its own privilege logs, United agreed to review and, as appropriate, revise its approximately 28,500 privilege log entries.

1 Indeed, the government's arguments about the deliberative process and law
 2 enforcement privileges are red herrings. United recognizes that this Court has told
 3 the parties that Magistrate Judge Segal would decide the propriety of any
 4 assertions of privilege, such as the government's assertion of the deliberative
 5 process privilege. *See* Ex. 2, Tr. of Apr. 9, 2018 Scheduling Conf. at 24:13–16.
 6 United brought this issue to Magistrate Judge Segal's attention recently and
 7 anticipates moving to compel documents the government has improperly withheld.

8 As relevant to this Motion, however, the mere possibility that those narrow,
 9 qualified privileges apply to a portion of the documents requested by United is no
 10 basis to categorically deny United discovery of other relevant information that is
 11 outside the scope of those privileges. *See United States v. McGraw-Hill Cos., Inc.*,
 12 No. CV 13-779-DOC (JCGx), 2014 WL 1647385, at *7 (C.D. Cal. Apr. 15, 2014)
 13 (stating that “the Government cannot escape its duty to disclose documents by
 14 merely brandishing a general claim of privilege” and ordering production of
 15 materials related to other market participants). In addition, even if the government
 16 had properly invoked the deliberative process privilege (which it has not), United's
 17 need for these highly relevant documents outweighs any harm that might result
 18 from disclosure. *See FTC v. Warner Commc'ns. Inc.*, 742 F.2d 1156, 1161 (“A
 19 litigant may obtain deliberative materials if his or her need for the materials and
 20 the need for accurate fact-finding override the government's interest in non-
 21 disclosure.”).¹⁷ At the very least, the government's argument about the burdens
 22 associated with the deliberative process privilege is premature.

23
 24
 25
 26 ¹⁷ If United prevails on its motion to compel such documents, any alleged burden
 27 the government faces related to its privilege logs would be significantly reduced
 28 because it would no longer be withholding documents solely on the basis of the
 deliberative process privilege—which currently accounts for approximately 83%
 of the documents on the government's privilege logs.

1 **IV. CONCLUSION**

2 The Court should deny the government's latest attempt to foreclose relevant
 3 discovery. Despite this Court's and Magistrate Judge Segal's admonitions, the
 4 government continues to pull out all the stops to prevent United from obtaining
 5 discovery. The government cannot accuse United of fraud and then turn around
 6 and prevent discovery into what the alleged victim of that fraud knew. The
 7 discovery the government seeks to foreclose is critical to the claims and defenses
 8 in this case—including the common law claims the government failed to mention
 9 in its Motion, the RACCR theory the government similarly ignores, and the only
 10 remaining False Claims Act count in this case. Contrary to the government's
 11 assertions, these issues have not been decided as a matter of law by this or any
 12 other court. The government dictated the size and scope of this case when it filed
 13 its Amended Complaint, and any burden associated with engaging in standard
 14 discovery stems from the government's own pleadings. Just as United has
 15 continued to engage in meaningful discovery that reflects the scale of the
 16 government's allegations, so too must the government engage in such discovery.

17
 18 Dated: August 27, 2018

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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA**

CASE NO. 2:16-cv-08697-MWF(SSx)

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

Plaintiff,

v.

UNITEDHEALTH GROUP, INC. *et al.*,

Defendants.

**DECLARATION OF REBECCA
MARTIN IN SUPPORT OF
UNITED'S OPPOSITION TO
PLAINTIFFS' JOINT MOTION
PURSUANT TO RULE 16(b)(3)
FOR ISSUANCE OF
SCHEDULING ORDER
MODIFYING EXTENT OF
DISCOVERY**

*[Opposition to Plaintiffs' Joint Motion
Pursuant to Rule 16(b)(3); Declaration
of Abid R. Qureshi; and Declaration of
MaryBeth Meyer filed concurrently
herewith]*

Date: September 17, 2018
Time: 10.00 a.m.
Courtroom: 5A
Judge: Hon. Michael W. Fitzgerald

DECLARATION OF REBECCA MARTIN

I, Rebecca Martin, hereby declare as follows:

1. I am a Director, General Management at Optum, one of the UnitedHealth Defendants (hereinafter “Optum”). I make this declaration in support of United’s Opposition to the Plaintiffs’ Joint Motion Pursuant to Rule 16(b)(3) for Issuance of a Scheduling Order Modifying Extent of Discovery in this matter.

2. I have personal knowledge, information, or belief of the facts stated herein and, if called as a witness, I could and would testify competently thereto.

3. I have held my current position of Director, General Management at Optum since February 2018.

4. Prior to that role, I served as Director, Business Process at Optum from June 2010 to February 2018.

5. In both roles, my responsibilities have included managing the team responsible for processing and submitting delete transactions to the Centers for Medicare & Medicaid Services (“CMS”), overseeing risk adjustment delete submissions, and developing and managing the policies, procedures, and controls related to the processing and submission of deletes.

6. As a result, I have significant experience with, and extensive involvement in and knowledge of CMS’s Risk Adjustment Payment System (“RAPS”) delete submission process.

7. Until approximately February 2015, CMS did not have a formal process in place for submitting delete files after the deadline for submitting codes to RAPS had passed (“closed period deletes”). See Ex. A, CMS, Guidance for Reporting and Returning Medicare Advantage Organization and/or Sponsor Identified Overpayments to the Centers for Medicare & Medicaid Services (CMS), (Feb. 18, 2015) (“2015 guidance document”).

1 8. Prior to issuing formal guidance in 2015, CMS sometimes required
 2 United to submit responses to the following six questions as part of the closed
 3 period delete submission process: (1) What payment year(s) are involved in the
 4 data submission issue(s); (2) How many records are affected? Please list by service
 5 year (Dates of Service) and Contract #; (3) Provide an impact estimate of the error
 6 in dollars (by payment year and Contract #); (4) Provide a detailed technical
 7 explanation of the cause of the problem; (5) If a submission deadline was missed
 8 provide a detailed explanation of why the submission deadline was missed; and (6)
 9 Provide a narrative of the steps your organization has taken to ensure this does not
 10 reoccur, including the internal controls your organization is implementing/has
 11 implemented to ensure the problem does not occur again. Although CMS's closed
 12 period delete process was not formalized or uniform at this time, it is my
 13 understanding that it was not uncommon for CMS to engage in additional back and
 14 forth with the United Medicare Advantage ("MA") plans regarding United's
 15 responses to these six questions prior to making a decision to process the deletes.

16 9. Throughout my tenure at Optum, CMS has at times rejected closed
 17 period delete files that Optum attempted to submit to RAPS on United's behalf for
 18 a variety of reasons and sometimes without clear explanation. For example, in
 19 anticipation of Risk Adjustment Data Validation (RADV) audits for 2010 dates of
 20 service ("DOS"), CMS imposed a May 31, 2013 deadline for submitting closed
 21 period delete files for 2010 DOS. CMS repeatedly rejected certain delete files for
 22 2010 DOS submitted after May 31, 2013, despite attempts by Optum to continue
 23 submitting deletes on United's behalf. I have also personally participated in
 24 multiple telephonic conversations with CMS officials in an attempt to better
 25 understand why CMS was rejecting certain closed period delete files Optum was
 26 attempting to submit to RAPS on United's behalf. It sometimes took multiple
 27 conversations and many months of working with CMS officials to understand the
 28

1 root cause of why they were rejecting certain closed period deletes and come to a
2 resolution.

3 10. After CMS receives a closed period delete file submission in RAPS,
4 any reconciliation and corresponding payment adjustment is performed by CMS.
5 To the best of my knowledge, this overpayment recovery process does not happen
6 automatically. Rather, it is my understanding that, at least prior to formalizing its
7 process in 2015, it was up to a CMS official to decide whether and at what time to
8 run the reconciliation and recover any corresponding overpayment.

9 11. Pursuant to the formal process set forth by CMS in 2015, MA plans
10 are required to obtain a "Remedy ticket" number before being permitted to submit
11 a closed period delete file to RAPS. *See id.* at 8 ("If the organization attempts to
12 submit the delete file to RAPS sooner than [receiving a Remedy ticket number],
13 the submission will be rejected by the system."). CMS initially required MA plans
14 to call or email CMS's internal help desk to start the manual process of obtaining a
15 Remedy ticket number. *See id.* at 5. It was not uncommon for this Remedy ticket
16 process to require months of failed attempts and follow-up correspondence with
17 CMS before CMS provided a valid Remedy ticket number and permitted the delete
18 file submissions to RAPS. Although CMS improved the Remedy ticket process in
19 or about 2016, MA plans are still required to obtain a Remedy ticket number from
20 CMS prior to submitting a delete file to RAPS during the closed period.

21 12. As set forth in CMS's 2015 guidance document, the reconciliation and
22 recovery of any overpayment is still performed by CMS, not the MA plan. *See id.*
23 at 9. To the best of my knowledge, this overpayment recovery process still does
24 not happen automatically.

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

2 Executed on August 27, 2018, in Huntington Beach California.

3
4 By Rebecca Martin

5 Rebecca Martin
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850



CENTER FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP

DATE: February 18, 2015

TO: All Medicare Advantage, Prescription Drug Plan, Cost, PACE, and Demonstration Organizations

FROM: Cheri Rice /s/
Director, Medicare Plan Payment Group

SUBJECT: Guidance for Reporting and Returning Medicare Advantage Organization and/or Sponsor Identified Overpayments to the Centers for Medicare & Medicaid Services (CMS)

On May 23, 2014, CMS published final regulations to implement procedures for the reporting and returning of overpayments requirement in the Affordable Care Act (ACA). These regulations, 42 CFR §§ 422.326 and 423.360, were effective beginning July 22, 2014. This document announces the process for reporting and returning overpayments in accordance with the new regulations. The process that implements these regulations is effective beginning January 1, 2015.

Pursuant to section 6402 of the Affordable Care Act (ACA), which established section 1128J(d) of the Social Security Act (the Act), every organization offering a Medicare Advantage (MA) plan and/or sponsor offering Part D benefits, including any PACE organization that is a Part D sponsor, is required to report and return to CMS any overpayment it received no later than 60 days after the date on which the organization or sponsor identified the overpayment.

The purpose of this memorandum is to provide organizations and/or sponsors with operational guidance for reporting and returning overpayments.

If you have questions about the guidance contained in this memorandum, please submit them to the appropriate contact as provided in this memorandum.

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I. Overpayment Requirements

The term “overpayment” is defined in section 1128J(d)(4)(B) of the Act as, “any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliations, is not entitled under such title.” Failure to comply with this statutory requirement may result in potential liability under the False Claims Act (31 USC § 3729).

CMS issued regulations at 42 CFR §§ 422.326 and 423.360 which establish the process for an organization offering a Medicare Advantage (MA) plan and/or a sponsor offering Part D benefits to report and return any overpayment it received no later than 60 days after the date the organization or sponsor identifies the overpayment (79 FR 29843 at 29958). Section 423.360 applies to Part D sponsors, which include PACE organizations offering a PACE plan that includes qualified prescription drug coverage (see definition of “Part D sponsor” in 42 C.F.R. § 423.4).

An organization or sponsor has identified an overpayment when it determines that it received an overpayment due to the organization or sponsor submitting erroneous data to CMS. The following four general categories of data submissions that have the potential to result in overpayments are subject to the guidance contained in this memorandum:

- Risk Adjustment (Risk Adjustment Processing System (RAPS) data and encounter data)
- Prescription Drug Event (PDE) and Direct and Indirect Remuneration (DIR)
- Low Income Premium Subsidy (LIPS) for Employer Group Waiver Plans (EGWPs)¹
- Other

Additional information about these categories is provided throughout this memorandum.

Enrollment-Related Overpayments: If an organization or sponsor needs to submit corrections to enrollment data to resolve an overpayment, it must follow the normal process for correcting enrollment data. See the Plan Communications User Guide for more information: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelptdesk/Plan_Communications_User_Guide.html

II. Reporting Overpayments

A. Overpayment Categories, Applicable Reconciliation, and Look-Back Periods

MA organizations and Part D sponsors are required to report and return any overpayment that they identify within the six most recently completed payment years², referred to hereinafter as the “look-back period.” The report and return obligation begins on the day after the applicable reconciliation for the payment year. The sections below provide more information about the look-back period and when the applicable reconciliation occurs for Part C and Part D.

- *Risk Adjustment*
Generally, if an overpayment results from the submission of risk adjustment data (i.e., RAPS data and encounter data), the obligation to report an identified overpayment for a given payment year begins on the day after the Part C applicable reconciliation date, which is the final risk adjustment data submission deadline under § 422.310(g). That deadline generally occurs about thirteen

¹ This category of overpayment occurs when a sponsor discovers it received a Low Income Premium Subsidy payment for an enrollee from both CMS and the enrollee’s Employer Group Waiver Plan.

² In this context, the term “completed payment year” refers to a calendar year for which the applicable reconciliation date has passed.

months after the end of the data collection year. (Note that overpayments may result from the submission of encounter data starting with 2014 dates of service.). Please note that the reporting deadline for Part D risk adjustment data is the same as the Part C risk adjustment data submission deadline, but the applicable reconciliation dates for Part C and Part D in the overpayment context are different.

- *Prescription Drug Event or Direct and Indirect Remuneration*

If an overpayment results from the submission of incorrect PDE or DIR data, the obligation to report an identified overpayment for a given year begins on the day after the Part D applicable reconciliation date (i.e., the later of the deadlines for submitting PDE or DIR data for the applicable year). That deadline generally occurs towards the end of June in the year directly following the payment year.

- *Low Income Premium Subsidy for Employer Group Waiver Plans*

If an overpayment arises when the total of the LIPS payment comes from CMS and the EGWP contribution for a beneficiary exceeds the amount of his or her premium, the obligation to report the overpayment (i.e., the portion of CMS's LIPS payment that exceeds the premium amount) for a given year begins on the day after the Part D applicable reconciliation date for that year (i.e., the later of the deadlines for submitting PDE or DIR data for that year).

- *Other*

Overpayments that are a result of incorrect data submissions by MA organizations and Part D sponsors that do not fall into the Risk Adjustment, PDE, DIR, or LIPS for EGWPs categories will be classified as "Other." In addition, an overpayment that results from the submission of data that an organization or sponsor may have lost as a result of a thoroughly-documented catastrophic loss of stored data is also classified as "Other." If the "Other" overpayment falls under Part D, the obligation to report an identified overpayment for a given year begins on the day after the Part D applicable reconciliation date for that year (i.e., the later of the deadlines for submitting PDE or DIR data for that year). If the "Other" overpayment relates to Part C, the obligation to report an identified overpayment for a given year begins on the day after the Part C applicable reconciliation date, which is the final risk adjustment data submission deadline under § 422.310(g).

The following table shows the look-back periods for the 2015 through 2020 calendar years:

Calendar Year	Look-back Period Prior to the Applicable Reconciliation*	Look-back Period After the Applicable Reconciliation*
2015	2013-2008	2014-2009
2016	2014-2009	2015-2010
2017	2015-2010	2016-2011
2018	2016-2011	2017-2012
2019	2017-2012	2018-2013
2020	2018-2013	2019-2014

*Part C applicable reconciliation typically occurs around 13 months after the end of the risk adjustment data collection year. Part D applicable reconciliation typically occurs around 6 months after the end of the payment year.

B. Reporting Process

1. General

Once an organization or sponsor has identified an overpayment, it must report it to CMS no later than 60 days after the date on which it identified it received the overpayment by contacting the MAPD help desk at 1-800-927-8069 or mapdhelp@cms.hhs.gov and opening a Remedy ticket. If an organization or sponsor reports an overpayment to the help desk by email, the subject line of the email should include the phrase “Overpayment Report.” Note that organizations and sponsors should not open an overpayment Remedy ticket until after the applicable reconciliation date for the applicable payment year has passed.

MA organizations and Part D sponsors must ensure confidentiality of enrollee information. Please observe HIPAA security and privacy rules, and ensure that appropriate safeguards for securing protected health information and personally identifiable information (PHI/PII) are used when submitting any materials to the MAPD helpdesk.

In order to create a Remedy ticket for the incident, the organization or sponsor must provide the help desk representative with the following information:

- Plan User Information: EUA (4 Digit) or IACS (7 digit)
- Parent Organization
- Contract Number(s)
- Overpayment Reason Category:
 - Risk Adjustment Data (RAPS and encounter data) - when corrected data is being submitted, otherwise use the “Other” category
 - PDE/DIR - when corrected data is begin submitted, otherwise use the “Other” category
 - LIPS for EGWP
 - Other (e.g., catastrophic loss of data)
- Payment Year for Overpayment
- Explanation for Inaccurate Payment Data (provide detailed explanation for why payment data are inaccurate)
- Supporting Documentation (if applicable, see Section II.B.3)

2. Remedy Ticket Creation

The process for creating Remedy tickets is slightly different depending on the type of overpayment category involved.

Risk Adjustment, LIPS for EGWP, and Other Categories

For Risk Adjustment (RAPS and encounter data), LIPS for EGWP, or Other categories, the help desk will create one Remedy ticket for each overpayment category, contract number, and payment year. For example, the help desk will create one Remedy ticket for an organization that reports a RAPS overpayment for contract H8888 for the 2011 payment year. If the organization also needs to report a RAPS overpayment for the same contract but for the 2010 payment year, the help desk will need to create a separate Remedy ticket for that incident.

PDE/DIR Category

If an overpayment falls into the PDE/DIR category, the help desk will create one Remedy ticket for each parent organization and payment year. If the sponsor needs to report PDE/DIR data that results in an overpayment for the same payment year for multiple contracts, it should do so under the same Remedy ticket number (a sponsor may subsequently revise the number of contracts by contacting the help desk and updating the original Remedy ticket). But, if a sponsor needs to report an overpayment for more than one payment year, it will need to open separate tickets for each year.

