LATHAM & WATKINS LLP
David J. Schindler (Bar No. 130490)
david.schindler@lw.com
355 South Grand Avenue, Suite 100
Los Angeles, California 90071-1560
Telephone: +1.213.485.1234
Facsimile: +1.213.891.8763

LATHAM & WATKINS LLP
Daniel Meron (appearing *pro hac vice*)
daniel.meron@lw.com
Kathryn H. Ruemmler (appearing *pro hac vice*)
kathryn.ruemmler@lw.com
Abid R. Qureshi (appearing *pro hac vice*)
abid.qureshi@lw.com
555 Eleventh Street, NW, Suite 1000
Washington, DC 20004-1304
Telephone: +1.202.637.2200
Facsimile: +1.202.637.2201

Attorneys for United Defendants

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.

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

RULES

REGULATIONS

I. INTRODUCTION

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

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

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

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

The government also ignores its two common law claims. As explained in 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

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

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

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

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

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

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

II. PROCEDURAL & FACTUAL BACKGROUND

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

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

United served its first document requests on the government in August 2017. More than a year later, the government has produced only about 44,000 documents. Meanwhile, United has produced over 376,000 documents[1] since receiving the government's first document requests in October 2017, in addition to

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

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

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

United first sought judicial intervention after the government refused to make two CMS officials available for depositions, arguing that depositions should be delayed because of the possibility that motion practice might alter the scope of discovery. *See* Ex. 1, Tr. of Dec. 18, 2017 Conf. at 5:1–4.[2] Magistrate Judge Segal rejected this argument, stating that United was entitled to proceed with the depositions. *Id.* at 10:12–11:15. These depositions confirmed United's positions on several critical issues. *See, e.g.*, *infra* at 10 n.7, 12 n.9.

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

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

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

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

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

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

III. ARGUMENT

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

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

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

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

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

- "[Defendants'] effort to identify the invalid codes submitted by these incentivized providers was limited to the RACCR Program. Moreover, [Defendants] designed and implemented the RACCR Program to limit its scope and to minimize the number of invalid diagnoses for which [Defendants] would have to return overpayments to CMS," *id.* ¶ 239;
- "[Defendants] knew they had an obligation to review diagnoses reported by incentivized providers to determine their validity," *id.* ¶ 244;
- "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

> diagnosis codes. There were various fundamental limitations on the RACCR Program," *id.* ¶ 245

None of these allegations relate in any way to unsupported codes allegedly "revealed" (at 7) by United's chart reviews.

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

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

[3] For example, United is seeking discovery "regarding any obligation or requirement that MA Plans validate the accuracy of diagnosis codes submitted on claims data before they submit claims data to CMS," United's Request for 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.

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

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

---

[5] United seeks documents "regarding the RADV Medicare fee-for-service ('FFS') error rate adjuster," including documents describing the government's efforts to calculate a Medicare FFS error rate and analyses related to measuring the accuracy of diagnoses submitted on FFS claims. RFP No. 6.

[6] Citations to "Schindler Decl." refer to exhibits to the Declaration of David J. Schindler in Support of United's Opposition to Plaintiffs' Motion for Partial Summary Judgment (Dkt. 254).

[7] The government produced a document in response to a FOIA request—though it attempted to shield that document in this litigation—that contains notes from an internal CMS presentation about the need to account for CMS's own error rate in 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 deposed in this case to date) testified that, assuming the coding intensity adjustment fully offsets any activities that an MA plan undertakes to code more 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.

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

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

[8] For example, United seeks discovery "relating to CMS policies, guidance, or procedures relating to the requirement . . . that CMS pay MA plans in a manner that 'ensures actuarial equivalence.'" RFP No. 2-19.

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

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

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

[9] Jeffrey Grant—a CMS official who oversaw the creation of the risk adjustment 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

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

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

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

---

very specific data element . . . that [it] know[s] is wrong." Schindler Decl. Ex. 7, Grant Dep. at 321:21–23 (Dkt. 254-1). He stated that performing one-way reviews that add diagnosis codes, without looking at whether previously-submitted codes 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.

