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UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

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

Plaintiffs,

v.

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

Defendants.

No. CV 16-08697 MWF (SSx)

PLAINTIFFS' REPLY MEMORANDUM IN SUPPORT OF MOTION PURSUANT TO RULE 16(b)(3) FOR SCHEDULING ORDER MODIFYING DISCOVERY

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

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I. INTRODUCTION

For the reasons set forth in the United States' and relator Poehling's opening brief and in this reply brief, Plaintiffs are entitled to a scheduling order under Rule 16(b)(3), precluding unnecessary and burdensome discovery about factual issues that are wholly immaterial to the resolution of this matter. The arguments made by the UnitedHealth Group defendants ("United") in their opposition are without merit for numerous reasons, including, but not limited to, the following reasons.

First, Rule 16 expressly allows the Court to consider limits on discovery as part of its scheduling order. In this case, a Rule 16 order can and should properly modify the scope of discovery based on the Court's rulings on Plaintiffs' pending motions for partial summary judgment, to strike certain of United's affirmative defenses, and to dismiss United's Counterclaim. The Court's rulings on those motions and its expressed views on the legal issues raised by the motions should and, Plaintiffs hope, will focus discovery in this case on those factual issues that are material to the resolution of the case. The proper scope of discovery should also reflect that key issues in this case can and should be resolved a matter of law, especially in light of the controlling Ninth Circuit precedent provided by *Swoben* and *Silingo*. Discovery is unnecessary to resolve these issues.

Second, contrary to United's assertions in its opposition, Plaintiffs do not seek to foreclose relevant factual discovery in this case. Plaintiffs have produced and will continue to produce such factual information (*e.g.*, documents, deposition testimony), subject to relevancy, proportionality, and privilege objections and rulings. Rather, the instant motion is principally concerned with internal non-public agency deliberations and law enforcement investigative materials that are plainly irrelevant and immaterial.

Third, United's opposition is based on a mischaracterization of Plaintiffs' claims relating to its Risk Adjustment Coding Compliance Review ("RACCR") Program. Contrary to United's assertion, the United States' First Amended Complaint ("FAC") does not plead any claim based on United's failure to have a different compliance program. The focus of the FAC, on its face, is United's knowing failure to address the

significant invalid coding by certain financially incentivized providers when it learned of the problems with these providers. These problems were revealed to United by its own chart reviews that it conducted as part of the RACCR program. The claims focus on *United's turning a blind eye to the information* the RACCR chart reviews revealed and not identifying and deleting all of the invalid codes reported by these providers. The claims do not focus on whether United would have discovered other problems with other providers if it had designed a different compliance program.

Fourth, United mischaracterizes Plaintiffs' burden under the False Claims Act ("FCA") with respect to proving knowledge and materiality. Under the FCA, it is Plaintiffs' burden to prove that United had actual knowledge of invalid diagnoses or deliberately or recklessly turned a blind eye to information in its possession about the invalidity of diagnoses that it submitted for payment. Thus, fact discovery regarding this element will be directed to evidence about what *United* knew and what information about invalid diagnoses was in its possession or available to it, including what it did or did not do with the results of its own chart reviews conducted as part of its Chart Review, Claims Verification, and RACCR Programs. Non-public internal government deliberations and internal law enforcement investigative documents have no bearing on United's state of mind as United was not privy to those internal deliberations and investigative efforts during the relevant times.

United also ignores that the "materiality" of diagnosis codes to risk adjustment payments is undisputable. The Ninth Circuit and this Court have recognized and not doubted this. Further, this Court has already rejected United's arguments that CMS' generalized knowledge about chart reviews and coding problems is relevant. This Court has ruled that what is relevant is CMS' actual knowledge of specific invalid diagnoses. *See* Order re Mot. To Dismiss at 21 (filed Feb. 12, 2018) (Dkt. 212) ("generalized knowledge does not amount to actual knowledge of specific invalid diagnoses"). Nonetheless, United's discovery goes far beyond seeking information about CMS' actual knowledge of specific invalid diagnoses and what actions CMS takes to recover

improper payments under circumstances in which an MAO has failed to comply with its obligation to delete invalid diagnoses when it is in possession of information about them.