Number of Remedy Tickets to Create

Organizations and sponsors are responsible for determining how many overpayment tickets need to be created prior to contacting the help desk. The following examples may help organizations and sponsors understand how many tickets should be created:

- Example 1: An MA organization offering Part D benefits (MAPD) identified overpayments for contract H8888 and H9999 for payment year (PY) 2009. The overpayments are based on incorrect risk adjustment, PDE, and DIR data. The MAPD needs to open the following Remedy tickets:
 - Remedy ticket 1 includes risk adjustment overpayments for H8888
 - Remedy ticket 2 includes risk adjustment overpayments for H9999
 - Remedy ticket 3 includes PDE/DIR overpayments for H8888 and H9999
- Example 2: An MA organization identified risk adjustment overpayments for contracts H8888 and H9999 for PY 2008 and PY 2009. The organization needs to open the following Remedy tickets:
 - Remedy ticket 1 includes H8888 for PY 2008
 - Remedy ticket 2 includes H9999 for PY 2008
 - Remedy ticket 3 includes H8888 for PY 2009
 - Remedy ticket 4 includes H9999 for PY 2009

3. Submission of Supporting Documentation

An organization or sponsor should send supporting documentation to CMS when it is reporting an overpayment in the “Other” category. In these instances, the organization or sponsor should provide supporting documentation that addresses:

- The reason for the loss of the data (if applicable), including a catastrophic system loss;
- The reason for the overpayment; and
- An auditable estimate of the overpayment amount, including how the estimate was derived for each Remedy ticket.

The attached documentation should be in a Microsoft Word, WordPerfect, or searchable PDF format. Spreadsheets should be submitted in Microsoft Excel.

If the organization or sponsor opened the Remedy ticket by phone, or the initial email to the help desk did not include the supporting documentation, the subject line of the subsequent email should include the Remedy ticket number(s) associated with the supporting documentation.

Part D sponsors reporting an overpayment will also have to request a reopening of the payment year(s) in which the submission of inaccurate data occurred. The Part D sponsor will make the reopening request through the existing process and will not submit the reopening request as supporting documentation. See the section III.B “Overpayments Involving PDE or DIR Data” below for more information.

4. Contact Information for the “Other” Category

In addition to satisfying all of the other reporting requirements described in this section of the memorandum, an organization or sponsor that reports an overpayment in the “Other” category should provide the name, telephone number, and email address of a person who is permitted to discuss how the overpayment will be returned to CMS (i.e., by offset, electronic funds transfer, or check). The contact information may be submitted with the supporting documentation, or it may be provided to the help desk by telephone and associated with the Remedy ticket.

If the organization or plan is reporting an overpayment that is based on data that the organization or sponsor no longer has due, for example, to a catastrophic system loss, it should also provide the supporting documentation described in section II.B.3.

5. Updating Existing Remedy Tickets

An organization or sponsor may need to update an existing Remedy ticket when it discovers additional overpayments that match the description of an overpayment in an existing Remedy ticket (e.g., when an organization discovers it needs to delete additional risk-adjustment data occurring in the 2010 payment year for H8888 after it already opened a Remedy ticket for risk adjustment data for that contract number and payment year). The organization or sponsor may add that information to the existing Remedy ticket by emailing the help desk.

The subject line of the email should include the following phrase “Update Remedy ticket number” and the Remedy ticket number.

The following information should be included in the body of the email:

- Parent Organization
- Contract Number(s)
- Overpayment Error Category (Risk Adjustment, PDE/DIR, LIPS for EGWP, or Other)
- Payment Year for Overpayment

III. Returning Overpayments

Once an organization or sponsor reports an overpayment to the help desk and has obtained a Remedy ticket, it must return the associated overpayment to CMS no later than 60 days after the date on which the organization or sponsor identified the overpayment. Overpayments involving risk adjustment (i.e., RAPS and encounter data), PDE, or DIR data are returned to CMS by the process of sending the corrected data to the appropriate CMS system in accordance with the existing instructions provided by CMS for the submission of such data. The majority of this section discusses how the data are submitted to CMS.

However, there are situations where the return of an overpayment may not involve the submission of corrected data, for example, when the data are no longer available due to a catastrophic system loss. In those instances, CMS will either conduct a payment offset against the contract's prospective monthly payments, or may request that the MA organization or Part D sponsor send the funds directly to CMS in order to return the overpayment.

CMS generally expects that an organization's or sponsor's return of overpayments will be implemented with the submission of corrected data. CMS' systems will then recover the returned overpayment through routine processing according to our payment systems' schedules. See Section III.D for information on handling the rare exception when corrected data cannot be submitted to CMS.

The following sections outline how the specific categories of overpayments must be returned to CMS.

A. Overpayments Involving Risk Adjustment Data

1. General

A risk adjustment-related overpayment involves erroneously submitted diagnoses that were submitted to CMS prior to the risk adjustment data submission deadline but were not deleted by the risk adjustment data submission deadline. These diagnoses may be included in both Part C and/or Part D risk scores. The diagnoses must be deleted through an overpayment risk adjustment file submission to RAPS no earlier than the day after the organization reports the overpayment to the help desk and obtains a Remedy ticket number. If the organization attempts to submit the delete file to RAPS sooner than that, the submission will be rejected by the system.

Overpayments must be submitted to RAPS in the following format:

1. The entire RAPS file must only contain deletes;
2. Only one payment year can be submitted per file;
3. The PROD-TEST-IND in the AAA record must be populated with OPMT;
4. The assigned Remedy Ticket Number must be placed in the OVERPAYMENT-ID field in the BBB record;
5. The contract number that is in the BBB record must match the contract number that is in the assigned Remedy ticket;
6. The payment year of the deletes being processed must be populated in the PAYMENT-YEAR field on the BBB record; and
7. The DELETE-IND field in the CCC record must be populated with a 'D' for each diagnosis code on the file.

CMS updated the RAPS File Format to include the Overpayment fields described above. An organization will use the overpayment fields only when reporting overpayments to CMS.

For more information about the new RAPS file format and RAPS error codes, please see the memorandum "Announcement of the November 2014 Software Release" published by CMS through the Health Plan Management System (HPMS) on August 12, 2014, or visit <http://www.csscooperations.com>.

For guidance on deleting and correcting encounter data, please see the information from the August 14, 2014 Encounter Data National Technical Assistance materials, available at <http://www.csscooperations.com> (Medicare Encounter Data/Training Information).

2. Recovery Process

The risk adjustment-related overpayments will be addressed through our routine payment processes. CMS will announce the prior payment years for which we will rerun risk scores on an annual basis and will provide rerun-specific schedules as they become available. When CMS completes a rerun for the payment year in order to incorporate reported risk adjustment overpayments (deletes), the payment adjustments will be automatically processed by the Medicare Advantage and Prescription Drug System (MARx) and will appear on the corresponding Monthly Membership Report (MMR). CMS will announce when each completed risk score rerun will go into payment in the corresponding monthly payment letter that is sent to organizations and sponsors.

3. Contact Information

Questions regarding the return and recovery of identified RAPS-related overpayments may be sent to riskadjustment@cms.hhs.gov. Questions regarding encounter data may be sent to encounterdata@cms.hhs.gov.

B. Overpayments Involving PDE or DIR Data

1. General

PDE data or DIR data may be the source of a Part D-related overpayment. After receiving a Remedy ticket number from the help desk, the Part D sponsor will return the Part D-related overpayment to CMS in accordance with the guidance contained in this section.

The Part D sponsor will request a reopening through the Part D Payment Reconciliation Support Contractor, currently Acumen, LLC, in accordance with reopening instructions provided in the HPMS memorandum “The Part D Reopenings Process and the Part D Appeals Process” published on May 8, 2008. Pursuant to that guidance, the Part D sponsor should provide sufficient documentation of the reason(s) for the reopening request. The documentation should include the Remedy ticket number associated with the Part D-related overpayment. The Remedy ticket number should be provided in the column titled, “Reason for Reopening Request” in the reopening spreadsheet.

The Part D sponsor may submit an electronic copy of the reopening request and all applicable documentation to PartDPaymentSupport@acumenllc.com

Alternatively, the Part D sponsor may send the reopening request and all applicable documentation to:

Acumen, LLC
Attn: Part D Payment Support
500 Airport Blvd., Suite 365
Burlingame, CA 94010

2. Overpayments Involving PDE Data

If PDE data is the source of the Part D-related overpayment, the Part D sponsor will adjust, delete, or resubmit the PDE data to rectify the reported overpayment. Corrected PDE data may be submitted immediately after a Remedy ticket number is assigned for the overpayment.

As described in the HPMS memorandums “Updates to the Prescription Drug Event (PDE) layout and the Coverage Gap Discount Program (CGDP) Reconciliation Reports,” published on September 4, 2014, and “Updates to the Prescription Drug Event (PDE) layout- Adjustment Reason Code and Adjustment Reason Code Qualifier,” published on October 3, 2014, the Part D sponsor will use the Adjustment Reason Code

Qualifier field and the Adjustment Reason Code field on the PDE to associate the Remedy ticket number with each adjusted, deleted, or resubmitted PDE to rectify the reported overpayment. The Part D sponsor will submit the PDEs with an Adjustment Reason Code Qualifier of '1' and an Adjustment Reason Code that is the 12-digit Remedy ticket number with leading zeroes (i.e., 000001234567).

Note that the Part D sponsor should only associate the Remedy ticket number with the PDEs that are the direct cause of the overpayments. For example, a Part D sponsor finds that it paid for a National Drug Code (NDC) that is not a Part D drug, which results in the beneficiary entering into the catastrophic phase earlier than he or she should have. To correct the overpayment, the Part D sponsor will report the overpayment to the help desk, receive a Remedy ticket number, and adjust or delete the PDE associated with the non-Part D NDC in accordance with the point-of-sale claims adjustment guidance released through HPMS on July 3, 2013, for benefit years 2012 and beyond. The Part D sponsor will use the Adjustment Reason Code Qualifier field and the Adjustment Reason Code field on the PDE to associate the Remedy ticket number with the adjusted or deleted PDE. If the sponsor needs to adjust subsequent PDEs, the Adjustment Reason Code is not required on the subsequent PDE adjustments.

3. Overpayments Involving DIR Data

If DIR data is the source of the Part D-related overpayment, the Part D sponsor will modify the DIR data to rectify the reported overpayment. DIR overpayments may be returned after a Remedy ticket number is assigned to the reporting entity (i.e., the Part D sponsor may request a reopening). The Part D sponsor should submit the revised DIR data in a manner consistent with the annual Medicare Part D DIR Reporting Requirements released mid-year. The resubmission window for submitting DIR reports for previous benefit years occurs in the month of July. The Part D sponsor will satisfy the requirement to return the overpayment by submitting a reopening request to Part D Payment Reconciliation Support Contractor, which is currently Acumen, LLC, and subsequently resubmitting the DIR report for the applicable year during the next DIR resubmission window. See, for example, the HPMS memorandum "Final Medicare Part D DIR Reporting Requirements for 2013," Section G "Resubmitting Summary DIR Reports for Prior Coverage Years" published on May 28, 2014. When resubmitting the DIR report, the sponsor should report the Remedy ticket number in the "Explanation for Resubmission" text box in the DIR submission information. In this text box, the sponsor should report the Remedy ticket number and the dollar amount adjusted for each DIR column associated with the overpayment on the report. If insufficient information is reported in this text box, CMS may contact the sponsor to provide additional information in the "Explanation for Resubmission" text box.

4. Recovery Process

CMS will recover overpayments involving PDE or DIR data through the routine Part D payment processes. The reopening schedule will be developed by CMS and announced through HPMS memoranda. CMS may reopen and revise an initial or reconsidered payment determination consistent with 42 CFR § 423.346. However, CMS typically performs one global reopening each year. We anticipate being able to recover the majority of overpayments through this global reopening process but may perform targeted reopenings at our discretion consistent with § 423.346.

5. Contact Information

Questions regarding the return and recovery of identified Part D-related overpayments may be sent to pdejan2011@cms.hhs.gov.

C. Overpayments Involving LIPS for EGWP Members

1. General

An overpayment occurs when the total of the LIPS payment from CMS and the EGWP contribution for a beneficiary exceeds the premium amount. In this case, the plan sponsor must return the portion of CMS's LIPS payment that exceeds the premium amount. Since there is no automated method for determining the amount that an EGWP is paying on behalf of a member, CMS must manually collect the LIPS overpayment. Plans currently report the LIPS overpayment amounts to the CMS Regional Offices. Effective January 1, 2015, a sponsor should report a LIPS overpayment by obtaining a Remedy ticket and submitting a Microsoft Excel spreadsheet to the help desk indicating the contract numbers and associated overpayments. The submission of this spreadsheet will satisfy the requirement of returning the LIPS overpayment made to the EGWP.

2. Recovery Process

CMS will offset the LIPS overpayment amount from a future monthly payment to the plan sponsor. When the overpayment is processed, CMS will announce the adjustments in the appropriate monthly plan payment letter, and organizations or sponsors can verify the adjustments on the Plan Payment Report.

3. Contact Information

Questions regarding the return and recovery of overpayments involving LIPS for EGWP members may be addressed to the help desk.

D. Overpayments in the "Other" Category

1. General

Once an organization or sponsor has reported an overpayment in the "Other" category to the help desk, obtained a Remedy ticket, and submitted the required documentation described in section II.B.3, a CMS representative will contact the organization or sponsor to discuss how the overpayment will be returned to CMS (i.e., by offsetting a monthly payment, electronic funds transfer, or check).

2. Recovery Process

Once an overpayment return method is determined, the CMS representative will provide information about how to return the payment to CMS. If an offset is possible, the return requirement is met on the date the agreement to offset is reached. If the funds must be returned to CMS by electronic transfer or check, the return requirement is met when CMS receives the electronic transfer or check.

3. Contact Information

Questions regarding the return and recovery of identified "Other"-related overpayments may be addressed to the help desk.

IV. How Overpayments will be Processed by CMS and Closing Remedy Tickets

CMS will process overpayments differently depending on the category of overpayment that is being returned to CMS.

If an overpayment is returned to CMS by submitting revised Risk Adjustment, PDE, or DIR data to the appropriate system, CMS will use our routine processes to recover the overpayment. This will depend on

the schedule for conducting reruns/reopenings for that data type and payment year. When a rerun/reopening has been completed, the associated payment adjustments will be processed and reported in a subsequent monthly payment and MMR/plan payment report.

Overpayments returned by electronic transfer or check will be processed upon receipt. If CMS is able to offset a sponsor's monthly payment to resolve an overpayment, it will be processed in a future payment.

CMS will close the associated Remedy ticket when the overpayment has been processed. MA organizations and Part D sponsors will receive a notice from the Remedy system when tickets are closed. Once a ticket is closed, it may not be reopened for updating.

V. Risk Adjustment Data Validation (RADV)

MA organizations that are selected for a RADV audit will be subject to special procedures relating to risk adjustment data and overpayments. MA organizations that are selected for a RADV audit will receive information about these procedures at the start of the RADV audit process.

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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA**

CASE NO. 2:16-cv-08697-MWF(SSx)

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

Plaintiff,

v.

UNITEDHEALTH GROUP, INC. *et al.*,

Defendants.

**DECLARATION OF MARYBETH
MEYER IN SUPPORT OF
UNITED'S OPPOSITION TO
PLAINTIFFS' JOINT MOTION
PURSUANT TO RULE 16(b)(3)
FOR ISSUANCE OF
SCHEDULING ORDER
MODIFYING EXTENT OF
DISCOVERY**

*[Opposition to Plaintiffs' Joint Motion
Pursuant to Rule 16(b)(3); Declaration
of Abid R. Qureshi; and Declaration of
Rebecca Martin filed concurrently
herewith]*

Date: September 17, 2018
Time: 10.00 a.m.
Courtroom: 5A
Judge: Hon. Michael W. Fitzgerald

DECLARATION OF MARYBETH MEYER

I, MaryBeth Meyer, hereby declare as follows:

1. I am a Vice President, Finance at UnitedHealthcare, one of the UnitedHealth Defendants (hereinafter “United”). I make this declaration in support of United’s Opposition to the Plaintiffs’ Joint Motion Pursuant to Rule 16(b)(3) for Issuance of a Scheduling Order Modifying Extent of Discovery in this matter.

2. I have personal knowledge, information, or belief of the facts stated herein and, if called as a witness, I could and would testify competently thereto.

3. I have held my current position of Vice President, Finance at UnitedHealthcare since September 2016.

4. Prior to that role, I served as Vice President, General Management at UnitedHealthcare, Finance, from December 2012 to September 2016.

5. In both of these roles, my responsibilities have included, but were and are not limited to, approving risk adjustment delete submissions made to the Centers for Medicare & Medicaid Services (“CMS”) on United’s behalf, and managing the team performing financial analysis of the reconciliation and corresponding payment adjustments made by CMS.

6. As a result, I have significant experience with, and extensive involvement in and knowledge of United’s risk adjustment delete submissions, including delete submissions made after the deadline for submitting codes has passed (“closed period deletes”), and CMS’s corresponding payment adjustments.

7. As described in more detail in my colleague’s declaration, I am aware of numerous instances where CMS has rejected Optum’s attempts to submit closed period deletes on United’s behalf. *See* Decl. of Rebecca Martin at p. 3-4.

8. After receiving a closed period delete file submission, CMS performs a reconciliation and determines whether or not to recover any related payments. I

1 am personally aware of closed period delete files that Optum submitted to CMS on
2 United's behalf in 2011 for which CMS has not yet fully recouped corresponding
3 payments. My colleagues and I have sent email correspondence to CMS officials
4 on multiple occasions over the years in an attempt to resolve this issue without
5 success.

6
7 I declare under penalty of perjury that the foregoing is true and correct.

8 Executed on August 27, 2018, in Minnetonka, Minnesota.

9
10 By MaryBeth Meyer
11 MaryBeth Meyer
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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA**

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

Plaintiff,

v.

UNITEDHEALTH GROUP, INC. *et al.*,

Defendants.