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

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

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

---

[10] For example, United is seeking discovery relating to the government's 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.

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

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

[11] The deletes the government alleges United should have made would be "closed 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.

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

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

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

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

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

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

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

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

---

[13] The *Silingo* court went so far as to state: "We assuredly do not hold now that 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.

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

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

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

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

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

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

---

[14] The Ninth Circuit also stated that Silingo was "entitled to continue taking discovery before her claims are resolved on summary judgment or at trial." Id. at 633. United similarly is entitled to discovery.

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

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

The government claims that United is seeking "burdensome discovery" and laments that it must collect and review an "inordinate volume of documents." (Mot. at 3, 14.) The government's complaints ring hollow, given that the government opted to bring this action and knew the scope of this case, the volume 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:

Discovery by United	**Discovery by the Government**
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 *Swoben*	About 600 mostly publicly available produced documents in *Swoben*

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]	*N/A. United has not served any Interrogatories to date.*
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 *solely* 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.

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

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

[17] If United prevails on its motion to compel such documents, any alleged burden the government faces related to its privilege logs would be significantly reduced 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.

IV. CONCLUSION

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

Dated: August 27, 2018

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

By /s/ David J. Schindler
David J. Schindler
Attorneys for United Defendants

LATHAM & WATKINS LLP
David J. Schindler (Bar No. 130490)
david.schindler@lw.com
355 South Grand Avenue, Suite 100
Los Angeles, California 90071-1560
Telephone: +1.213.485.1234
Facsimile: +1.213.891.8763

LATHAM & WATKINS LLP
Daniel Meron (appearing *pro hac vice*)
daniel.meron@lw.com
Kathryn H. Ruemmler (appearing *pro hac vice*)
kathryn.ruemmler@lw.com
Abid R. Qureshi (appearing *pro hac vice*)
abid.qureshi@lw.com
555 Eleventh Street, NW, Suite 1000
Washington, DC 20004-1304
Telephone: +1.202.637.2200
Facsimile: +1.202.637.2201

Attorneys for United Defendants

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 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").

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

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

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

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

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

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

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

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

By Rebecca Martin
Rebecca Martin

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.

Contents

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/mapdhelpdesk/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 years[2], 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.csscoperations.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.csscoperations.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.

LATHAM & WATKINS LLP
David J. Schindler (Bar No. 130490)
david.schindler@lw.com
355 South Grand Avenue, Suite 100
Los Angeles, California 90071-1560
Telephone: +1.213.485.1234
Facsimile: +1.213.891.8763

LATHAM & WATKINS LLP
Daniel Meron (appearing *pro hac vice*)
daniel.meron@lw.com
Kathryn H. Ruemmler (appearing *pro hac vice*)
kathryn.ruemmler@lw.com
Abid R. Qureshi (appearing *pro hac vice*)
abid.qureshi@lw.com
555 Eleventh Street, NW, Suite 1000
Washington, DC 20004-1304
Telephone: +1.202.637.2200
Facsimile: +1.202.637.2201

Attorneys for United Defendants

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 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

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

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

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

By MaryBeth Meyer
MaryBeth Meyer

LATHAM & WATKINS LLP
David J. Schindler (Bar No. 130490)
david.schindler@lw.com
355 South Grand Avenue, Suite 100
Los Angeles, California 90071-1560
Telephone: +1.213.485.1234
Facsimile: +1.213.891.8763

LATHAM & WATKINS LLP
Daniel Meron (appearing *pro hac vice*)
daniel.meron@lw.com
Kathryn H. Ruemmler (appearing *pro hac vice*)
kathryn.ruemmler@lw.com
Abid R. Qureshi (appearing *pro hac vice*)
abid.qureshi@lw.com
555 Eleventh Street, NW, Suite 1000
Washington, DC 20004-1304
Telephone: +1.202.637.2200
Facsimile: +1.202.637.2201

Attorneys for United Defendants

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.).