Fifth, the United States' common law claims do not warrant broad factual discovery. Like the FCA claim, the government's common law claims are also based on the fundamental assumption, built into the automated claims processing system, that MAOs will comply with their obligation to delete invalid payment data from that system, including previously-submitted invalid diagnoses codes, based on information in their possession or otherwise available to them. Extrinsic evidence cannot change this fundamental contractual and regulatory obligation and the ordinary financial consequences if that obligation is ignored.

Sixth, United's complaint regarding the purportedly disproportionate volume of documents produced by each side to date is not pertinent to whether irrelevant discovery ought to be allowed in this case. This is particularly so given that much of the information on the government's side is already and has long been publicly available. Abundant information about CMS' implementation and administration of risk-adjustment under Medicare Parts C and D has been widely available, including via several public websites such as cms.gov and csscoperations.com (including information going back to 2003) and CMS' Health Plan Management System, and is set forth in various types of documents, including, but not limited to, Program Manuals, Participant Guides, regulations, Federal Register notices, training materials, announcements, notices, and memoranda. These types of materials have been available to United over the last two decades. Moreover, because the proper focus in a fraud case is on a defendant's conduct and knowledge, there is no reason to expect that the government will possess an equal number of relevant documents or any amount near that number.[1]

[1] Also, United received the first request for documents from the government during the investigative phase in 2012 and produced documents over several years, mostly from 2014 to 2016. Thus, it is neither surprising nor concerning that, to date, United has produced more documents than the government, which received its first request from United in 2017.

II. ARGUMENT

A. The Scope Of Discovery Should Be Consistent With Ninth Circuit Law And This Court's Rulings On Motions

In the five months since the parties appeared for an initial scheduling conference in this case on April 9, 2018, there have been several significant developments that should shape the scope of discovery. These include: (1) United's filing of an Answer and Counterclaim (Dkt. 223); (2) Plaintiffs' filing of three substantive motions that involve central issues of law in the case (Dkts. 234, 245, 236); and (3) the Ninth Circuit's issuance in July 2018 of a second published decision once again addressing invalid diagnosis coding in the context of risk-adjusted payments under Medicare Part C. During the same period, this Court has deferred the issuance of an initial scheduling order pursuant to Rule 16(b) – which, Plaintiffs believe, is for good reason and related to the items noted above.

Notwithstanding the foregoing, United attributes ill motives to Plaintiffs for requesting clarification and direction from this Court regarding an issue at the heart of Rules 16(b) and 26(b) – the appropriate scope of discovery. But the current motion is not only procedurally proper under the Rules but also practical and consistent with Rule 1, Fed. R. Civ. P ("just, speedy, and inexpensive determination"). Given that the Court has before it Plaintiffs' motions for partial summary judgment, to strike certain of United's affirmative defenses, and dismiss United's Counterclaim, it makes sense for the Court to address in a scheduling order whether and how its rulings should shape the scope of discovery. Plaintiffs therefore do not share United's view that the Court's rulings on the pending motions, and what the Court says about the issues covered by the Rule 16 motion, will be inconsequential to how the parties conduct discovery and prepare this case for trial and whether they do so efficiently and productively.

B. Plaintiffs Are Not Asking The Court To Forestall All Factual Discovery

Plaintiffs have asked this Court to enter an order limiting discovery only as to certain issues in this case that have been, or will be, decided as a matter of law. The two

principal issues raised by Plaintiffs' motion for partial summary judgment are (1) the legal obligation of United to delete invalid diagnosis codes submitted to the Medicare Program for payments and (2) the materiality of the United's failure to delete invalid diagnosis codes on amounts paid to it by the Medicare Program. Plaintiffs submitted a proposed order consistent with their request. Such an order would provide welcome guidance to Magistrate Judge Segal, who has already been called upon to mediate several discovery disputes involving issues squarely encompassed by Plaintiffs' motions. Because any legitimate question concerning how risk adjustment payments are administered by CMS under Part C of the Medicare Program can and ought to be answered by regulation, contract, program manual, official pronouncements and guidance, discovery into confidential internal deliberations of CMS employees and sensitive law enforcement activities conducted by the Office of Inspector General of the Department of Health and Human Services is immaterial and unnecessarily and improperly invades privileges associated with the internal agency deliberations and law enforcement files.