CASE NO. 2:16-cv-08697-MWF(SSx)

**DECLARATION OF ABID R.
QURESHI IN SUPPORT OF
UNITED'S OPPOSITION TO
PLAINTIFF'S JOINT MOTION
PURSUANT TO RULE 16(b)(3)
FOR ISSUANCE OF
SCHEDULING ORDER
MODIFYING EXTENT OF
DISCOVERY**

*[Opposition to Rule 16(b)(3) Motion,
Declaration of MaryBeth Meyer, and
Declaration of Rebecca Martin filed
concurrently herewith]*

Hon. Michael W. Fitzgerald
Courtroom: 5A

Date: September 17, 2018
Time: 10:00 a.m.

DECLARATION OF ABID R. QURESHI

I, Abid R. Qureshi, hereby declare as follows:

1. I am a partner at Latham & Watkins LLP, the law firm which represents Defendant UnitedHealth Group Incorporated and its affiliated entities named as Defendants in this action (collectively, "United"). I submit this Declaration in support of United's Opposition to Plaintiffs' Joint Motion Pursuant to Rule 16(b)(3) for Issuance of Scheduling Order Modifying Extent of Discovery. I have personal knowledge, information, or belief of the facts stated herein and, if called as a witness, I could and would testify competently thereto.

2. Attached as **Exhibit 1** is a true and correct copy of a transcript excerpt from a December 18, 2017 telephonic discovery conference before the Honorable Suzanne H. Segal in this litigation.

3. Attached as **Exhibit 2** is a true and correct copy of a transcript excerpt from an April 9, 2018 scheduling conference before the Honorable Michael Fitzgerald in this litigation.

4. Attached as **Exhibit 3** is a true and correct copy of a transcript excerpt from a February 8, 2018 telephonic discovery conference before the Honorable Suzanne H. Segal in this litigation.

5. Attached as **Exhibit 4** is a true and correct copy of a transcript excerpt from an August 16, 2018 telephonic discovery conference before the Honorable Suzanne H. Segal in this litigation.

6. Attached as **Exhibit 5** is a true and correct copy of a transcript from an August 8, 2018 motions hearing before the Honorable Rosemary M. Collyer in *UnitedHealthcare Insurance Co. v. Azar*, No. 1:16-cv-00157, (D.D.C.).

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

3
4 Executed: August 27, 2018, at Washington, D.C.

5
6 By: /s/ Abid R. Qureshi
7 Abid R. Qureshi
8 Attorney for United Defendants
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EXHIBIT 1

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION - LOS ANGELES

UNITED STATES OF AMERICA,	)	CASE NO: 2:16-CV-08697-MWF-SS
	)	
Plaintiff,	)	CIVIL
	)	
vs.	)	Los Angeles, California
	)	
UNITED HEALTH GROUP, INC,	)	Monday, December 18, 2017
ET AL,	)	
	)	
Defendants.	)	

TELEPHONIC CONFERENCE RE DISCOVERY

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

<u>APPEARANCES:</u>	SEE PAGE 2
Court Reporter:	Recorded; XTR 12/18/17
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.

EXCEPTIONAL REPORTING SERVICES, INC

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Los Angeles, California; Monday, December 18, 2017

(Call to Order)

THE CLERK: Hi. This is Clerk to Judge Segal, Marlene Ramirez. We're here today on the record on Case CV-16-8697, United States of America, et al. versus United Health Group, Inc., et al. Counsel, please state your appearance.

MR. FREEBORNE: This is Paul Freeborne. I'm joined on the call today by John Lee from the U.S. Attorney's Office.

THE COURT: Good afternoon.

MR. SU: And this is -- and this is Henry Su from Constantine Cannon appearing on behalf of Relator. I'm also joined by John Lahad from Susman Godfrey also for Relator.

THE COURT: Good afternoon.

MR. SCHINDLER: And this is David Schindler from Latham and Watkins and I'm joined by Dan Meron and Abid Qureshi on behalf of United.

THE COURT: Good afternoon.

All right. So Mr. Schindler, maybe you could share with us what this is about and then -- and then I'll hear from counsel for the United States and the Relator.

MR. SCHINDLER: Absolutely. Good afternoon, your Honor.

We're here on really the government's request as part of an anticipated motion that the government intends to bring

1 seeking a protective order to preclude United from proceeding
2 with a deposition that has been noticed for mid-February. You
3 may recall from our last informal conference at that point in
4 time the question of the -- of United's right to proceed with
5 depositions came up. We discussed it with you. There was a
6 question about holding a Rule 26 conference which in fact
7 proceeded in conjunction with the schedule that we discussed
8 with you back in November.

9 And at this point the government has indicated to us
10 that they intend to seek a protective order from the Court,
11 from you, barring us from proceeding with the deposition and
12 particularly have been in two depositions that have been
13 noticed. One is of a former government employee named Marilyn
14 Tavner (phonetic), the other is of an individual named Jeffrey
15 Grant who is still employed by the government. And so this
16 informal conference was called by the government and is the
17 first step in conjunction with their anticipated motion for a
18 protective order.

19 **THE COURT:** All right. Thank you.

20 So for the United States?

21 **MR. FREEBORNE:** Your Honor, this is Paul Freeborne.

22 So first to be clear, we seek to defer the
23 depositions until the Court, Judge Fitzgerald, rules on
24 dispositive motions. The defendants have filed a motion to
25 dismiss. We're likely to join on the same issues in a motion

1 for partial summary judgment. We believe that a ruling on
2 those issues will define the scope of discovery under 26(d) and
3 therefore it's appropriate to defer any depositions until the
4 Court rules on the parties' dispositive motions. And that's
5 really our essential argument, your Honor, in terms of just
6 efficiency, also to alleviate any undue burden on the
7 witnesses, one of whom is, like we said, a former government
8 official. She is the former administrator of CMS. And so
9 again, while it's a good-cause standard, we also need to be
10 cognizant, in our view, of the undue burden that we're placing
11 on third parties.

12 **THE COURT:** And what is that burden? I'm not
13 following.

14 **MR. FREEBORNE:** Well, just first and foremost that
15 the case would be aided by ruling on the dispositive motions
16 because the legal issues that will be joined by the parties in
17 their respective motions are likely to be at least instructive
18 if not dispositive of the depositions in that they -- we could
19 potentially narrow the scope of depositions, if not negate them
20 all together, depending on the Court's legal rulings.

21 The parties will be filing motions on materiality
22 which relates to the government's payment process. Depending
23 on the Court's legal rulings there, neither deposition may be
24 necessary.

25 **THE COURT:** All right. So let me ask what the nature

1 she has outside of -- that the government may not have.

2 **THE COURT:** All right. And then as to the other
3 witness?

4 **MR. SCHINDLER:** Mr. Grant is currently there. He was
5 also part of -- his role -- and again, a little hard to
6 articulate in the context of our informal conference but he
7 played a seminal role in some of the actuarial issues that are
8 at issue here and (indisc.) are more complicated but again, he
9 was somebody who we believe can disprove fundamentally or at
10 least allow us to test some of the validity of the allegations
11 that are contained in the government's complaint.

12 **THE COURT:** All right. So yeah, this all sounds
13 familiar to me from our last discussion. Well, not all the
14 various details but they're kind of coming back to me. And I
15 don't have a different feeling than I had when we talked about
16 it before. And it may be that the United States and their
17 counsel have different experiences in other parts of the
18 country but it's our practice here that as soon as the parties
19 hold their Rule 26 meet -- meeting, that a discovery plan is
20 created and the parties can proceed with discovery. And
21 particularly in a case like this of what appears to be some
22 degree of complexity, I would suspect that Judge Fitzgerald --
23 I don't know that -- but I would suspect that he would prefer
24 that people immediately begin discovery and not delay it for
25 any purpose.

1 And in terms of the burden on the two witnesses,
2 because the deposition date is set after the date of the motion
3 to dismiss hearing, I don't see exactly how they're presented
4 with an undue burden because you'll know very quickly, I think,
5 whether or not the motion to dismiss is going to be granted
6 without leave to amend or denied and what the status of the
7 case is. But if it is either granted with leave to amend or
8 it's denied and the defendant is ordered to answer, I would
9 suspect that it would be the court's preference that discovery
10 proceed as quickly as possible. So if it's (indisc.) on a
11 motion for protective order, I wouldn't find that the
12 articulated burden satisfies the good-cause standard here,
13 based on what's been provided to me, so I would probably deny
14 that motion if it came to me under the circumstances that the
15 parties have described.

16 Does that at all give you some guidance on how to
17 proceed?

18 **MR. FREEBORNE:** Your Honor, just one further point.
19 Again, the government, just to be clear, we are anticipating
20 filing a motion for partial summary judgment so I don't want
21 the Court left with the impression that it's just a motion to
22 dismiss. And again, we're going to join on the legal issues of
23 materiality that Counsel has represented that Ms. Tavner will
24 be deposed on. And so again, sort of (indisc.) -- and that may
25 -- if the ruling is favorable to the government -- limit

1 discovery. Just from an administrative standpoint, you know,
2 noticing a deposti -- or noticing a motion in the district,
3 incorporating the Court's findings, we would ask for some
4 latitude there. The February 13th and 20th just doesn't give
5 us enough time to move for a protective order incorporating the
6 Court's rulings. So we would ask at a minimum for that, just
7 enough time to incorporate the Court's rulings.

8 **THE COURT:** And Judge --

9 **(Voices overlapping)**

10 **MR. FREEBORNE:** (indisc.)

11 **THE COURT:** -- ruling on the motion to dismiss?

12 **MR. FREEBORNE:** On either the motion for partial
13 summary judgment or on the motion to dismiss.

14 **THE COURT:** When are you planning to set the motion
15 for partial summary judgment for hearing?

16 **MR. FREEBORNE:** Well we'll exchange schedules
17 tomorrow with Opposing Counsel but I can generally I think
18 early February.

19 **THE COURT:** All right. I mean, one thing that I have
20 seen -- there may be exceptions to this -- but generally with
21 Judge Fitzgerald, he's got a ruling on a pending motion very
22 quickly in conjunction with the hearing. So -- and not all of
23 our judges operate on that same or follow that same practice so
24 -- and there could be exceptions to it in various cases. But I
25 think I could comfortably say that I would predict that you'll

1 have an order in early February on the motion for summary
2 judgment.

3 So you're saying that a February 13th and 20th date
4 doesn't give you enough time to incorporate the findings on
5 that and you think the scope of discovery will be too broad?

6 **MR. FREEBORNE:** Well, it just wouldn't allow us
7 enough time to file a properly noticed motion incorporating the
8 Court's findings. And that's why we suggested having the Rule
9 16(b) at the same time oral argument is heard with the mind
10 that if we have a tentative ruling then the Court -- we could
11 gear the parties out as to the appropriate scope of discovery
12 moving forward. Absent that, again, we wouldn't have enough
13 time to file a properly noticed motion under the Local Rules.

14 **THE COURT:** I mean, you know, parties bring motions
15 for partial summary judgment all the time here. Sometimes they
16 win, sometimes they lose. But we tend not to halt discovery in
17 the anticipation that they may win their motion for partial
18 summary judgment. It's just -- I recognize that that's not
19 exactly how every party would like us to handle discovery. It
20 would be perhaps cleaner and neater if we could just conduct
21 discovery on only those issues that will survive a motion for
22 partial summary judgment but that's not the practice here. The
23 practice is that the claims and defenses are framed by the
24 complaint and by the answer. But even if there's no answer on
25 file, we generally let the defendant proceed to address the

1 allegations in the complaint through discovery and we don't --
2 we don't wait. We've had too many cases --

3 **MR. FREEBORNE:** Your Honor, I'm sorry. I'm having a
4 hard time hearing. Somebody is breathing really into the phone
5 so whoever it is, can you just take a step back from there but
6 not the judge.

7 **THE COURT:** Anyway, I was just saying that I
8 understand why the government would prefer the kind of
9 structured process that they are suggesting but that isn't --
10 that isn't my understanding of how we handle discovery here.
11 That we just -- we do not tend to stay discovery or block
12 discovery under the possibility that a party may prevail in a
13 motion for partial summary judgment. There may be exceptions
14 to that and times in which, you know, discovery is stayed for
15 various reasons but it's really the exception and not the
16 common practice here. So -- and I guess the taking of two
17 depositions doesn't, for me, generally rise to the level of
18 undue burden for a party. So I just haven't heard a reason
19 from the United States that, in my mind, would satisfy the
20 good-cause standard.

21 **MR. SCHINDLER:** Well, your Honor, we thank you for
22 your time.

23 **THE COURT:** All right. I wish I could be of more
24 assistance to you. I guess what I would hope that the parties
25 would do, if you're going to schedule that motion for partial

CERTIFICATION

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



December 21, 2017

Signed

Dated

TONI HUDSON, TRANSCRIBER

EXHIBIT 2

1 UNITED STATES DISTRICT COURT
2 CENTRAL DISTRICT OF CALIFORNIA - WESTERN DIVISION
3 HONORABLE MICHAEL FITZGERALD U.S. DISTRICT JUDGE
4

5 UNITED STATES ex rel)
6 BENJAMIN POEHLING,)
7)
8 Plaintiffs) CV-16-8697-MWF
9 VS)
10)
11 UNITEDHEALTH GROUP, INC.,)
12 et al,)
13)
14 Defendants)
15

16 REPORTER'S TRANSCRIPT OF PROCEEDINGS
17

18 LOS ANGELES, CALIFORNIA
19

20 Monday, April 9, 2018
21

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7
8 * * *

1 they want to see Magistrate Segal, we will go. But I don't
2 think there is any reason at all to treat this case any
3 differently. Indeed, to the contrary, our clients have a
4 right finally after seven years to try and clear their name.

5 THE COURT: There is -- there is obviously going to
6 be multiple issues for Judge Segal here. Right now there is
7 two issues for me: One is whether to have sort of this
8 overall phasing or quasi-phasing as set forth in the report.
9 And the answer to that is going to be no.

10 To the extent that the defense wants to depose a
11 particular person, wants to do it a particular time, could
12 maybe work out with the Government getting certain documents.

13 On the other hand, you know, the document -- the
14 Government in the report was laying out some -- just some
15 practical issues. You know, no matter how much UnitedHealth
16 might want to get documents by a certain date or pound on the
17 table, if there is a certain volume which the Government can
18 only process at a certain speed, if that -- if the date that
19 you are getting as to when they will be produced just seems
20 to one side to be unreasonable, then you can go to Judge
21 Segal, who is much more versed in these matters and the
22 mechanics of it than I am, and I'm sure she will know, based
23 on her extensive experience, whether the amount of time that
24 the Government is taking is reasonable or not.

25 But what this comes down to is there is going to be

1 this phasing, to which I just said the answer is no. The
2 other thing is how much time does there have to be. When the
3 case is this big, I would rather pick a trial date which I am
4 certain is realistic, which the parties are certain is
5 realistic, which witnesses can count on, which I can plan my
6 vacation around, if it's going to be of the length that both
7 sides are suggesting, and that seems to me to be something
8 which is closer to February 18th, 2020 than August 27th,
9 2019.

10 And I do think that the ability to, in a way which
11 is cooperative, to resolve many of these specific discovery
12 disputes, can simply get resolved if there is less of a
13 concern. You know, I suspected that the difference, because
14 it's often the case, was between the one -- was between of
15 the trial dates just arose from the difference that was
16 suggested for the discovery cutoff.

17 And what I'm going to do here is take the actual
18 dates under submission. Both sides, within a week from
19 today, if you wish to propose a different discovery date than
20 the two dates that you proposed and the reasons for those
21 dates, then you may do so. Like spend no more than like two
22 pages. I don't want this to be some tome. And the issue
23 here isn't so much a trial date, it's clearly the discovery
24 cutoff is driving the dates both before and after. So if I
25 can pick a fair date for that, then it shouldn't be difficult

1 depositions until that happens. If you want to go ahead,
2 then go ahead. But again, absent something extraordinary,
3 you aren't going to be able to depose the person a second
4 time. You already know that. You already figured this out
5 on the other depositions. So it's really you've got to
6 decide what is in the interests of your client.

7 MR. SCHINDLER: The other thing I will add on that --
8 and I agree entirely with everything you said -- this issue
9 will come up, and we will end up having to depose people
10 twice in part because, as Ms. Wallack has said, they've had
11 this expansive assertion of deliberative privilege where they
12 are essentially instructing witnesses not to answer.

13 THE COURT: But that is for Judge Segal to resolve
14 the objections. That is a garden variety thing. So we don't
15 need to worry about that, or I don't need to worry about it,
16 she does.

17 All right. Thank you, counsel.

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I certify that the foregoing is a correct transcript from the
record of proceedings in the above-titled matter.

Amy C. Diaz, RPR, CRR April 20, 2018
S/ Amy Diaz

EXHIBIT 3

1
2
3
4 UNITED STATES DISTRICT COURT
5 CENTRAL DISTRICT OF CALIFORNIA
6 WESTERN DIVISION

7 UNITED STATES OF AMERICA,)
8)
9)
10 PLAINTIFF,)
11)
12 V.)
13)
14 UNITEDHEALTH GROUP, INC.,)
15 ET AL.,)
16) 16-CV-08697-MWF(SSX)
17 DEFENDANTS.) FEBRUARY 8, 2018
18 _____)

19
20 TELEPHONIC CONFERENCE

21
22 BEFORE THE HONORABLE SUZANNE H. SEGAL
23 UNITED STATES MAGISTRATE JUDGE

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TRANSCRIPT PRODUCED BY TRANSCRIPTION SERVICE.

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FEBRUARY 8, 2018

Exhibit 3 - 024

1 PRIORITIZE THEM WHICH IS WHY WE'RE NOT GOING TO SEE DATA OR
2 DOCUMENTS PERTAINING TO THOSE WITNESSES UNTIL THE END OF MARCH.
3 AND THAT'S WHAT'S CAUSED THE CONSTERNATION YOU'RE HEARING FROM
4 US.