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

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

By: /s/ Abid R. Qureshi
Abid R. Qureshi
Attorney for United Defendants

EXHIBIT 1

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

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

TELEPHONIC CONFERENCE RE DISCOVERY

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

APPEARANCES:	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.

APPEARANCES:

For Plaintiff:

HENRY C. SU, ESQ.
Constantine Cannon
1001 Pennsylvania Ave. NW
Suite 1300N
Washington, DC 20004

JOHN E. LEE, ESQ.
Office of the U.S. Attorney
300 N. Los Angeles, Rm. 7516
Los Angeles, CA 90012

JOHN P. LAHAD, ESQ.
Susman Godfrey
1000 Louisiana St., Suite 5100
Houston, TX 77002

PAUL G. FREEBORNE, ESQ.
U.S. Department of Justice
601 D Street NW, Suite 9934
Washington, TX 20004

For Defendants:

DAVID J. SCHINDLER, ESQ.
Latham & Watkins
355 S. Grand Ave., Suite 100
Los Angeles, CA 90071

DANIEL MERON, ESQ.
ABID R. QURESHI, ESQ.
Latham & Watkins
555 Eleventh St. NW, Suite 1000
Washington, DC 20004

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

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

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

THE COURT: All right. Thank you.

So for the United States?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COURT: And Judge --

(Voices overlapping)

MR. FREEBORNE: (indisc.)

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COURT: All right. I wish I could be of more assistance to you. I guess what I would hope that the parties 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.

Signed **December 21, 2017**

Dated

TONI HUDSON, TRANSCRIBER

EXHIBIT 2

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

UNITED STATES ex rel BENJAMIN POEHLING,	)	
Plaintiffs	)	CV-16-8697-MWF
VS	)	
UNITEDHEALTH GROUP, INC., et al,	)	
Defendants	)	

REPORTER'S TRANSCRIPT OF PROCEEDINGS

LOS ANGELES, CALIFORNIA

Monday, April 9, 2018

Amy C. Diaz, RPR, CRR, FCRR
U.S. Official Court Reporter
350 W. 1st Street, #4455
Los Angeles, CA 90012
www.amydiazfedreporter.com

APPEARANCES OF COUNSEL:

For the Plaintiffs

CAROL WALLACK
U.S. Department of Justice
P.O. Box 261
Washington, D.C. 20044

JOHN E. LEE
U.S. Department of Justice
Central District of California
300 North Los Angeles Street
Suite 7516
Los Angeles, CA 90012

MARK JUSTIN DRAYCOTT
JESSICA KRIEG
PAUL FREEBORNE
U.S. Department of Justice
601 D Street NW Room 9135
Washington, DC 20004

For the Relator:

ANNE HAYES HARTMAN, ESQ.
HARRY P. LITMAN, ESQ.
Constantine Cannon LLP
150 California Street Suite 1600
San Francisco, CA 94111

JOHN LAHAD, ESQ.
Susman Godfrey LLP
1000 Louisiana Street Suite 5100
Houston, TX 77002

STEPHEN HASEGAWA, ESQ.
Phillips and Cohen LLP
100 The Embarcadero Suite 300
San Francisco, CA 94105

For the Defendant UnitedHealth Group	DAVID SCHINDLER, ESQ. Latham & Watkins LLP 355 South Grand Avenue Los Angeles, CA 90071
	DANIEL MERON, ESQ. Latham & Watkins LLP 555 Eleventh Street NW Suite 1000 Washington, D.C. 20004

* * *

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

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

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

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

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

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

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

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

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

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

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

All right. Thank you, counsel.

***** ***** *****

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

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

UNITED STATES OF AMERICA, PLAINTIFF, V. UNITEDHEALTH GROUP, INC., ET AL., DEFENDANTS.	16-CV-08697-MWF(SSX) FEBRUARY 8, 2018

TELEPHONIC CONFERENCE

BEFORE THE HONORABLE SUZANNE H. SEGAL
UNITED STATES MAGISTRATE JUDGE

APPEARANCES:	SEE NEXT PAGE
COURT REPORTER:	RECORDED; XTR
COURTROOM DEPUTY:	YVETTE FOR MARLENE RAMIREZ
TRANSCRIBER:	DOROTHY BABYKIN COURTHOUSE SERVICES 1218 VALEBROOK PLACE GLENDORA, CALIFORNIA 91740 (626) 963-0566

PROCEEDINGS RECORDED BY ELECTRONIC SOUND RECORDING;
TRANSCRIPT PRODUCED BY TRANSCRIPTION SERVICE.