Contrary to United's contentions in its opposition, the relief sought by Plaintiffs' motion is reasonably tailored to the points argued in support of the motion. United incorrectly contends that the relief sought sweeps far more broadly than what is set forth in Plaintiffs' proposed order. For example, a principal objection that United states in opposition to the Rule 16 motion is that "the government seeks to forestall discovery showing the error rate in CMS's own data [*i.e.*, fee-for service claims data]." Opp. at 10, 12. That simply is not the case. The parties have conferred repeatedly over this particular item and the government has advised United that it is producing certain information relating to this issue. To be clear, however, Plaintiffs do not concede that such information is relevant to any legitimate issue in this case and expect that the Court may be called upon to resolve questions of relevancy and proportionality with respect to information relating to United's actuarial equivalence and coding intensity adjuster defenses (if they remain in the case after the Court rules on Plaintiffs' motion for partial

summary judgment) – but that is not today's issue. In sum, a ruling on the Rule 16 motion should be based on what Plaintiffs have actually asked of the Court, not on United's mischaracterization of the requested relief.

C. The Complaint Alleges That United Turned A Blind Eye To The Invalid Coding By Incentivized Providers As Revealed By Its RACCR Chart Reviews

In its partial summary judgment motion briefs, Plaintiffs have asked the Court to rule that United was required to correct the diagnoses that its own chart reviews had revealed to be invalid – and thereby resolve the legal issue at the very center of this case. In opposing the Rule 16 motion, United contends that the government has mischaracterized its own allegations. In so doing, United selectively excerpts, out of context, three short paragraphs from the twenty pages of the FAC that pertain to United's RACCR Program. It then argues that those allegations justify the extraordinarily expansive and burdensome discovery that it has propounded on the government, *i.e.*, that those allegations render such discovery relevant.

However, Plaintiffs' RACCR claims focus on misconduct similar to that alleged for United's Chart Review Program and do not render the requested discovery relevant. Specifically, the RACCR claims focus on United's failure to delete diagnoses found invalid by the RACCR chart reviews that it performed. *See* FAC ¶¶ 280-81. The claims also focus on United's failure to perform further reviews of the diagnosis data submitted by the financially-incentivized providers that failed to pass United's own test based on sample medical record reviews. *See id.* ¶¶ 274-279, 284, and Ex. 15 thereto. The other allegations in the RACCR section of the FAC provide background about the RACCR Program and show that United knew there was a significant problem with the validity of diagnoses reported by its financially-incentivized providers and United knew it bore responsibility for the problem by giving the incentives. Ultimately, the program turned out to be a sham, and United terminated RACCR as a compliance program so that it could avoid losing revenue for codes that the program would reveal were invalid. In its recitation of the FAC's allegations, United critically omits those

allegations that pertain *to what United did or failed to do with the information that its RACCR reviews revealed*, even under the program's strictures.

A full and fair reading of the entire RACCR section thus belies United's characterization of this lawsuit as contending that "United did not do enough affirmatively to audit and review" diagnosis codes. Opp. at 7. As the FAC makes clear, this case is about what United did or failed to do after it obtained information about provider coding problems from its Chart Review, Claims Verification, and RACCR Programs. There is no claim in this case that is premised on the contention that the RACCR Program should have been designed differently. As much as United may wish otherwise, this case is about *what United learned* about provider coding from RACCR, *despite the limitations* it designed into the program, *and what United did or did not do regarding the information* that it indisputably acquired through RACCR.

Accordingly, Plaintiffs' RACCR claims do not justify United's discovery any more than Plaintiffs' claims relating to United's Chart Review Program. Both are based on the same reverse false claims act provision (Count One of the FAC), both focus on United's knowing avoidance of its obligation to repay Medicare for risk-adjusted payments based on invalid diagnosis data, and both focus on the fact that valid diagnoses are material to payment.