5 THE COURT: ALL RIGHT.

6 SO, YOU KNOW, AS I THINK I'VE SHARED WITH THE PARTIES
7 WHEN WE HAD ONE OF THESE CONFERENCES PREVIOUSLY, I GENERALLY --
8 YOU KNOW, WITH SOME EXCEPTIONS, BUT I GENERALLY DON'T ISSUE
9 ORDERS FROM THESE INFORMAL CONFERENCES BECAUSE IT HASN'T BEEN
10 FULLY BRIEFED. AND OFTENTIMES PARTIES FEEL THAT IT'S UNFAIR
11 FOR THE COURT TO ISSUE AN ORDER WITHOUT BRIEFING.

12 BUT I TRY TO GIVE YOU AN UNDERSTANDING OF HOW I WOULD
13 APPROACH THIS PROBLEM IF IT CAME TO ME ON A MOTION. AND I DO
14 THINK THAT THE DEFENDANT HAS A RIGHT TO, YOU KNOW, VIGOROUSLY
15 AND QUICKLY DEFEND ITSELF.

16 AND SO -- AND WE DON'T-- YOU KNOW, WE DON'T HAVE
17 BUILT-IN DELAYS OR BUILT-IN PHASING NECESSARILY IN FEDERAL
18 COURT. WE SOMETIMES PHASE DISCOVERY, BUT USUALLY WHEN WE DO
19 THAT IT'S WITH BOTH PARTIES' AGREEMENT ABOUT THE USEFULNESS OF
20 PHASING.

21 IF ONE SIDE GETS TO DICTATE SORT OF THE PHASING OF
22 DISCOVERY, SOMETIMES THAT CAN BE USED AS A STRATEGY POINT IN A
23 CASE. AND THAT'S WHAT WE TRY TO AVOID.

24 SO, I WOULD -- I WOULD LOOK TO SEE IN THE
25 DECLARATIONS THAT I WOULD ANTICIPATE BEING FILED BY THE UNITED

1 STATES THE INDIVIDUALS WHO ARE INVOLVED IN THE DISCOVERY
2 PROCESS AND FOR A MORE DETAILED EXPLANATION AS TO WHY THE
3 DELAY.

4 AND I AM TROUBLED THAT THEY'RE NOT WILLING TO
5 PRIORITIZE. IF A NOTICE OF DEPOSITION WAS TIMELY SERVED, AND
6 THERE WAS A REQUEST FOR PRODUCTION OF DOCUMENTS WITH THAT
7 NOTICE OF DEPOSITION, I WOULD EXPECT THE GOVERNMENT TO
8 PRIORITIZE THEIR REVIEW OF THOSE DOCUMENTS AND PRODUCE THEM IN
9 A TIMELY WAY.

10 AND IF MR. SCHINDLER NOTICED THESE DEPOSITIONS AND,
11 YOU KNOW, REALLY THE RULE IS REASONABLE NOTICE. TWO MONTHS IS
12 -- YOU KNOW, THAT'S OFTEN INTERPRETED AS 10 DAYS.

13 SO -- AND I UNDERSTAND THIS IS A MUCH BIGGER CASE
14 THAN MAYBE THE AVERAGE CASE. BUT STILL 60 DAYS WOULD COMMONLY
15 BE SEEN AS QUITE REASONABLE NOTICE.

16 AND, SO, I WOULD EXPECT THE UNITED STATES TO PRODUCE
17 DOCUMENTS UNLESS THEY COULD SHOW GOOD CAUSE WHY THEY COULD NOT.
18 AND THE MERE FACT THAT A CASE HAS VOLUMINOUS RECORDS IS NOT
19 GOOD CAUSE.

20 AND, SO, YOU KNOW, I WOULD PROBABLY, AGAIN, IF THIS
21 CAME TO ME ON A MOTION, I WOULD HAVE TO SEE, YOU KNOW, WHAT
22 EFFORTS HAD BEEN MADE TO PRODUCE DOCUMENTS FOR THOSE PARTICULAR
23 WITNESSES. THEY HAVE A RIGHT TO NOTICE DEPOSITIONS. WE
24 HAVEN'T ENTERED A PROTECTIVE ORDER. AND I TOLD YOU THAT I
25 WOULDN'T LIKELY ENTER A PROTECTIVE ORDER BECAUSE THERE'S

1 NOTHING IN THE RULES THAT WOULD JUSTIFY IT HERE.

2 SO, YOU KNOW, I THINK WHAT WILL BE THE BETTER
3 APPROACH HERE -- AND IT'S GOOD FOR THE PARTIES IN A SENSE THAT
4 THERE'S NO CUT-OFF DATES YET SET, BUT I'M SURE ONCE YOU HAVE
5 YOUR SCHEDULING CONFERENCE, THEY WILL BE SET. AND I'M SURE
6 JUDGE -- JUDGE FITZGERALD WILL SET THAT SHORTLY AFTER HE ISSUES
7 A FINAL ORDER ON THE MOTION TO DISMISS.

8 AND GIVEN THE COMPLEXITY OF THIS CASE, AGAIN, I DON'T
9 THINK IT'S INAPPROPRIATE FOR A DEFENDANT TO BE MOVING QUICKLY
10 TO TRY AND GATHER INFORMATION AND PREPARE ITS DEFENSES.

11 SO, YOU KNOW, I WOULD -- I WOULD PROBABLY SET A FIRM
12 DEADLINE FOR THE PRODUCTION AS TO THESE TWO WITNESSES AND A
13 FIRM DATE FOR THEIR DEPOSITIONS TO BE TAKEN. AND, THEN, IF
14 THEY -- IF THOSE DEADLINES WERE MISSED, THERE WOULD HAVE TO BE,
15 YOU KNOW, SOME KIND OF CONSEQUENCE AS A RESULT OF MISSING IT
16 UNLESS THERE WAS GOOD CAUSE.

17 SO, I GUESS WHAT I'D LIKE TO KNOW FROM THE UNITED
18 STATES YOU KEEP SAYING THE END OF MARCH. AND I'M JUST TRYING
19 TO UNDERSTAND WHY IT IS YOU NEED ANOTHER ESSENTIALLY 45 DAYS
20 FOR TWO WITNESSES TO -- TO CULL OUT RECORDS AS TO TWO
21 WITNESSES.

22 MR. PERKINS: SURE, YOUR HONOR. I APPRECIATE THE
23 OPPORTUNITY TO RESPOND TO THAT QUESTION.

24 SO -- AND EXCUSE ME IF THIS BECOMES A LITTLE TOO
25 TECHNICAL, BUT -- SO, WITH THE TECHNOLOGY SYSTEM REVIEW

1 DEFENDANTS ABOUT THE PARTICULAR -- MAYBE HAVE A MORE -- A
2 BETTER UNDERSTANDING OF THE ISSUES THAT THE DEFENDANTS ARE
3 GOING TO RAISE IN MS. TAVENNER'S DEPOSITION. AND THEN WE CAN
4 IDENTIFY THOSE PARTICULAR REQUESTS AND PULL OUT THOSE
5 DOCUMENTS.

6 THE COURT: SO, I DON'T THINK THIS DEPOSITION IS
7 GOING TO GO FORWARD ON THE 13TH GIVEN THE TIMEFRAME RIGHT NOW.
8 BUT I DO THINK IT COULD GO FORWARD, SAY, IN THE NEXT 15 TO 20
9 DAYS.

10 AND I THINK WHAT THE APPROACH THAT I'D LIKE TO SEE
11 THE PARTIES PURSUE IS FOR THE DEFENDANTS TO IDENTIFY A LIMITED
12 SET OF ISSUES THAT THEY WANT TO DEPOSE THESE TWO WITNESSES ON
13 FOR WHICH THEY WOULD, GIVEN THEIR UNDERSTANDING OF THE CASE,
14 REASONABLY BELIEVE THAT THERE COULD BE A SUBCATEGORY OR A
15 SUBSET OF DOCUMENTS THAT COULD BE MANUALLY REVIEWED BY
16 PLAINTIFF'S COUNSEL.

17 AND THAT THEY -- AND THAT THEY WOULD KNOW THAT IF A
18 MASS PRODUCTION HAPPENED IN TWO MONTHS FROM NOW, THAT -- AND
19 THERE WERE ISSUES THAT WERE RELEVANT TO THAT PARTICULAR
20 WITNESS, THAT I WOULD -- I WOULD PERMIT A LIMITED -- AND I
21 EMPHASIZE LIMITED -- SECOND DEPOSITION OF THAT WITNESS. AND
22 THAT WOULD BE FOR THE PURPOSE OF MOVING THE CASE FORWARD, TO
23 ALLOW THE DEFENDANT TO EXPLORE ITS DEFENSES NOW THAT IT WANTS
24 TO RAISE WITH THE COURT. IF THE MOTION TO DISMISS IS PARTIALLY
25 DENIED, I WOULD SUSPECT THERE WOULD BE A SECOND MOTION OF SOME

1 KIND BROUGHT BY THE DEFENDANTS, AND THAT THIS TESTIMONY MIGHT
2 BE IMPORTANT TO THAT MOTION.

3 SO, AGAIN, I WOULDN'T WANT TO DELAY THE CASE AND
4 DELAY THEIR ABILITY TO DEFEND THEMSELVES.

5 SO, I GUESS I'D LIKE THE PARTIES TO MEET AND CONFER
6 ABOUT THOSE TOPICS AS TO THESE TWO WITNESSES. AND FOR THE
7 GOVERNMENT TO EXPLORE WHAT THEY CAN SEGREGATE OUT THAT WOULD BE
8 RESPONSIVE TO THOSE TOPICS AND SET UP A PRODUCTION TIMETABLE
9 FOR THE DOCUMENTS AND ALSO FOR THE DEPOSITIONS.

10 SO, MR. SCHINDLER, WHAT DO YOU THINK OF THAT
11 APPROACH.

12 MR. SCHINDLER: WELL, I THINK THAT'S PERFECT, YOUR
13 HONOR. IN FACT, I APPRECIATE MR. PERKINS ACKNOWLEDGING OR
14 HELPING US HERE WITH THE 55,000 DOCUMENTS. I MEAN, I -- I
15 THINK THOSE 55,000 DOCUMENTS AS AN INITIAL SET OUGHT TO BE
16 EASIER TO REVIEW AND TO SEGREGATE OUT EXACTLY AS THE COURT HAS
17 INDICATED. SO, I APPRECIATE IT VERY MUCH.

18 WE'RE PREPARED TO MEET AND CONFER FURTHER WITH THE
19 GOVERNMENT TODAY TO TALK ABOUT THOSE 55,000 DOCUMENTS AND TO
20 PUT OURSELVES ON A SCHEDULE ALONG THE LINES THAT THE COURT HAS
21 INDICATED. SO, APPRECIATE VERY MUCH.

22 THE COURT: DO YOU HAVE ANY QUESTIONS ABOUT THAT, MR.
23 PERKINS?

24 MR. PERKINS: WELL, MAYBE JUST A CLARIFYING POINT
25 JUST BECAUSE OF SOMETHING MR. SCHINDLER SAID.

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C E R T I F I C A T E

I CERTIFY THAT THE FOREGOING IS A CORRECT TRANSCRIPT
FROM THE ELECTRONIC SOUND RECORDING OF THE PROCEEDINGS IN THE
ABOVE-ENTITLED MATTER.

/S/ DOROTHY BABYKIN

2/11/18

FEDERALLY CERTIFIED TRANSCRIBER

DATED

DOROTHY BABYKIN

EXHIBIT 4

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,	)	Thursday, August 16, 2018
ET AL,	)	
	)	
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:

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1 discoverable information under 26(b)(5), and then to have the
2 Government assert and perfect on that.

3 And with respect to perfecting the privilege, your
4 Honor, or explaining the privilege, the case law that
5 Mr. Schindler references requires references of declaration.

6 So that's what we've been working with the agency to
7 see if that we can do that, so that we can provide a more
8 fulsome explanation in the hope of obviating any privilege
9 disputes.

10 So and that address -- I think that addresses both of
11 Mr. Schindler's points.

12 **THE COURT:** All right, thank you.

13 So here are my thoughts on this. And, you know, I'm
14 the last person to actually invite motion practice.

15 Now, this doesn't improve my workload, but, you know,
16 I think we're getting to the point where I'm not sure how much
17 value there is to the parties in -- in the informal process.

18 Because, generally, what I try to do is hear parties
19 out on an issue and say to them, so if this came to any motion,
20 I think this is how I would approach it so the parties can make
21 an informed decision about whether it's worth their time and
22 money to file a motion or whether or not, you know, given my
23 leanings, it makes more sense to try and resolve it a different
24 way.

25 So that's -- that's my general practice, would be

1 informal discovery conference. And -- and I will tell you that
2 one of the toughest issues that I find to resolve on an
3 informal discovery call is issues of privilege.

4 Because for discovery purposes, that usually often
5 will raise, really, a legal issue that is -- is more difficult
6 for -- for me to resolve without looking at the logs themselves
7 and -- and the types of documents.

8 But having said that, you know, it does seem to me
9 that we're back to a place that we were previously at with the
10 United States. And I respect very much your desire to do this
11 in an efficient manner and I know you're working hard and
12 you're very busy.

13 But, you know, I have limits to my authority.
14 There's limits to what I can do. And so I can't -- I can't say
15 to parties, "Oh, you have a potential motion that someday may
16 culminate a particular claim or defense. Sure, we'll stop
17 discovery on that."

18 I mean, I understand this case may be a little more
19 indifferent in the sense that the kinds of motions that you've
20 brought, you feel very confident, in some fashion, are going to
21 really narrow the case and limit the claims and defenses in the
22 case and focus the discovery. And maybe that's true.

23 But -- but in general speaking, if I adopted the
24 practice you're suggesting that I adopt, you know, parties
25 would be here every single day, saying, "Hey, I filed a Motion

1 to Dismiss. I don't want to respond to their discovery."

2 So it's not -- that's not a general practice that we
3 accept from Magistrate Judges who are managing discovery in a
4 case.

5 We take our cues from the District Judge who sets the
6 schedule in a case and gets to decide whether or not discovery
7 is stayed or not stayed. And I haven't heard anything from
8 Judge Fitzgerald.

9 I mean, you initiated the case; you knew the volume
10 of the case; you knew the response that you would likely get
11 from United; you are not new to this kind of litigation.

12 So it was, you know, that the -- the volume of work
13 involved in responding to discovery requests and participating
14 in this case was something the Government needed to kind of
15 assess before they filed the complaint in this action.

16 And if it was a situation where you knew that you
17 were going to need a stay until certain fundamental issues were
18 resolved, that Stay Motion needed to be filed a long time ago.

19 And I haven't seen -- I mean, I've seen the motion
20 that was filed before Judge Fitzgerald that's pending now, but
21 there are ways to get emergency relief.

22 I'm not suggesting that you should. This is not my
23 recommendation. I am not recommending that you file such a
24 motion or ex-parte application, but there are procedural
25 mechanisms available for parties who think they need immediate

1 relief in some fashion from the District Judge. Again, I'm
2 not endorsing that. I'm just saying it wasn't done here.

3 So in the absence of an order from the District Judge
4 staying discovery, I apply the Federal Rule. And the Federal
5 Rules say after a certain point, you know, discovery is open
6 and -- and going forward.

7 So I can apply periods of relevance and
8 proportionality as I go forward, and that's -- those are tools
9 for me to limit discovery. But I can't simply say no discovery
10 goes forward because there's a procedural motion out there.
11 That's just not a practice that we would -- that we could apply
12 fairly to parties.

13 So you know -- so, again, if this came before me and
14 the Government's argument was, you know, we really wanted to
15 wait until Judge Fitzgerald adjudicated our relevance issues,
16 you know, and our request for a stay in September, and this was
17 brought before me before that, I would say I can't stop
18 discovery on the potential that a judge may, someday, agree
19 with you on that issue.

20 So -- so that -- that's how I would respond if -- if
21 this issue of whether or not the Government has an obligation
22 to participate right now came before me.

23 On the issue of the -- the privilege logs, that's a
24 difficult issue. It comes up quite often. Because the test in
25 Rule 26 is not entirely helpful. The test is, under Rule

CERTIFICATION

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

A handwritten signature in cursive script, appearing to read "Toni Hudson", is written above a horizontal line.

Signed

August 19, 2018

Dated

TONI HUDSON, TRANSCRIBER

EXHIBIT 5

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITEDHEALTHCARE INSURANCE
COMPANY, et al.,

Plaintiffs,

vs.

ALEX M. AZAR, II, et al.,

Defendants.

Civil Action

No. 1:16-cv-00157-RMC

Washington, DC

August 8, 2018

10:04 a.m.

TRANSCRIPT OF MOTIONS HEARING
BEFORE THE HONORABLE ROSEMARY M. COLLYER
UNITED STATES DISTRICT JUDGE

APPEARANCES:

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BENJAMIN SNYDER

GRAHAM PHILLIPS

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For the Defendants:

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Office of the General Counsel

CMS Division

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Cohen Building, Room 5300

Washington, DC 20201

Court Reporter:

JEFF M. HOOK, CSR, RPR

Official Court Reporter

U.S. District & Bankruptcy Courts

333 Constitution Avenue, NW

Room 4700-C

Washington, DC 20001

P R O C E E D I N G S

DEPUTY CLERK: Your Honor, this is civil action 16-157, United HealthCare Insurance Company, et al. versus Alex M. Azar, et al. For the plaintiff, Daniel Meron, Benjamin Snyder and Graham Phillips. For the defense, James Bickford and John Tyler. Scott Sasjack is agency counsel.

THE COURT: Good morning, everyone. I am very grateful for all of your briefs. Can you believe a judge actually saying that? But actually I am. I have read and read and read. I read last night, I read this morning, very early I was thinking about you people, so I don't want you to think that I don't care.

But I did have some questions I wanted to ask the Government at the very beginning to make sure that I get on the record exactly what the Government's explanation is for a couple of things. So who's going to speak?