APPEARANCES:

FOR THE PLAINTIFF UNITED STATES OF AMERICA:

U.S. DEPARTMENT OF JUSTICE
CIVIL DIVISION - FRAUD SECTION
BY: PAUL PERKINS
MARK JUSTIN DRAYCOTT
PAUL G. FREEBORNE
TRIAL ATTORNEYS
601 D STREET NW
SUITE 9135
WASHINGTON, DC 20004

OFFICE OF THE UNITED STATES ATTORNEY
BY: JOHN E. LEE
ASSISTANT UNITED STATES ATTORNEY
300 NORTH LOS ANGELES
ROOM 7516
LOS ANGELES, CALIFORNIA 90012

FOR THE RELATOR:

CONSTANTINE CANNON LLP
BY: MAX VOLDMAN
ATTORNEY AT LAW
1001 PENNSYLVANIA AVENUE NW
SUITE 1300N
WASHINGTON, DC 20004

SUSSMAN GODFREY LLP
BY: JOHN P. LAHAD
ATTORNEY AT LAW
1000 LOUISIANA STREET
SUITE 5100
HOUSTON, TEXAS 77002

APPEARANCES: (CONTINUED)

FOR UNITEDHEALTH GROUP, INC.:

LATHAM & WATKINS
BY: DAVID J. SCHLINDLER
ATTORNEY AT LAW
355 SOUTH GRAND AVENUE
SUITE 100
LOS ANGELES, CALIFORNIA 90071

LATHAM & WATKINS
BY: DANIEL MERON
ATTORNEY AT LAW
555 ELEVENTH STREET NW
SUITE 1000
WASHINGTON, DC 20004

LATHAM & WATKINS
BY: KIRSTIN DO
ATTORNEY AT LAW
330 NORTH WABASH AVENUE
SUITE 2800
CHICAGO, ILLINOIS 60611

LATHAM & WATKINS
BY: ANNE W. ROBINSON
ATTORNEY AT LAW
555 ELEVENTH STREET NW
SUITE 1000
WASHINGTON, DC 20004

I N D E X

16-CV-08697-MWF(SSX) FEBRUARY 8, 2018

PROCEEDINGS: TELEPHONIC CONFERENCE RE DISCOVERY

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

THE COURT: ALL RIGHT.

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

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

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

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

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

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

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

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

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

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

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

NOTHING IN THE RULES THAT WOULD JUSTIFY IT HERE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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, Plaintiff, vs. UNITED HEALTH GROUP, INC, ET AL, Defendants.	CASE NO: 2:16-CV-08697-MWF-SS CIVIL Los Angeles, California Thursday, August 16, 2018

TELEPHONIC CONFERENCE RE DISCOVERY

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

APPEARANCES: SEE PAGE 2

Court Reporter: Recorded; XTR

Courtroom Deputy: Marlene Ramirez

Transcribed by: Exceptional Reporting Services, Inc.
P.O. Box 18668
Corpus Christi, TX 78480-8668
361 949-2988

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

APPEARANCES FOR:

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

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

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

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

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

THE COURT: All right, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On the issue of the -- the privilege logs, that's a difficult issue. It comes up quite often. Because the test in 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.

August 19, 2018

Signed **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:

For the Plaintiffs:
DANIEL MERON
BENJAMIN SNYDER
GRAHAM PHILLIPS
Latham & Watkins
555 11th Street, NW, Suite 1000
Washington, DC 20004

For the Defendants:
JAMES BICKFORD
JOHN TYLER
U.S. Department of Justice
Federal Programs Branch
Civil Division
20 Massachusetts Avenue, NW
Washington, DC 20001

Agency Counsel:
SCOTT SASJACK
U.S. Department of Health and Human Services
Office of the General Counsel
CMS Division
330 Independence Avenue, S.W.
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.