D. The FCA's "Knowledge" Element Focuses On United's State Of Mind At The Time Of The Alleged Misconduct, Not That Of The Government

According to United, establishing FCA liability in this case "requires the government to prove . . . 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" the fee-for-service ("FFS") coding error rate under Parts A and B of the Medicare Program. Opp. at 12. As to the question of whether its "belief" was "objectively unreasonable," United further contends it is entitled to explore through unfettered discovery whether

some unnamed CMS official may have "shared its views." *Id*. at 13.[2] The various premises underlying these assertions are incorrect and, in this case, untenable.

First, United incorrectly suggests that, in order to prevail, Plaintiffs must prove "the retention of an overpayment" and that the overpayment must be fixed. *See* Opp. at 9-10. However, Plaintiffs have not pled that United violated the sixty-day Overpayment Statute, 42 U.S.C. § 1320a-7k(d), or CMS' Overpayment Rule promulgated pursuant to that statute. Plaintiffs may prevail by proving an obligation to delete or repay established by a contractual relationship, by a fee-based or similar relationship, or by a statute or regulation as well as by the retention of an overpayment and, moreover, this obligation need not be fixed. *See* 31 U.S.C. § 3729(b)(3).[3] Also, contrary to United's contention (Opp. at 15-16 n.11), whether the deletes that United was obligated to make were "open period" or "closed period" deletes is inconsequential to the issues before this Court. Although United should have deleted unsupported diagnoses from its Chart Review Program in the "open period," at the same time that it submitted the additional diagnoses, the fact that United often voluntarily decided to delay making those deletes until the closed period does not alter its legal obligation to make those deletes.

Second, any FFS coding errors that might exist in the FFS data would not excuse United from deleting invalid diagnoses based on information available to it about such diagnoses. *See* Plaintiffs' Reply in Support of Motion for Partial Summary Judgment at 25-43 (Dkt. 272). United's argument that it is entitled to some free pass for a certain number or percentage of invalid diagnoses is absurd.

Third, United's scienter in this case does not depend on its knowledge of some FFS coding error rate. Rather, it depends on what United knew about the invalidity of

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[2] United continues to mischaracterize the testimony provided by Jeffrey Grant. As explained in Plaintiffs' Reply in Support of Motion for Partial Summary Judgment, at 20-21 (Dkt. 272), Mr. Grant did not say what United claims he said.

[3] Plaintiffs' Motion for Partial Summary Judgment is based on establish the duty to delete and repay arising from contract and regulation. It is not based on United's retention of an overpayment, although Plaintiffs have pled that in the alternative and do not waive the right to make that alternative argument if necessary.

the diagnosis data that it had submitted for payment and, thus, the data that needed to be deleted. The Ninth Circuit's opinions in *United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161 (9th Cir. 2016), and *United States ex rel. Silingo v. Wellpoint, Inc.*, 895 F.3d 619 (9th Cir. 2018), were clear about the proper focus of the knowledge requirement. In *Swoben*, the Ninth Circuit held that the scienter requirement was satisfied when the United defendants "were on notice that their data included a significant number of erroneously reported diagnosis codes" but they nevertheless "turn[] a blind eye to the over-reporting errors." 848 F.3d at 1175. In *Silingo*, the court held that the scienter requirement associated with the submission of invalid risk adjustment data was met when the defendants' contractor "was allegedly obtaining worse-than-average diagnostic information from enrollees who did not otherwise visit a healthcare provider during a calendar year, and thus would not seem to be in such dire health." 895 F.3d at 632. There is no way either Ninth Circuit decision can be construed to support the notion that an FCA defendant's knowledge of inaccurate diagnosis coding, as extensively explicated in those cases, turns on what that defendant knows about error rates in other parts of the Medicare Program.