MR. BICKFORD: May I approach, your Honor?

THE COURT: Yes, please, sir. Are you Mr. Bickford?

MR. BICKFORD: I am, Judge.

THE COURT: Thank you.

MR. BICKFORD: Good morning, your Honor.

THE COURT: Good morning, sir. Some of my questions you're going to say oh, this woman hasn't even read anything. No, I promise I have.

1 **MR. BICKFORD:** I promise I won't say that, your
2 Honor.

3 **THE COURT:** Well, you might not say it in front of
4 me, but you might say it. Of course you couldn't say it in
5 front of me, I mean, you're quite well trained.

6 Okay. I understand diagnostic codes of which
7 there are 60,000 or so for illnesses and conditions and
8 broken bones and diabetes and cancer and everything, right?
9 You have to say yes, because otherwise it won't come out on
10 transcript.

11 **MR. BICKFORD:** So there are --

12 **THE COURT:** Just say yes or no.

13 **MR. BICKFORD:** There are many, many diagnostic
14 codes, but they don't all go into the Medicare Advantage
15 risk adjustment model. But in the ICD-9, the standard
16 coding guidelines -- I actually don't know the total number,
17 there are many, many, many. Very few of them define unique
18 risk adjustment diagnostic categories within the risk
19 adjustment model.

20 **THE COURT:** Okay. But besides diagnostic codes,
21 one also in doing a calculus takes into account the gender
22 of the population, the age of the population, the region of
23 the country in which they live and other semi-external
24 factors.

25 **MR. BICKFORD:** Roughly, yes, your Honor. There is

1 a sort of collection of risk factors the agency refers to as
2 demographics which are age, gender, institutional status --
3 that is, whether a person lives independently or not, and
4 disability status. So those four factors together get
5 calculated as one demographic risk coefficient. There are
6 other adjustments to the payments which have to do with
7 geography and other things.

8 **THE COURT:** Okay. So the question I that have,
9 when you take all of those pieces together, when you're
10 doing a comparison -- and I'm not yet to the rule. But when
11 you're doing a comparison so that you can determine whether
12 the population covered by an insurance contract is
13 particularly healthy, particularly not healthy, sort of
14 average, whatever, and you need to compare that population
15 to the Medicare population, the fee-for-service population,
16 is the population in this individual insurance contract
17 compared to the entirety of the Medicare population? How is
18 that comparison done?

19 **MR. BICKFORD:** So your Honor, it's done -- it's
20 actually not a population-to-population comparison, it is --
21 you are calculating the expected risk for each individual
22 beneficiary insured under a Medicare Advantage contract. It
23 might be helpful if I could show you a page or two from the
24 administrative record.

25 **THE COURT:** Well, just a minute. You're getting

1 ahead of me. I have some really basic questions and you're
2 going too fast.

3 **MR. BICKFORD:** So could I back up?

4 **THE COURT:** Yes.

5 **MR. BICKFORD:** So each insurance contract, each
6 Medicare Advantage insurer on each contract has a base rate
7 that is established. That's the rate that the insurer is
8 paid for a beneficiary of average risk.

9 **THE COURT:** And how is that rate determined?

10 **MR. BICKFORD:** It is a complicated calculation.
11 It does --

12 **THE COURT:** Oh, don't talk to me about complicated
13 calculations.

14 **MR. BICKFORD:** Rough --

15 **THE COURT:** Don't talk to me about that. I
16 thought it was supposed to be essentially comparing the
17 Medicare population to the insurance population to make sure
18 that approximately if you have diabetes in one and you have
19 diabetes in the other, the cost is about the same.

20 **MR. BICKFORD:** So before we even get to that,
21 roughly what the base rate establishes is what it would cost
22 to treat a beneficiary of average risk in a given area. And
23 the insurers submit bids that say we can -- you, the agency,
24 have said that here in --

25 **THE COURT:** Okay, so where does the average come

1 from?

2 **MR. BICKFORD:** The average comes from the many --
3 it comes from the agency's own data as to what it costs to
4 treat a beneficiary under traditional Medicare.

5 **THE COURT:** And that is an average across the
6 entirety of the Medicare population?

7 **MR. BICKFORD:** It is an -- I believe that it is an
8 average across the entire Part A and B, not Part C, Medicare
9 population --

10 **THE COURT:** We're not talking Part C.

11 **MR. BICKFORD:** -- adjusted for geography. So it's
12 the average beneficiary in Peoria versus the average
13 beneficiary in Minneapolis versus the average beneficiary in
14 Los Angeles and so on. And that is, the calculation is
15 done -- the first thing that is calculated is the average
16 cost to treat a traditional Medicare beneficiary. And then
17 that is adjusted on the basis of how risky -- relatively
18 risky or relatively unrisky the beneficiaries -- the
19 traditional beneficiaries in a given region are. I believe
20 that is how it's done.

21 **THE COURT:** And then that adjustment for the cost,
22 the risk of the traditional beneficiaries, is that also then
23 applied to the insurance contract or does the insurance
24 contractor, the insurance company, have this base rate --
25 that's what I have, I have a base rate on an average in

1 Minneapolis. And then I look at my own population and I say
2 well, this is a healthy person. They're only -- we're
3 talking Medicare, so they have to at least be in their 70s,
4 65, 70, something like that, unless they're disabled, but
5 we'll see. Pretty much everybody in Medicare is a senior
6 citizen, right?

7 **MR. BICKFORD:** The majority of Medicare
8 beneficiaries. There are also people with certain
9 disabilities who --

10 **THE COURT:** Right, I said that part, I know that
11 part. Okay. What about in the Medicare Advantage program,
12 are there also predominantly senior citizens?

13 **MR. BICKFORD:** Yes, your Honor.

14 **THE COURT:** And so I'm an insurance company, and I
15 get the notice in April from CMS that says your base rate
16 for next year starting in -- September I think?

17 **MR. BICKFORD:** I believe that's right, but I'm not
18 completely confident.

19 **THE COURT:** Okay, whatever. I'm not sure whether
20 it's calendar or fiscal. But in any event, for next year
21 your base rate is \$20. I picked that number out of nowhere.
22 Yeah, well, I'm glad you laugh. Twenty dollars. And then
23 I, the insurance company, say \$20, oh my word. And then I
24 go and I look at my population, and I discover that in my
25 population they're not really 65, they're all 82, whatever.

1 So they cost more money when they're 82. So in fact, my \$20
2 ends up to be \$26.02. And I say that I can do, and I submit
3 a bid at \$20 thinking that it's really going to turn out to
4 be \$26.02.

5 **MR. BICKFORD:** The number is closer to \$10,000,
6 but the number --

7 **THE COURT:** The number doesn't actually matter,
8 okay.

9 **MR. BICKFORD:** I understand, your Honor. But yes,
10 that is roughly right. I'm sure that the insurance -- I
11 suspect that the insurers think about it in terms of
12 population. The way the model as I gather the Court
13 understands actually runs is okay, base of \$20. Bill isn't
14 that risky, you get \$17 for Bill. Sue is very risky. You
15 get \$40 for Sue. It literally looks at the characteristics
16 of each beneficiary insured under the contract.

17 **THE COURT:** Right, exactly. Now we've got that
18 part straightened out. Now along comes the audits, RADV I
19 think is what it is.

20 **MR. BICKFORD:** Risk Adjustment Data Validation.
21 Risk adjustment data is simply the reporting.

22 **THE COURT:** Tell me this, do insurance companies
23 actually have the medical charts?

24 **MR. BICKFORD:** I don't know what insurance
25 companies actually have, your Honor. Certainly -- and I

1 suspect that my opposing counsel could speak more crisply to
2 that. They certainly have contractually the ability to get
3 them from the doctors. I don't imagine that an insurer in
4 fact keeps some hard copy or digital record of each of its
5 beneficiary's entire medical histories.

6 **THE COURT:** And does Medicare have access to the
7 charts?

8 **MR. BICKFORD:** Does Medicare keep copies of the
9 Part C beneficiary's medical records?

10 **THE COURT:** No, no, A and B. When I say Medicare,
11 I mean A and B. I'm not talking Medica, I mean Medicare
12 Advantage. They're different.

13 **MR. BICKFORD:** I don't believe they do, your
14 Honor. I believe again that they could turn to a hospital
15 or a doctor or whoever the provider was and acquire the
16 charts. But I don't believe --

17 **THE COURT:** So they can look to an individual
18 incident, but they don't say okay, send everything in?

19 **MR. BICKFORD:** I guess they could, but they do
20 not.

21 **THE COURT:** All right. Are you going to argue
22 first or are the plaintiffs going to argue first?

23 **MR. BICKFORD:** I expected that the plaintiffs
24 would argue first as it's their --

25 **THE COURT:** Why don't you go first, then. Thank

1 you, I appreciate your answers.

2 **MR. BICKFORD:** Thank you, your Honor.

3 **MR. MERON:** May it please the Court, the
4 Government agrees that the actuarial equivalence mandate --

5 **THE COURT:** And your name's Meron?

6 **MR. MERON:** Meron.

7 **THE COURT:** Meron, thank you, sir. Okay, go on.

8 **MR. MERON:** There's actually a division of
9 authority within my own family as to how to pronounce it,
10 your Honor. But I pronounce it Meron.

11 The Government agrees that the actuarial
12 equivalence mandate requires that CMS pay Medicare Advantage
13 plans an amount equivalent to what CMS would pay to insure
14 an identical beneficiary under traditional Medicare. And it
15 agrees with the D.C. Circuit's definition of the term. The
16 two payments are actuarially equivalent if they have the
17 same present value under a given set which means same set of
18 actuarial assumptions. And it likewise does not dispute
19 that the same methodology mandate requires that CMS
20 calculate the risk scores of its beneficiaries using the
21 same methodology that it uses when it makes payments to MA
22 plans.

23 Now, the overpayment rule here violates both those
24 mandates. If a plan's population is completely identical to
25 CMS's -- the same exact health conditions in reality, the

1 same exact set of reported codes, require the MA plan to
2 delete the codes that are unsupported, while CMS does not do
3 the same, will necessarily result in the plan being
4 systematically underpaid. That's the same conclusion that
5 the American Academy of Actuaries reached as well as CMS's
6 own internal experts at the time the RADV audit methodology
7 was adopted.

8 And what follows from that is that a plan's
9 submission of unsupported codes results in overpayment only
10 if, and to the extent that, its rate of unsupported codes
11 exceeds that of CMS. Because the rule here requires a plan
12 to delete any unsupported code from among its tens of
13 millions of codes, even though CMS makes no effort on its
14 side to audit its data, and without accounting for that
15 difference, it necessarily violates the actuarial
16 equivalence mandate.

17 The violation of same methodology, your Honor, we
18 think is equally clear. When CMS computes the risk scores
19 of its members, what it does is it simply adds up all the
20 individual coefficients that correspond to diagnoses in its
21 claims files.

22 With respect to MA plans, the overpayment rule
23 imposes a second step. CMS first computes and adds up those
24 same coefficients for the beneficiary, but it then requires
25 the MA plan, unlike CMS, to delete any coefficient that's

1 unsupported -- they are identified as unsupported by chart.
2 And the result of that is that you can have two absolutely
3 identical people, but the MA plan's beneficiary will have a
4 lower risk score than their CMS counterpart. And they'll
5 appear artificially to be healthier even though in reality
6 they're exactly the same. Congress mandated the same
7 methodology requirement as well as the actuarial equivalence
8 mandate precisely to prevent that kind of irrational, skewed
9 apples to oranges comparison.

10 **THE COURT:** Okay. So I think I actually
11 understand the argument having spent some time on it, but I
12 have a couple of questions for you if I wanted to turn it
13 into more dollars and cents.

14 If I'm CMS, Part A or B, what CMS pays are doctor
15 bills.

16 **MR. MERON:** Correct.

17 **THE COURT:** A doctor who accepts a Medicare
18 patient submits the report to CMS that says I treated this
19 patient for X and Y. And CMS looks at that and says well,
20 you charged him \$400 and we only pay \$220, here's your \$220,
21 right. So the doctor gets the \$220.

22 And if one of the codes that he has claimed is
23 incorrect, the doctor is still getting that money, right?

24 **MR. MERON:** CMS does -- the diagnosis code does
25 not impact on the physician's payment, that's correct.

1 **THE COURT:** I'm not quite sure, I think that a
2 doctor only sends the diagnostic codes part of his records
3 when he's claiming or she's claiming recovery from CMS. Is
4 that not right?

5 **MR. MERON:** No, well, if your Honor's asking do
6 they send the medical chart, they do not send the medical
7 chart.

8 **THE COURT:** That much I figured.

9 **MR. MERON:** Okay. With respect to the codes they
10 submit, physicians are generally paid by CMS for what they
11 do, not why they do it. So what the -- in other words, what
12 we call in the industry procedures, office visit, injection,
13 et cetera. So however, as a matter of billing requirements,
14 they do designate a diagnostic code on there to sort of
15 explain why the patient was there. But what they're paid on
16 is the procedure, not the diagnosis code.

17 And that's really the heart and the source, your
18 Honor, of why we have this problem here that's before you
19 which is physicians are essentially indifferent to the
20 diagnosis of the patient. There's no financial incentive to
21 be particularly careful about what diagnostic code they
22 circle on the claims form if you're in the olden days, today
23 it's obviously largely electronic. And they don't have any
24 incentive to document the diagnosis carefully in their
25 medical chart. Because if they are ever audited on their

1 payment, what matters is what procedure they did. I saw the
2 patient, had an office visit, I've got that in the chart,
3 I've been careful about that part of it.

4 And so CMS built a model here -- and CMS knows
5 that. So CMS built the model here that draws on data that
6 has a lot of errors in it. Not maliciously, just careless,
7 good faith, human error by many well-meaning physicians who
8 don't really have financial incentives to be particularly
9 careful about their diagnostic coding. But it has those
10 errors in its data.

11 When it calculates what an average -- how healthy
12 an average beneficiary for CMS is, it takes every code in
13 its system and every diagnostic code is treated as
14 conclusively valid. And so when it tries to figure out what
15 the average cost is of diabetes or of any of its conditions,
16 it takes its costs and it distributes them among every one
17 of those codes, including the unsupported codes.

18 And what that necessarily does -- I mean, the
19 Government says oh, it's really hard to tell in specific
20 cases. It's not hard to tell on an average, system-wide
21 basis. If an average beneficiary -- the way the model
22 works, your Honor, I think you know this from the briefs, an
23 average is -- it's calibrated is the word that's used so
24 that the average beneficiary is a 1.0. They just
25 mathematically make that happen. If an average beneficiary

1 using unaudited data would have a total of five
2 coefficients, their demographic coefficient plus say the
3 four diagnostic codes, the average value of a coefficient
4 that CMS would calculate across its whole system would be
5 .2, it just has to be.

6 If CMS first audited its data, removed unsupported
7 codes and then on average a CMS beneficiary now had four
8 coefficients -- the same demographic, three diagnostic
9 codes, just simple math, now you're dividing one by four.
10 An average coefficient across the whole system would have
11 been higher, it would be 0.25.

12 And your Honor, it's quite notable, we've cited a
13 number of times the American Academy of Actuaries. They
14 made the same point. There's no response from D.O.J. on
15 that. There's no response to our demonstration about more
16 coefficients result in lower payments. And the problem here
17 is what CMS wants to do is have it both ways.

18 When it comes to calculating the value of a
19 coefficient, it's using raw, unaudited claims data that
20 contain many errors. And that's to its financial advantage.
21 It saves itself auditing costs. But perhaps more
22 importantly, it results in a calculation of a lower payment
23 amount than CMS would have calculated had it first audited
24 its data.

25 But then when it comes to the MA plan, it says oh

1 wait, we're only going to pay those lower per code amounts
2 only on the subset of your population that not only has the
3 code in its claims data, but also has it in medical charts.
4 Because then for that purpose, it's again to its financial
5 advantage to pay less. And so you have what we call this
6 mix and match system. The way I tried to put it in the
7 brief, your Honor, in just kind of a colloquial term, what
8 essentially they're doing, it's very analogous to the
9 Government calculating a per person food subsidy and then
10 saying they're going to pay it on a per household basis.
11 It's not going to be sufficient. What Congress mandated was
12 an apples to apples fair comparison of all populations.

13 **THE COURT:** Well, the interesting thing is that
14 when you look at what the law says about actuarial
15 equivalence, it doesn't say actuarially equivalent to what.
16 To what. I mean, actuarial equivalence has to be between A
17 and B, A and Z, 10 and 10,000, you and me, whatever. It's
18 crowds of course. The people on the right and the people on
19 the left. It doesn't say that in the statute, it just says
20 actuarial equivalence, period.

21 **MR. MERON:** I agree, your Honor, it doesn't
22 expressly say that. I think it's heavily --

23 **THE COURT:** I knew you'd agree with that.

24 **MR. MERON:** It says CMS has to ensure actuarial
25 equivalence. I think it is implicit to the point I think of

1 perfect clarity that what they mean is between MA and CMS.
2 And that's not a point of contention. There's a lot of
3 things disputed in this case. I think that I can safely say
4 is not one of the things that's disputed. The Government
5 and we agree that the comparisons are between us and CMS.
6 And that's what --

7 **THE COURT:** Now, if that's so, then the
8 Government's argument is that the Medicare Advantage
9 insurers -- excuse me, I'm sorry. I have a bad voice and I
10 have a cough, the combination is very poor. That the United
11 Healthcare insurers really want money for illnesses that
12 aren't there. And that's just awful. I think that's a
13 quote, like that.

14 **MR. MERON:** And your Honor, we want no such thing.
15 We want to be paid our actual costs for conditions that
16 people actually have which CMS's model has chosen to
17 allocate to unsupported codes. And I don't know, your
18 Honor, if it would be helpful to have a demonstrative or
19 not. I don't want to unduly complicate it. But the
20 Government in its brief gives you an example, it's the
21 Government's own example.