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

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

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

MR. BICKFORD: So there are --

THE COURT: Just say yes or no.

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

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

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

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

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

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

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

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

MR. BICKFORD: So could I back up?

THE COURT: Yes.

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

THE COURT: And how is that rate determined?

MR. BICKFORD: It is a complicated calculation. It does --

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

MR. BICKFORD: Rough --

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

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

THE COURT: Okay, so where does the average come

from?

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

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

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

THE COURT: We're not talking Part C.

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

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

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

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

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

MR. BICKFORD: Yes, your Honor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

you, I appreciate your answers.

MR. BICKFORD: Thank you, your Honor.

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

THE COURT: And your name's Meron?

MR. MERON: Meron.

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

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

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

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

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

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

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

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

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

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

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

MR. MERON: Correct.

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

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

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

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

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

THE COURT: That much I figured.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THE COURT: No, I understand that.

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

Your Honor admitted into the administrative record

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

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

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

actuarially.

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

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

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

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

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

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

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

$10,000.

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

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

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

applying to us.

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

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

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

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

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

MR. MERON: That's right.

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

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

THE COURT: Do you know?

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

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

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

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

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

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

THE COURT: I did that wrong.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

payments?

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

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

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

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

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

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

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

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

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

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

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

THE COURT: Okay, thank you.

MR. MERON: You're welcome.

THE COURT: Mr. Bickford.

MR. BICKFORD: Thank you, your Honor.

THE COURT: Now I have a question for you.

MR. BICKFORD: Good.

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

MR. BICKFORD: So your Honor --

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

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

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

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

THE COURT: Right.

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

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

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

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

THE COURT: Okay, that's helpful.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

not again a new obligation imposed by the overpayment rule.

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

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

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

MR. BICKFORD: Yes, that's correct.

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

audit or the review?

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

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

MR. BICKFORD: Yes, your Honor.

THE COURT: That's all negligence.

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

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

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

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

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

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

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

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

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

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

MR. BICKFORD: Sure.

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

MR. BICKFORD: Okay.

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

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

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

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

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

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

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

their --

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

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

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

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

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

But anyway, it now says that the Medicare

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

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

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

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

MR. BICKFORD: Sue.

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

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

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

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

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

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

MR. BICKFORD: So --

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

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

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

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

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

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

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

Now, how do you get around that?

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

THE COURT: Okay.

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

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

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

What they're arguing is that Congress has required

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

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

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

THE COURT: Push back one more time.

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

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

But even United accepts that the agency can hold

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

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

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

the coefficients.

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

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

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

MR. BICKFORD: So your Honor --

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

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

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

THE COURT: Yeah, keep trying.

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

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

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

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

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

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

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

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

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

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

THE COURT: Yes.

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

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

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

A further step down the spectrum, the Court could

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

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

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

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

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

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

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

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

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

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

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

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

THE COURT: Go right ahead.

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

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

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

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

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

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

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

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

I'm happy to address any questions.

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

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

In any event, does that answer your problem?

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

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

THE COURT: Okay, thank you.

MR. MERON: You're welcome.

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

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

before I decide, it just seems only fair.

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

MR. BICKFORD: Yes, your Honor.

THE COURT: And why would that be?

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

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

MR. BICKFORD: May I?

THE COURT: Yes, please.

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

THE COURT: Right.

MR. BICKFORD: And there is no reason to

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

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

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

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

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

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

MR. BICKFORD: Your Honor --

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

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

THE COURT: Okay.

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

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

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

the program.

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

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

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

MR. BICKFORD: I apologize.

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

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

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

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

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

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

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

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

THE COURT: Okay.

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

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

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

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

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

THE COURT: Okay.

MR. BICKFORD: Unless there are any further questions?

THE COURT: There are not.

MR. BICKFORD: Thank you.

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

Thank you, everybody. It was very good to see

you.

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

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