22 They give you an example of a 72-year-old female
23 who has Multiple Sclerosis, and she actually has that,
24 that's documented in her chart. And she has diabetes, but
25 that's not documented, and for purposes of today, we'll

1 assume she doesn't have diabetes. The Government says that
2 person actually costs CMS \$10,000. What the Government
3 acknowledges is when it runs its calculations, it's going to
4 treat that diabetes as real, as existing. So it's going to
5 take the actual costs that it incurred, \$10,000, for this
6 actual human being. And although we now know from the
7 example that in fact those \$10,000 were purely resulting
8 from her demographics and her Multiple Sclerosis, the model
9 will distribute those actual costs to all three coefficients
10 including the diabetes code.

11 So what happens when that identical person --
12 let's say she has an identical twin, is on Medicare
13 Advantage? What happens suddenly is CMS says woe, you've
14 got to delete your diabetes code.

15 **THE COURT:** No, I understand that.

16 **MR. MERON:** But what I'm trying to say, your
17 Honor, is what the Government's own example shows is that
18 the payment associated with an unsupported diabetes code is
19 a portion of an actual \$10,000 that was actually incurred by
20 CMS and would actually be incurred by United if it had the
21 same patient due to the Multiple Sclerosis and the age.
22 It's not our fault that the model has been run by CMS this
23 way. It had a lot of discretion as to how to do it, it just
24 has to be consistent.

25 Your Honor admitted into the administrative record

1 last week a presentation by the head of CMS's payment
2 validation division. I'm sure she understands -- I mean,
3 the Government kind of tries to mock that same example in
4 our brief, but I'm sure the head of CMS's payment validation
5 division -- division of payment validation understands how
6 the model works, and she gives exactly the model of
7 diabetes. What she demonstrates through her slide
8 presentation is that unless the plan receives some portion
9 of the payments from the unsupported costs -- unsupported
10 code, it will be underpaid for actual costs.

11 **THE COURT:** Well, what CMS says is that the
12 actuarial equivalence needs to be between the money spent in
13 Medicare for the 72-year-old woman, and the payment for
14 which the Medicare Advantage insurer applies for the
15 72-year-old woman, each of which under your hypothesis is
16 the same \$10,000. And that's the actuarial equivalent.

17 Now, if on audit it turns out that the Medicare
18 Advantage 72-year-old woman doesn't actually have diabetes,
19 then you're not entitled to \$10,000, you're only getting
20 \$9,000. But the actuarial equivalence rule was met -- I
21 think I'm saying your argument correctly. The actuarial
22 equivalence rule was met because they paid out \$10,000 to
23 this 72-year-old woman, and you expected and they sent you
24 \$10,000 for this 72-year-old woman. It just so happens you
25 weren't entitled to the entire \$10,000 in fact as opposed to

1 actuarially.

2 **MR. MERON:** So I think what's wrong with that is
3 two things, your Honor -- and when I say what's wrong with
4 it --

5 **THE COURT:** I'm responding to the Government's
6 argument.

7 **MR. MERON:** Respectfully, when I say what's wrong
8 with that, I mean what's wrong with the Government's
9 argument.

10 **THE COURT:** You can feel free to say what's wrong
11 with my argument. I mean, I'm not arguing with you, I'm
12 just trying to understand.

13 **MR. MERON:** Yes, I understand. I never understood
14 judges to be arguing, your Honor. So what's wrong with
15 that --

16 **THE COURT:** Don't put too much on judges. Go
17 ahead.

18 **MR. MERON:** Your Honor, there's two things wrong
19 with that. First of all, the identical 72-year-old for CMS
20 did not actually have diabetes, just like ours didn't. That
21 person actually cost CMS \$10,000 just like it would
22 presumptively cost us \$10,000. These two individuals are
23 completely identical. They have the same actual conditions
24 and the same reported codes, and we'd be paid on this
25 example \$8,800 I think for someone who actually costs CMS

1 \$10,000.

2 What the Government's response on that in its
3 brief is to walk away from its own example and say well, it
4 doesn't work that way. We don't match up particular human
5 beings that way when we run the model. Well, we understand
6 that, your Honor. We're giving you an example that repeats
7 itself systematically across the whole population. Across
8 the whole population, CMS takes all of its costs and
9 allocates them to unsupported codes.

10 The other thing I would say, your Honor, that's
11 wrong with that is CMS can't accomplish on the back end, if
12 you will, what it could not accomplish on the front end. So
13 if your Honor is in agreement that it could not ab initio
14 say this person cost us \$10,000, you only get \$9,000, that
15 would violate actuarial equivalence. It can't accomplish
16 that exact same result by saying well, you know, you signed
17 this attestation, we're now going to audit you and we're
18 going to take back the money.

19 Now, you use the word audit, and it's interesting,
20 we know how CMS addressed this very same question when it
21 considered its audit methodology. We made -- the industry
22 made the exact same arguments to CMS that we made in our
23 briefs here, and CMS agreed with them. It instituted an
24 adjuster expressly to account for the fact that it was
25 measuring its population under looser criteria than it was

1 applying to us.

2 **THE COURT:** Yeah, and I'll ask them about that,
3 because I understand that. But it is true that under the
4 Affordable Care Act, Congress did impose new obligations on
5 CMS to collect, and perhaps new obligations on Medicare
6 Advantage insurers to avoid overpayments, isn't that right?

7 **MR. MERON:** Yes. Now, in our example we say we're
8 not overpaid by virtue of this unsupported code, because the
9 way you are paid under this program by statute is on a
10 comparative basis. And if we have the same costs as they do
11 and the same set of codes, our unsupported code does not
12 represent an overpayment.

13 And your Honor, what's important, when CMS looked
14 at RADV, first of all that was in 2012 so it postdates the
15 ACA. And they used the same exact word, overpayment.
16 That's the word that CMS uses in its audit methodology, your
17 Honor, and I'll give you the cite for that. It's at 5311,
18 and it uses the term overpayment to describe what the RADV
19 methodology is going to measure. It used the words payment
20 error too, it used those interchangeably. And at AR2819 is
21 the 2010 rule that put forward the procedural rules for how
22 RADVs will be done. They repeatedly on that page -- you'll
23 see when you look at it, used the word overpayment to
24 describe what the RADV process is designed to measure. And
25 we know how that came out. What they said is you are not

1 overpaid unless you are -- your errors are greater than
2 ours, there will have to be an offset.

3 **THE COURT:** Can I ask you a question? This is a
4 comparison that I'm trying to do here. As I remember, your
5 brief said that Medicare Advantage insurers cover about
6 one-third of the total Medicare population?

7 **MR. MERON:** That's right.

8 **THE COURT:** Do you know what the Government pays
9 for that one-third?

10 **MR. MERON:** What the total expenditure for
11 Medicare Advantage is, I'm not --

12 **THE COURT:** Do you know?

13 **MR. MERON:** It's in the billions, but I don't know
14 what it is, your Honor.

15 **MR. BICKFORD:** It's approximately \$200 billion a
16 year, your Honor.

17 **THE COURT:** And what does the Government pay for
18 Medicare?

19 **MR. BICKFORD:** I do not have that number off the
20 top of my head, but I'd be happy to provide that.

21 **THE COURT:** My assumption is it would be, if it
22 were apples to apples, about 600 -- no, wait.

23 **MR. MERON:** Well, your Honor, it's --

24 **THE COURT:** I did that wrong.

25 **MR. MERON:** -- complicated. You would have to

1 know what the relative health of our population is compared
2 to theirs. You'd have to look at --

3 **THE COURT:** Believe me, you've made all those
4 things exceptionally clear. I think I understand your
5 arguments about actuarial equivalence. You had a second
6 argument?

7 **MR. MERON:** Yeah, and I'd like to address it. In
8 some respects, it's maybe even simpler. I think they're
9 both very strong. The statute expressly says to CMS you
10 must calculate the risk scores. So let me just pause there,
11 your Honor. The actual language in the statute is risk
12 factor. It is -- that's a synonym for risk score. I don't
13 think that's at issue between us and the Government based on
14 its brief.

15 So there's the individual coefficients, and you
16 add those and that becomes the risk score or the risk
17 factor, those are interchangeable terms. So what Congress
18 said to CMS was you must calculate the risk scores of your
19 population using the same methodology that you are going to
20 use when you make payments to MA plans. And again, apples
21 to apples. It's sort of basic rationality. If I'm going to
22 compare two things, I've got to compare them the same way.

23 So what happens if we take that 72-year-old
24 example in the Government's brief? On the Government's side
25 of the comparator, you have -- they add up all those

1 coefficients. So they add the demographics, they add MS,
2 they add diabetes, and you end up with a total risk score I
3 think, if I remember correctly, of 1.022. I think that's
4 the number that was in their brief.

5 So the person comes over to Medicare Advantage,
6 that exact identical person, and we have to delete the
7 diabetes code because it's not supported.

8 **THE COURT:** You can put it up if you want.

9 **MR. MERON:** Your Honor, if it's helpful, I'm happy
10 to do it. And I'm also happy to hand you a copy if you want
11 to write on it.

12 **THE COURT:** I'm perfectly happy to have you do it
13 however you wish. I am not Judge Ellis.

14 **MR. MERON:** So I call it twin A and twin B. So
15 twin A is the CMS beneficiary, and what happens is CMS adds
16 all those coefficients together and results in a risk score
17 of 1.022. The same exact person signs up for Medicare
18 Advantage, their identical twin. What happens is CMS first
19 adds the three codes, but then plan finds out wait a second,
20 this diabetes code is unsupported. The overpayment rule
21 says you've got to delete it. There's going to be no
22 adjustment to account for our own equivalent error. Now
23 that same exact person has absolutely all the same real
24 world characteristics, but now their risk score is .9.

25 What we show at the bottom, your Honor, is CMS

1 says while our actual expenditures are \$10,000, if we had
2 bid the full benchmark, we said okay, we'll take the same
3 amount that it would cost you, our premium is reduced there
4 for that identical person to \$8,845. That just can't be
5 right. It's just treating identical people differently.
6 It's putting a thumb on the scale in a way that
7 disadvantages systematically the Medicare Advantage plan.

8 There's all this talk -- and we understand, your
9 Honor, that CMS has a legitimate concern about accuracy in
10 the system. We don't dispute it. But there are many ways
11 in which it could achieve that without violating the
12 statutory mandates. All we're asking is that they apply the
13 same criteria to us as they apply to them. If they first
14 audited their data, used a robust sample to do that, and
15 then calculated the coefficients based on audited data,
16 there would be no issue here whatsoever in making the plans
17 delete every single code that is identify as unsupported.
18 Or they could make an adjustment on the back end.

19 But what they can't do is what's shown here, is
20 make an apples to oranges comparison where identical people
21 are artificially made to look less costly and healthier to
22 us than they would be if they remained on CMS. That's what
23 the statute prohibits.

24 **THE COURT:** Again, isn't the same methodology
25 requirement the methodology for determining the benchmark

1 payments?

2 **MR. MERON:** That's not the only thing they're used
3 for, and the statute isn't limited that way. It says you
4 must calculate and publish the risk scores for your
5 population using the same methodology. One impact it has is
6 it impacts on the calculation of the benchmark. So
7 essentially the sicker CMS makes its population look by not
8 removing unsupported codes, the lower the resulting
9 benchmark cap for a standard person's going to be for an
10 insurer.

11 So again, it's very much to its financial
12 advantage here. It has this methodology skewed to its
13 advantage under which it artificially -- you know, and they
14 always like to talk about plans have an incentive to make
15 our population look sicker. They've got -- we're at a
16 comparative situation under a contract, you can turn that
17 around. They've got the same financial incentives to make
18 us look healthier than we are, and that's what they've done.

19 They've got to implement the scheme, just
20 fundamental administrative law. First of all, the statute
21 obviously takes precedence to the regulations. There's lots
22 of talks in their brief about supposed long-standing
23 Medicare Advantage sub-regulatory guidances that have been
24 issued and regulations, none of which directly have ever
25 said before it's a no error standard, that you have to have

1 perfection. They've never said that until the 2014 rule.
2 But even if they did, we're allowed to challenge it because
3 it was the basis for this regulation. And the statute has
4 to take precedence.

5 As I said, there are many ways in which they could
6 harmonize their concern about accuracy, harmonize their
7 concern about preventing abuse while respecting our
8 statutory right to be paid an equivalent amount. They can
9 audit themselves is one way. If there are adjusters on the
10 back end, they could do it. And they did it when they
11 considered how to audit us under RADV. It makes absolutely
12 no sense, your Honor, that whether you've been overpaid and
13 by how much can depend so radically on who does the audit.

14 They audit us, we could have a 20 percent error
15 rate. If they have a 20 percent error rate, the recovery is
16 zero. We audit ourselves and we have a 20 percent error
17 rate, every last dime has to be returned. That cannot be
18 right. Whether we're overpaid can't turn on who is looking.

19 **THE COURT:** Okay, I have one more question for
20 you, and that is what remedy really -- precisely what remedy
21 are you seeking? Do you want me to invalidate the entire
22 rule, send it back to them? What do you want?

23 **MR. MERON:** I'm asking you to vacate the
24 overpayment rule, that portion of the -- they did an omnibus
25 rule that touched on lots of different things. We're just

1 asking for the overpayment regulation to be vacated. We
2 think, your Honor, it's very important that your Honor
3 address and rule on the statutory questions before you as
4 part of that.

5 We have here an agency that's -- you know, they're
6 unabashedly telling you effectively that they don't think
7 this rule is necessary, it was superfluous. They could have
8 just brought enforcement actions based on those
9 sub-regulatory guidances, whatever. If you simply send it
10 back to them and ask them to give more explanation, I think
11 what you're going to see is exactly what's happened with the
12 RADV methodology. Remember, six years have gone by and they
13 still haven't issued it.

14 They're not going to make the mistake a second
15 time of creating a reviewable rule. They're just going to
16 rely and continue to regulate as it were quote, unquote
17 based on these sub-regulatory guidances that we can't seek
18 review of. It would be a waste of their time as well as
19 ours for them to go back and try to create explanations for
20 things that we believe the statute prohibits in any event.

21 **THE COURT:** Okay, thank you.

22 **MR. MERON:** You're welcome.

23 **THE COURT:** Mr. Bickford.

24 **MR. BICKFORD:** Thank you, your Honor.

25 **THE COURT:** Now I have a question for you.

1 **MR. BICKFORD:** Good.

2 **THE COURT:** I understand and I know that you're
3 not happy with this, but I understand that when CMS set up
4 the audit process, that it received comments that said that
5 you cannot set your payments based on unaudited files and
6 then require repayment from very strictly audited files.
7 You have to make an adjustment there. And CMS agreed that
8 there was a difference, and so therefore --

9 **MR. BICKFORD:** So your Honor --

10 **THE COURT:** And so my question is how is it that
11 in putting out the overpayment rule, that's no longer
12 relevant?

13 **MR. BICKFORD:** Your Honor has gone straight to the
14 hardest part of this case.

15 **THE COURT:** Well, I didn't want you to think I
16 wasn't listening.

17 **MR. BICKFORD:** I appreciate that, your Honor. So
18 what you're describing is what the agency has referred to as
19 the FFS adjuster which is an adjustment that it agreed to
20 make to recoveries that would otherwise be due for Medicare
21 Advantage insurers who are subject to audits.

22 **THE COURT:** Right.

23 **MR. BICKFORD:** As my colleague has noted, that was
24 a decision that was made nearly six and a half years ago
25 now. And what the agency said --

1 **THE COURT:** What the agency said at the time was
2 this is going to probably -- I'm not going to quote it
3 properly because I don't have it in front of my eyes. But
4 what it said was we think this is really temporary, because
5 we're going to undertake an audit of our own files. That
6 hasn't happened yet, and so therefore what was supposed to
7 be temporary has continued in effect.

8 **MR. BICKFORD:** So your Honor, I believe that
9 the -- what is described in -- and I'm going to read from
10 pages 5314 and 5315 of the administrative record -- I'm
11 sorry, this is just page 5315. It says, "The adjuster will
12 be calculated by CMS based on a RADV-like" -- that's the
13 audit process, "review of records submitted to support FFS
14 claims data."

15 So it wasn't that the adjuster would be temporary
16 until the audit was complete, rather the review of the
17 effect, if any, of errors in the Medicare Part A and B data
18 on payments under Part C was going to be the basis for this
19 adjustment that would be applied in the audit context.

20 **THE COURT:** Okay, that's helpful.

21 **MR. BICKFORD:** So the record as to the adjuster is
22 rather thin. There are four sentences at the end of the
23 RADV methodology in February of 2012. And over the
24 intervening years, CMS has undertaken the review, the audit
25 of its own FFS claims data that is described in the RADV

1 methodology. But the agency has not yet completed this
2 study nor has it published a finalized FFS adjuster. The
3 agency's --

4 **THE COURT:** Well, but that would be a moving
5 target, wouldn't it? I mean, to have done that, the audit
6 of FFS claims data three years ago to identify the proper
7 adjustment wouldn't necessarily be accurate in 2017, would
8 it? Don't you have to do that regularly?

9 **MR. BICKFORD:** And the coefficients, the risk
10 coefficients themselves are regularly updated. I imagine
11 that once an FFS adjuster was published, it might well also
12 be updated as the coefficients themselves were updated. But
13 we just don't know at the moment, because the agency has not
14 completed that study and it hasn't made the final
15 announcement.

16 So there were certainly issues at play in the
17 audit context that I think form the basis for a reasonable
18 distinction between Medicare Advantage contracts subject to
19 audit and those that are not. They're roughly -- one, the
20 agency was concerned frankly that the audits might recover
21 very large sums that would present insurers with
22 difficulties, financial difficulties. And you can see that
23 at what is now page 12077 of the documents that your Honor
24 just added to the administrative record. In the bullet
25 pointed document, someone within the agency suggests that

1 the FFS adjuster, quote, will help bring the overpayments
2 into a range that is more realistic for plans to be able to
3 accommodate. Essentially, will soften the blow of the
4 audits.

5 The second difference between the audit context
6 and unaudited Medicare Advantage contracts has to do with
7 the punitive nature of the overpayment statute and then
8 rule. In the Affordable Care Act -- or before the
9 Affordable Care Act, insurers were not permitted to claim
10 overpayments. And when they had identified an overpayment
11 that they had received, they were required to return it.
12 The agency regularly -- we regularly bring False Claims Act
13 actions on that basis.

14 The Affordable Care Act didn't impose a new
15 requirement of returning overpayments. It didn't in any way
16 change the definition of what an overpayment was. What it
17 said was once you identified an overpayment, we're going to
18 put a new clock on your obligation to return. You have 60
19 days, and if you have not returned within 60 days of
20 identifying the overpayment, now you're subject to
21 additional penalties.

22 So in the audit context, in the RADV context,
23 there is no suggestion that the Medicare Advantage insurer
24 is to blame in any way for the error it has submitted.
25 There's no finding of fault, it's just you submitted this

1 diagnosis code, you don't have any medical records support
2 for that diagnosis code so you weren't entitled to the
3 payment, you have to return it.

4 In the overpayment context, what happens is the
5 DOJ or someone enforcing the statute says you've received
6 this overpayment, you identified the overpayment that you
7 had received and you didn't report and return it within the
8 prescribed time. And therefore, you are now liable not only
9 for the return of the overpayment but for the additional
10 penalty. That is what the overpayment statute and rule
11 does.

12 **THE COURT:** And the identified now is a negligence
13 standard of identified, right?

14 **MR. BICKFORD:** I'm sorry, your Honor?

15 **THE COURT:** It's a negligence standard, knew or
16 should have known?

17 **MR. BICKFORD:** It is not precisely a negligence
18 standard, but we --

19 **THE COURT:** It doesn't say negligence. I will
20 grant you that it does not say negligence.

21 **MR. BICKFORD:** The overpayment rule -- Medicare
22 Advantage insurers have, as the Ninth Circuit recognized in
23 Swoben, always had an obligation to conduct compliance
24 programs to ensure that they and those who feed the data to
25 them are complying with CMS program requirements. That is

1 not again a new obligation imposed by the overpayment rule.

2 But yes, the rule does interpret the statutory
3 language identified to mean not only literally knew about
4 the overpayment, but also if you for instance have an
5 entirely deficient compliance program and that is the
6 reason, and your failure to have the appropriate compliance
7 program is the reason you didn't learn of an overpayment
8 that you should have learned of, then we will also begin the
9 clock on that.

10 Respectfully, that is a fairly minor portion of
11 the case. Even if the agency were wrong as to its
12 interpretation of identified, the statutory mechanism works
13 the same. If it were not the case that the agency could
14 deem an insurer to have identified a payment that it
15 reasonably should have known was an overpayment, it would
16 still be the case that the only thing the overpayment rule
17 actually did and the overpayment statute actually did was
18 impose a new penalty on payments that insurers were under an
19 existing obligation to return.

20 **THE COURT:** Well, the obligation is clear, the
21 penalty is new.

22 **MR. BICKFORD:** Yes, that's correct.

23 **THE COURT:** And the definition that's been adopted
24 is sufficiently broad that doesn't the penalty become at the
25 choice of whoever in the agency is actually conducting the

1 audit or the review?

2 **MR. BICKFORD:** The definition of what, your Honor,
3 I'm sorry?

4 **THE COURT:** The definition of knew or identified.
5 The definition of identified doesn't mean knew, it means
6 knew or with reasonable diligence should have known or maybe
7 didn't care to look.

8 **MR. BICKFORD:** Yes, your Honor.

9 **THE COURT:** That's all negligence.

10 **MR. BICKFORD:** It bears some similarities to
11 negligence, your Honor.

12 **THE COURT:** Right. So it's not a knowledge based
13 thing?

14 **MR. BICKFORD:** Not as it has been interpreted in
15 the overpayment rule.

16 **THE COURT:** Right. And so therefore, the
17 possibility of a fine or whatever the penalty is has been
18 increased, is that not right?

19 **MR. BICKFORD:** The possible fine that could be
20 imposed was increased by the statute.

21 **THE COURT:** I'm not talking about money, the
22 amount of the fine. I'm talking the fact of a fine. The
23 fact of a fine is increased in probability, because the
24 definition of identified is so much broader. And that's in
25 the eye of the beholder looking after the fact.

1 **MR. BICKFORD:** Your Honor, I believe that before
2 the overpayment rule, the agency could have sanctioned an
3 insurer that was not meeting its obligations to have an
4 effective compliance program.

5 **THE COURT:** That may be absolutely so, but that's
6 a different issue than having, quote, identified a specific
7 overpayment. I mean, you're mixing apples and oranges --
8 I'm sorry, that's a bad use of the term.

9 **MR. BICKFORD:** I sincerely hope that's not your
10 Honor's conclusion.

11 **THE COURT:** Everybody around here is using that to
12 argue about actuarial equivalence. Anyway, that part of the
13 case is not as critical as actuarial equivalence. And I
14 really need you to go back and tell me what the Government
15 thinks in this context actuarial equivalence means.

16 **MR. BICKFORD:** Sure.

17 **THE COURT:** And don't cite me to ERISA cases,
18 don't do that.

19 **MR. BICKFORD:** Okay.

20 **THE COURT:** I know lots of ERISA cases too. We've
21 all been there and done that. No, what I want to know is
22 what you think it means in this context.

23 **MR. BICKFORD:** Sure. So your Honor, I think the
24 most helpful way to answer that -- well, let's start by just
25 answering that. The statute requires actuarial equivalence

1 in the payments that are made to Medicare Advantage insurers
2 for covering a particular beneficiary. The agency has
3 implemented that requirement by paying the insurers a cost
4 equivalent to the expected cost it would bear itself for
5 covering a given beneficiary.

6 Now, the way it calculates that expected cost is
7 through a complicated regression model that produces these
8 risk adjustment coefficients. I think it's important for
9 the Court to understand that none of this was changed in any
10 way by the overpayment rule. This risk adjustment model has
11 been in place since 2004. It has been run the same way
12 since 2004. The documentation standard required for
13 diagnoses submitted for payment has been the same since the
14 beginning of the program in the year 2000.

15 So much of what my colleague argued moments ago
16 are long-standing disputes that the insurance industry has
17 had with the way in which CMS operates its risk adjustment
18 model. An overpayment within the meaning of the Affordable
19 Care Act --

20 **THE COURT:** You know I don't want overpayment, I
21 want actuarial equivalence.

22 **MR. BICKFORD:** So the whole point of the risk
23 adjustment model is to effectuate this statutory obligation
24 to make actuarially equivalent payments. For any given
25 person, it is effectively impossible to predict what

1 their --

2 **THE COURT:** Actuaries don't talk in terms of
3 individuals.

4 **MR. BICKFORD:** Understood. So we have a
5 population, the population has characteristics and we have
6 fed the best data that the agency has on the population and
7 its characteristics into this complicated model that
8 produces these coefficients. If the import of United's
9 argument here is that the coefficients are all wrong --

10 **THE COURT:** No, I don't think that's their
11 argument.

12 **MR. BICKFORD:** So their argument is the standard
13 by which --

14 **THE COURT:** Their argument is that by figuring the
15 coefficients on unaudited files and then paying out but
16 requiring repayment on anything that is not substantiated in
17 a medical record is to start at the beginning as if it were
18 actuarially equivalent, but set up a system whereby it no
19 longer is. The beginning is arguably equivalent, the
20 process is not. Because by the rule, by the definition of
21 identification and the change that you made to your brief --
22 I mean, they all kind of talk around it. You say that you
23 wanted to change this sentence, and I was glad you changed
24 it because it didn't make sense.

25 But anyway, it now says that the Medicare

1 Advantage insurers are required to adopt and implement an
2 effective compliance program which must include measures
3 that prevent, detect and correct noncompliance with CMS
4 program requirements. Well, now which program are we
5 talking about?

6 CMS does none of these things for its own program,
7 A and B. So when you say CMS program requirements and
8 they're supposed to be actuarially equivalent, how can you
9 impose on Medicare Advantage insurers compliance
10 requirements that CMS itself does not follow? Because as a
11 program, it comes out not actuarially equivalent, and it's
12 predictable and it's intended to come out that way.

13 So it's not good enough, is it, to say well, when
14 we pay them in the beginning it's the same? That's not
15 really the answer, because when you pay the \$10,000 for this
16 poor 72-year-old woman with MS -- who we've never even met,
17 but I'll call her Sally. When you pay \$10,000 for Sally,
18 you're paying -- you don't have any idea whether you're
19 paying Sally -- or Sally's doctor more importantly, Sally's
20 doctor for Sally's illnesses or not, but you just pay them
21 anyway.

22 So how could you say that when you pay \$10,000 for
23 Sally's twin...

24 **MR. BICKFORD:** Sue.

25 **THE COURT:** Sue, thank you, I appreciate that.

1 For Sally's twin Sue, but you know that in the end the
2 insurer has to go make sure that Sue actually has diabetes
3 or not, that it's not going to come out over an entire
4 population? I mean, this is the problem with actuarial
5 equivalence. It's an entire population.

6 The difference between Sue and Sally -- that's
7 \$1,500 or something in the example, \$1,500 isn't going to
8 kill anybody -- well, hopefully not. But over an entire
9 population, two populations, the reason CMS doesn't do this,
10 hasn't figured it out yet with its own population is because
11 it's such a huge population. And making sure that their
12 data is correct and that you're comparing the proper data to
13 the proper data, it's a nightmare. I understand that. How
14 many decisions say oh, this is a very complicated program.
15 I understand that.

16 But how can you achieve actuarial compliance if
17 you impose on the Medicare Advantage insurers a standard
18 that you don't impose on CMS? This is the critical question
19 here. And I don't think saying we pay them the same at the
20 beginning is satisfactory, because the program is now set up
21 in such a way that it's not going to be the same. It's
22 intended not to be the same.

23 How do you defend that? I mean, you know, I don't
24 run CMS. I understand you're talking billions and billions
25 of dollars. I want to save money as much as anybody else.

1 But I don't understand how you can get around actuarial
2 equivalence by saying we pay them the same at the beginning.

3 **MR. BICKFORD:** So --

4 **THE COURT:** Go ahead, please. I've gone on and
5 on, it's time for you to talk.

6 **MR. BICKFORD:** Your Honor, we have never said that
7 we pay them the same at the beginning.

8 **THE COURT:** Ah, okay, so we never paid them the
9 same, okay.

10 **MR. BICKFORD:** We would think about it this way:
11 The first question is when are insurers permitted to claim
12 payment for the margin of the expected costs associated with
13 one of their beneficiary's diseases, when can an insurer
14 claim payment. And the record is perfectly clear -- and I
15 have a slide deck of 12 slides I'd be happy to walk your
16 Honor through, but it's also in our briefs.

17 The Ninth Circuit has held, and the record makes
18 perfectly clear, that insurers can claim payment for the
19 expected cost of a disease when their beneficiary has that
20 disease as indicated in their medical records.

21 **THE COURT:** That is not at issue. You're getting
22 down into the weeds instead of staying up where actuarial
23 equivalence is. Actuarial equivalence is on populations.
24 The problem that you have as I understand it -- and I've
25 read the actuarial association or whatever it is of America,

1 man, oh man, back when it was Medicare Plus Choice and HCFA
2 and all of that. But there is an actuarial problem when you
3 devise a program based on unaudited data and then apply the
4 program to audited data. There is an actuarial problem.

5 Now, how do you get around that?

6 **MR. BICKFORD:** Your Honor, I was about to get to
7 the actuarial point. So I think if you start --

8 **THE COURT:** Okay.

9 **MR. BICKFORD:** If it is genuinely undisputed
10 between the parties that an insurer can only claim payment
11 for a disease with which the beneficiary has actually been
12 diagnosed --

13 **THE COURT:** As we agree that CMS can only pay
14 benefits to a doctor for treatment of a disease that the
15 patient actually has. Now, you have to understand that
16 those two things must be the same to be actuarially the
17 same, both factually and actuarially the same. And CMS pays
18 people without audit.

19 Now, I know in fact they audit doctors, so please
20 don't misunderstand. I've had those cases. I've had
21 criminal cases involving doctors who tried to defraud
22 Medicare. But it's such a huge system, it's very difficult.
23 Nobody is arguing that they should be paid for illnesses
24 people don't have.

25 What they're arguing is that Congress has required

1 actuarial equivalence. And that because of the rule, the
2 overpayment rule, CMS has decided we're going to give it to
3 you in the front, and we're take it away on the back and
4 it's not going to be actuarially equivalent.

5 I'm repeating myself and interrupting you instead
6 of letting you finish. Keep trying.

7 **MR. BICKFORD:** I'll try one more time, your Honor.

8 **THE COURT:** Push back one more time.

9 **MR. BICKFORD:** So I think if it is actually -- the
10 first point, I'll just say it one more time. If an insurer
11 can only claim payment for diseases with which the
12 beneficiary has actually been diagnosed as supported in the
13 medical record -- which has been the requirement for the
14 length of the program, the next question -- and this is the
15 actuarial equivalence question, is when we turn to the very
16 simple table that has a list of coefficients for age ranges
17 and diseases, do those coefficients actually achieve
18 actuarial equivalence in payments within the meaning of the
19 statute. That is certainly what they're designed to do.

20 The reason that there is this risk adjustment
21 system is because of the statutory mandate to achieve
22 actuarial equivalence in payments to insurers. And the
23 agency believes that the coefficients do that within an
24 actuarially tolerable range of accuracy.

25 But even United accepts that the agency can hold

1 an insurer to only submitting diagnoses which are claims for
2 payment from the Government on the basis of actually
3 diagnosed diseases. United does not dispute that the
4 Government can do that. And I don't think that there is any
5 reasonable dispute that the Government has done that so long
6 as the payment associated with each disease is adequate, is
7 the actuarial equivalent of the expected marginal cost
8 associated with that disease.

9 So when I say that what United is arguing is that
10 the numbers are all wrong, what I mean is they say if you
11 want to hold us to only submitting for payment diagnoses
12 that can be documented, then these aren't the right
13 coefficients, you need some other range of coefficients.

14 **THE COURT:** Yeah, and now I'm with you, now I'm
15 understanding your point. Because the coefficients are set
16 based on the unaudited CMS numbers and then applied in a
17 more strict fashion. And so if they're incorrect because
18 the CMS files are unaudited so that there is a larger number
19 of misdiagnoses or erroneous diagnoses than your
20 coefficients account for in CMS files, then your numbers
21 come out lower than they would otherwise. And those are the
22 lower numbers that are then given to the Medicare Advantage
23 insurers. But then they're held to a no error -- almost no
24 error, not quite, I know. Almost no error standard that
25 certainly isn't applied to CMS and doesn't go into setting

1 the coefficients.

2 I mean, you're right, you can look at it for
3 dollars at the end or coefficients at the beginning, but
4 it's the same problem. It's unaudited files being used to
5 compare to audited files. And that makes a distinction that
6 has a huge difference and comes out not meeting the
7 actuarial equivalence requirement.

8 Now, the alternative is to say well, we're not
9 going to do that. We don't care about actuarial
10 equivalence, we're just going to get Congress to take those
11 words out, that's fine, and the entire Medicare Advantage
12 program collapses. And then CMS has another one-third of
13 the population -- or it increases its population by
14 one-third.

15 And the theory -- and I don't know the fact, the
16 theory is that the insurers, somewhat smaller, more intense,
17 more efficient, whatever, they make their money off
18 efficiency. I don't understand it, but that's the theory.
19 So then you'd be left with --

20 **MR. BICKFORD:** So your Honor --

21 **THE COURT:** I mean, that doesn't seem like the
22 right answer.

23 **MR. BICKFORD:** Certainly CMS does not believe,
24 does not intend to do anything that would cause that effect
25 and does not believe that anything it has done would cause

1 that effect. If I can return to the actuarial equivalence?

2 **THE COURT:** Yeah, keep trying.

3 **MR. BICKFORD:** So I think it's important to
4 understand, as I was trying to make clear, that the import
5 of United's theory is that these coefficients are wrong.
6 The coefficients weren't changed by the overpayment rule in
7 any way.

8 Now as to the question -- there are certainly
9 errors in the CMS data associated with Parts A and B. If I
10 could just spend a moment on how CMS actually pays hospitals
11 and doctors in Parts A and B. I believe United's counsel
12 said that providers had no incentive to code accurately.
13 That's not true.

14 Hospitals have -- there is a very complicated --
15 I'm sorry that I keep saying that, but it's true. There's
16 something called the Inpatient Prospective Payment System
17 which is now how hospitals are paid under Part A which is
18 the larger portion of that program. Hospitals are paid on
19 the basis of the diagnosis-related group to which a given
20 admitted patient is assigned. As one might expect, the
21 patient's diagnosis plays a substantial part.

22 **THE COURT:** It sounds like you're importing
23 Medicare Advantage to the hospitals.

24 **MR. BICKFORD:** No, this is -- I believe that the
25 Inpatient Prospective Payment System has been operating

1 since 1983 which was long before Medicare Advantage came
2 into existence. So hospitals do actually have a strong
3 incentive to code their patients accurately, because it does
4 directly affect their payments. It affects the
5 diagnosis-related group to which a given patient is
6 assigned.

7 There had been concern at the beginning of the
8 Medicare Advantage program that outpatient doctors -- which
9 is what Part B covers, the associated visits might not be as
10 accustomed to accurate diagnosis coding, might not have the
11 same internal compliance systems that hospitals do. And
12 that there may be some greater incidence of inaccurate
13 coding. In the Part B population, there is now an analogous
14 Outpatient Prospective Payment System which is in most cases
15 how Part B beneficiaries are paid.

16 So we don't dispute that there are errors in the
17 underlying fee-for-service claims data, but it isn't the
18 case that providers in that population have no incentive to
19 code accurately.

20 **THE COURT:** I would understand lawyers advocacy, I
21 promise, including yours. But I understand lawyers
22 advocacy. You need to wrap up so that I can get fresh
23 coffee and we can have a reply argument.

24 **MR. BICKFORD:** Your Honor, so I'd like to turn to
25 the fee-for-service adjuster if I could briefly?

1 **THE COURT:** Yes.

2 **MR. BICKFORD:** So United has argued -- United is
3 asking this Court and the Amicus is asking this Court to
4 issue a very broad ruling which would have substantial
5 implications for a \$200 billion program. They have asked
6 your Honor to find that the risk adjustment system,
7 implemented by CMS since at least 2004 for the current
8 model, fails to meet the statutory requirement of actuarial
9 equivalence. That would -- we do not believe that's true.
10 And in any case, that is a far broader issue than need be
11 resolved to resolve the challenge here.

12 As your Honor is aware, the agency adopted a
13 fee-for-service adjuster to adjust the overpayment amount
14 applied to audited Medicare contracts. It has refused to
15 apply the same or analogous fee-for-service adjuster to
16 unaudited contracts despite being asked by the industry in
17 comments to the proposed overpayment rule to do so. Clearly
18 this Court has jurisdiction to review the agency's refusal
19 to adopt an FFS adjuster in the overpayment rule context.

20 This Court could, were it so inclined -- and we
21 don't encourage it to do so, but could find simply that the
22 agency did not adequately explain why it was refusing to
23 adopt the FFS adjuster in the overpayment rule context when
24 it had done so in the audit context.

25 A further step down the spectrum, the Court could

1 find that the agency itself in 2012, when it adopted the FFS
2 adjuster, had reached some conclusion about the validity of
3 United's theory of systemic underpayment; and that having
4 reached that conclusion, it was bound to follow it through
5 in the overpayment context. Neither of those holdings would
6 commit the Court itself to a view of whether the
7 long-standing risk adjustment model did or did not achieve
8 actuarial equivalence. Both would rest on the agency's own
9 ruling.

10 The agency, as the Court is aware -- the agency's
11 own reasoning as interpreted by the Court. As the Court is
12 aware, the agency has been studying the effect of these
13 errors in its fee-for-service claims data for the last six
14 and a half years. It has learned considerably more over the
15 course of its, quote, RADV-like review of records submitted
16 to support the FFS claims data. And once that review is
17 finalized, the agency will act on the FFS adjuster on the
18 basis of its current knowledge and not what it believed in
19 2012.

20 We would strongly encourage the Court not to
21 attempt to hold -- not to attempt to analyze whether the
22 actuarial validity of the entire risk adjustment system --
23 which is a question that you need not reach to resolve this
24 case and contains a great deal of technical complexity which
25 the agency itself has been looking into over the last six

1 and a half years, and not to attempt to hold the agency to
2 its views of that issue in 2012. Agencies are always free
3 to continue to study an issue. And so long as they have a
4 reasoned basis to do so, to alter course in some way subject
5 to judicial review.

6 I understand that your Honor will take it as
7 advocacy, but as an advocate, I object to my opposing
8 counsel's suggestion that were your Honor to resolve this
9 case on more limited grounds, the agency would engage in
10 some subterfuge to ensure that judicial review was never
11 available again.

12 We have conceded in this litigation that each time
13 the agency finalize those risk adjustment coefficients, that
14 is a final agency action subject to judicial review. If the
15 insurers believe that those risk adjustment coefficients
16 violate the statutory mandate for actuarial equivalence,
17 they can file an APA suit every time. They haven't done so.

18 What they can't do and what in any event we
19 discourage your Honor from ruling on the basis of is
20 bringing a challenge to a fairly technical rule about the
21 penalty associated with payments; and using that to try to
22 bring down the entire risk adjustment system that CMS has
23 been operating for 20 years.

24 Respectfully, your Honor, if there are no further
25 questions.

1 **THE COURT:** I thank you for saying that, sir. You
2 ended strongly. I'm going to take a break for 10 minutes,
3 we'll be back at 25 of. You'll have 15 or 20 minutes if you
4 need it.

5 (Off the record at 11:25 a.m.)

6 (Back on the record at 11:35 a.m.)

7 **MR. MERON:** May it please the Court, you've been
8 very indulgent. I obviously will answer any questions your
9 Honor has. But unless you have questions, I'd like just to
10 address what counsel for the Government said at the very end
11 of his argument.

12 **THE COURT:** Go right ahead.

13 **MR. MERON:** Our position, we think it's very clear
14 from the briefing and we said it below, was that a
15 fee-for-service adjuster was required in order to comply
16 with the statutory mandates of actuarial equivalence and
17 same methodology. We believe that your Honor should address
18 that issue and provide clarity, both to the Government and
19 to us, about the statutory scheme that applies here.

20 Now, the Government says it wants you to think
21 that the sky's going to fall, we're trying to sort of undo
22 what's been happening for decades. That's really not the
23 case. The reality is that these issues have all come up
24 very recently for the agency. And if you'd like, I can try
25 to explain why.

1 Prior to 2004, to the extent there was any risk
2 adjustment, it was based entirely on hospital diagnosis
3 codes which both sides agree are very, very accurate. And
4 even that component affected only 10 percent of the payment.
5 The history of this, your Honor, for your convenience, it's
6 laid out in 5679 of the administrative record and in 2409 of
7 the administrative record.

8 So prior to 2004, the data doesn't have many
9 diagnosis code errors in it, and to the extent they do it's
10 only 10 percent of your payment. It's a de minimis issue,
11 no one's focused on it. In 2004 -- which is not centuries
12 ago, they changed the system to now be based in very large
13 part on physician diagnosis coding which does have a lot of
14 error. That's phased in from 2004 to 2007.

15 During that period, the audits the Government does
16 are either purely educational and recovered no funds at all
17 or recovered only specific codes that were identified in the
18 sample. And the recoveries were again completely de
19 minimis. There's a particular audit at 11736 of the record,
20 and you can look at it and see that it resulted in
21 adjustment of less than 1/100th of 1 percent. So no one's
22 focused on this issue.

23 The Government then in 2008 says okay, we're now
24 going to make a major change -- and the word major change is
25 not mine, it's the Government's. It's at 2409. It says

1 we're now for the first time -- and this is in 2009, they're
2 saying we're going to now use these audits to adjust
3 payments on a contract. Immediately plans file comments
4 saying you can't do that, you have to account for your own
5 errors. This is going to lead to systemic underpayment. As
6 your Honor said, no one cares about \$1,500. But when you're
7 talking about ten of millions, people care and the
8 Government thinks about it. In 2010, CMS's response was
9 there's potential merit to that issue and we'll think about
10 it. And in 2012, it culminates with adoption of the
11 adjuster, and this rule is then proposed less than two years
12 later.

13 So the idea that we are trying to shake settled
14 ground here is just a massive exaggeration. The sky will
15 not fall if the agency essentially is required to do what it
16 did already with respect to its own audits which is to
17 account for the existence of its own errors in order to
18 comply with the statutory mandates of actuarial equivalence
19 and same methodology.

20 I'm happy to address any questions.

21 **THE COURT:** And so if the suggestion was made by
22 Mr. Bickford that maybe the answer is to direct CMS to apply
23 the FFS adjuster in this circumstance in determining
24 overpayments rather than just going without that adjustment,
25 either on the theory that that solves the problem or that

1 the agency reached that conclusion in 2012 and so it hasn't
2 really explained why that's not the right conclusion and so
3 it's stuck with it -- I said stuck, you said they were quite
4 granite I think.

5 In any event, does that answer your problem?

6 **MR. MERON:** So yes and no. So it answers the
7 problem in the sense of what plans asked for below was a
8 fee-for-service adjuster. And if the agency implements a
9 fee-for-service adjuster as part of its calculation of
10 overpayments, that would -- as long as they're really by the
11 way auditing themselves to the same strict standards they
12 apply to us so everything is truly being done on a fair
13 apples to apples basis, that would cure the injury.

14 But the legal basis that we believe they're
15 required to have a fee-for-service adjuster is the statutory
16 mandate of actuarial equivalence and same methodology, and
17 we're asking the Court to clarify that.

18 **THE COURT:** Okay, thank you.

19 **MR. MERON:** You're welcome.

20 **THE COURT:** I had some other questions for the
21 Government if I might, for Mr. Bickford.

22 What does the Government suggest I do if -- and I
23 haven't decided this. I've spent a lot of time on it, but I
24 haven't decided it because I really wanted to hear from you
25 folks. I usually wait until after I've heard argument

1 before I decide, it just seems only fair.

2 But anyway, if the decision is that actuarial
3 equivalence for purposes of audits and/or overpayments must
4 account for the problem that there are differences in the
5 datasets, one unaudited and one audited, does that tear
6 apart your entire fabric?

7 **MR. BICKFORD:** Yes, your Honor.

8 **THE COURT:** And why would that be?

9 **MR. BICKFORD:** Because that holding would imply
10 that all of the risk adjustment coefficients were incorrect.

11 **THE COURT:** I mean, I actually don't think so
12 because -- well, never mind what I think. You keep going.

13 **MR. BICKFORD:** May I?

14 **THE COURT:** Yes, please.

15 **MR. BICKFORD:** So the coefficients are calculated
16 on the basis of the Part A and B claims data as your Honor
17 is aware. And that is those -- that very simple table of
18 numbers is what the agency uses to administer the program.
19 If it is the case that some errors in the A and B data --
20 and I'd like to emphasize to the Court as we say in our
21 briefs, errors can go both ways. There can be diagnoses
22 that are erroneously included, and diagnoses that are
23 erroneous excluded.

24 **THE COURT:** Right.

25 **MR. BICKFORD:** And there is no reason to

1 believe -- the agency has at least not reached any
2 conclusion that the erroneously included errors outweigh the
3 erroneously excluded errors. If it were the case that for
4 some reason errors in the A and B data meant that propagated
5 through to the coefficients in a way that systematically
6 deflated them as United says, and then made their
7 application too accurate -- which is to say supported by
8 medical record documentation, accurate diagnoses in the Part
9 C system, made that application actuarially inequivalent,
10 the agency would need to recalculate the coefficients to
11 raise them by whatever. And that is the very problem the
12 agency has been studying since it finalized the RADV
13 methodology.

14 I don't frankly believe there is sufficient record
15 before this Court for this Court to reach the conclusion on
16 its own that the risk adjustment system does not achieve
17 actuarial equivalence.

18 **THE COURT:** Well, okay. Let me say that I think
19 the record is sufficient for me to conclude, if I agree with
20 those parts of the record that support this statement, that
21 basing audits of overpayment programs on comparing unaudited
22 data to audited data creates an actuarial inequivalence.

23 Now, I don't know -- I mean, I'm not an actuary.
24 I don't know that that necessarily means that the
25 coefficients are poor. Goodness knows HHS would know that

1 or CMS would know that, they've been studying it for six
2 years. But I don't know how to avoid the statutory language
3 that says actuarial equivalence. And so it would appear
4 from the record and past history that whatever the issue
5 might exist between the two databases which are used, that
6 that could be addressed through an adjuster.

7 And if an adjuster is sufficient for that purpose,
8 then the standard is actuarial equivalence which can be
9 achieved with an adjuster until and unless they change the
10 coefficients. But it doesn't say you have to change the
11 coefficients, it just says you have to calculate what the
12 adjuster should be --

13 **MR. BICKFORD:** Your Honor --

14 **THE COURT:** -- which they've already been doing.
15 I mean, I can't see that I can say well, that's the end of
16 the world. See what I mean?

17 **MR. BICKFORD:** Your Honor, whether the
18 coefficients achieve actuarial equivalence is respectfully
19 what we used to describe in law school as an empirical
20 question. If there is -- it's a question of whether the
21 model is valid or invalid. As we say repeatedly in our
22 briefs, it's clearly a question as to which this Court must
23 apply arbitrary and capricious review. The question is
24 about the validity of the agency's technical calculation
25 which is an arbitrary and capricious question.

1 **THE COURT:** Okay.

2 **MR. BICKFORD:** I don't think that this Court
3 could, or in any event should, in the first instance say I
4 am de novo interpreting the statutory language of actuarial
5 equivalence, and this is the United States District --

6 **THE COURT:** No, no, no, I'm saying if I did
7 something like that, what I would say is that the agency
8 itself has recognized this issue. I'm not making it up.
9 I'm not saying well, I'm just a genius so zot, I've got this
10 all figured out. But the statute is clear, the arguments
11 have been made by some very knowledgeable actuaries, and the
12 agency adjusted as a result. And it didn't this time, and
13 doesn't actually give me a good reason why not.

14 **MR. BICKFORD:** And if the Court were to say --
15 again, we discourage this, but if the Court were to say that
16 the agency itself had reached a conclusion about this
17 problem and that it was therefore obligated to apply that
18 conclusion in this context, I think that would -- while it
19 would disrupt the program in some ways, would give the
20 agency the freedom that it should have to continue to study
21 this issue; to publish the results of its study; to
22 receive -- to give notice and receive comment on what it
23 believes the actual facts of this problem to be or not be
24 and how it proposes to address them. And to then role that
25 out in a way that would allow for the fair administration of

1 the program.

2 **THE COURT:** And so explain to me why all of that
3 doesn't flow just as you described, exactly as you
4 described. If I look at the overpayment rule and I say
5 well, I have this actuarial issue. I have input in 2012 --
6 or 2010 on it. I have agency response to that issue. They
7 haven't done that in this rule. Actuarial equivalence is
8 the rule in the law. Therefore, the 2014 overpayment rule
9 doesn't work on its face. But if the agency adopted
10 actuarial equivalence again, that would probably cure the
11 problem.

12 **MR. BICKFORD:** So your Honor, I think the last
13 step is where I would respectfully quibble. What I heard
14 your Honor to say the agency hasn't adopted actuarial
15 equivalence or actuarial equivalence --

16 **THE COURT:** No, no, I said it didn't adopt the
17 adjuster.

18 **MR. BICKFORD:** I apologize.

19 **THE COURT:** I understand your point. You don't
20 want me to say in haec verba the diagnostic codes do not
21 achieve actuarial equivalence. What I'm proposing is
22 actuarial equivalence is what the standard essentially is.
23 No argument that insurers, doctors, hospitals are supposed
24 to return monies that they receive from CMS for improper
25 coding. It doesn't matter whether it's a Medicare Advantage

1 insurance doctor or a hospital doctor, everybody agrees with
2 that.

3 Okay, so we have this overpayment rule which has
4 this very wide definition of identified. But critically,
5 it's based on these two different datasets, and they're
6 significantly different enough that CMS itself said we need
7 an adjuster. And so it seems to me they haven't said
8 anything about why they shouldn't have an adjuster here --
9 I'll quote you. I'm making this up as I go along.
10 Hopefully one would be more articulate in writing it down.
11 But you're following my drift that I don't need to say to
12 get resolution of this overpayment rule case that the
13 coefficients do not achieve actuarial equivalence.

14 I can just say this is what the agency did because
15 they're two different datasets. This is what the Actuarial
16 Association of America said. This is what everybody said.
17 This is what they did. They haven't explained why they're
18 not doing it. I mean, you've started from a proposition if
19 we pay the same to begin with. But as I say, it seems to me
20 that doesn't actually answer it sufficiently.

21 But if I avoid saying oh my word, you have to redo
22 the whole program, then you can adopt, apply, calculate an
23 adjuster until you finish the study and you figure out, the
24 agency figures out how it wants to proceed. That may take
25 longer or shorter. It's highly complicated, I'm not

1 pretending it's not. But this isn't quite so complicated.
2 It's complicated enough, but not as complicated as what CMS
3 is trying to achieve.

4 So I don't want to tell them what they have to do,
5 I can just say well, you can't do this. You have to follow
6 the conclusion, the decision you made before because it is
7 so supported. And there is no real support for not
8 following it now.

9 **MR. BICKFORD:** So I think that would be a
10 reasonably narrow ruling, your Honor. Let me see if I can
11 move you off of it in the moment or two that I have left.

12 **THE COURT:** Okay.

13 **MR. BICKFORD:** We suggest in our briefs and today
14 several reasons why it would have made sense for the agency
15 to adopt an FFS adjuster in the audit context but not
16 outside of it. We suggest the agency was concerned with
17 large audit recoveries; that it wanted to soften the blow to
18 insurers who don't know whether they will be audited in a
19 given year. We suggest that the agency may have had some
20 concerns with the effect of the statistical extrapolation
21 that it was going to use to calculate --

22 **THE COURT:** I wanted to ask you about that, but it
23 just seemed to be kind of sidelined.

24 **MR. BICKFORD:** I don't think it's the central
25 issue, but we do think it was among the agency's concerns in

1 adopting the FFS adjuster in the audits. And then I
2 suggested as well today that to the extent that the adjuster
3 is an exercise of the agency's discretion and not compelled
4 by statute, it made sense for the agency to exercise its
5 discretion to soften the blow in the audit context where
6 there is no finding of blame; but not in the overpayment
7 context where the machinery only kicks in when the insurer
8 has identified an overpayment and failed to return it on a
9 timely basis.

10 Respectfully, your Honor, I don't believe that the
11 definition of identified affects the larger portion of the
12 case really in any way. I think that is a separate issue,
13 and we rest on our briefs as to that issue.

14 **THE COURT:** Okay.

15 **MR. BICKFORD:** Unless there are any further
16 questions?

17 **THE COURT:** There are not.

18 **MR. BICKFORD:** Thank you.

19 **THE COURT:** There are not. And I want to thank
20 you all for your briefs, for the education. I will say that
21 I like Medicare cases because they make you work so hard.
22 And this is no different than that. We will work as hard as
23 we can and try to come up with a decision that I hope will
24 make sense and abides by the law.

25 Thank you, everybody. It was very good to see

1 you.

2 (Proceedings adjourned at 11:57 a.m.)

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C E R T I F I C A T E

I, **Jeff M. Hook, CSR, RPR**, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

August 9, 2018

DATE



Jeff M. Hook, CSR, RPR

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