Fourth, whether United's feigned understanding of its obligation to correct its diagnosis data submissions constitutes an "objectively reasonable" interpretation of law presents *an issue of law*, and hence does not warrant further discovery. *United States ex rel. Purcell v. MWI Corp.*, 807 F.3d 281, 288 (D.C. Cir. 2015); *accord United States ex rel. Donegan v. Anesthesia Assocs. of Kansas City, P.C.*, 833 F.3d 874, 879 (8th Cir. 2016). United's argument presupposes that the federal regulations and Medicare Advantage contracts setting forth this obligation are somehow ambiguous, and that its interpretation of the purportedly ambiguous language is reasonable. *See Donegan*, 833 F.3d at 879 ("Here, the question is whether AAKC's reasonable interpretation of the ambiguous regulation [the term 'emergence'] precludes a finding that it *knowingly* submitted false or fraudulent claims, even if CMS or a reviewing court would interpret the regulation differently."); *Purcell*, 807 F.3d at 288 ("The interpretive questions

whether the term 'regular commissions' is ambiguous and whether MWI's interpretation is objectively reasonable are legal questions.").

As discussed more extensively in the government's motion for partial summary judgment, there is nothing ambiguous about the obligation to correct invalid diagnosis data, as set forth in the federal regulations and the Medicare Advantage contracts. United's argument is thus legally untenable. *See United States ex rel. Brown v. Celgene Corp.*, 226 F. Supp. 3d 1032, 1052 (C.D. Cal. 2016) ("We do not think Celgene's position was objectively reasonable at the time of the alleged violations. Then, as now, there was a CMS regulation stating that Medicare would only reimburse medically accepted uses. 42 C.F.R. § 423.100. There was no judicial authority to the contrary.").[4] Indeed, *Swoben* itself *expressly rejected* United's argument, made under *Safeco*, that its interpretation could be "objectively reasonable" where its obligation had been made clear. 848 F.3d at 1178 ("We again disagree.").

Fifth, even assuming that United were able to make a facially plausible argument regarding the ambiguity of its legal obligation, there would remain a *factual* issue as to whether United knew that its interpretation was unreasonable. Even an "objectively" reasonable interpretation of the law can give rise to liability if the evidence demonstrates that the defendant actually knew of, deliberately ignored, or recklessly disregarded the correct interpretation of the law. *See Brown*, 226 F. Supp. 3d at 1052 ("Celgene makes no effort to show the absence of a material dispute as to this factual question. This is just as well. The record includes no fewer than four presentations in which Celgene recognized that Medicare was prohibited from reimbursing uses that were not 'medically accepted.'"); *see also United States v. Kellogg Brown & Root Services, Inc.*, 2014 WL 1282275, at *7 (C.D. Ill. Mar. 31, 2014) ("[A]n objectively reasonable interpretation

[4] It bears noting that a judicial assessment of whether a legal obligation allows for more than one reasonable interpretation involves looking at "the statutory [or regulatory] text and *relevant court and agency guidance*." *Safeco Ins. Co. of Am. v. Burr*, 551 U.S. 47, 70 n.20 (2007) (emphasis added). Here, relevant CMS guidance only reinforces the absence of any ambiguity regarding United's obligation to correct invalid diagnosis data.

may be knowingly false if the speaker is cognizant of facts that undermine the basis for that interpretation.") (citing *United States ex. rel. Yannacopoulos v. Gen. Dynamics*, 652 F.3d 818, 833 (7th Cir. 2011)). And if a defendant has notice of the possibility that its interpretation is wrong and fails to inquire about the proper interpretation, then the defendant may be found to have acted with deliberate ignorance or reckless disregard. *See* S. Rep. No. 99-345, at 7, reprinted in 1986 U.S.C.C.A.N. at 5272.; *United States ex rel. Williams v. Renal Care Grp., Inc.*, 696 F.3d 518, 530 (6th Cir. 2012) (quoting the FCA's legislative history regarding a limited duty to inquire).[5]

Among the evidence relevant to whether United acted knowingly may be communications between United and CMS. On the other hand, evidence of what some unnamed CMS official with whom United *never* communicated thought about the obligation cannot possibly have had any bearing on United's state of mind. Confidential internal deliberations of the agency or sensitive law enforcement materials to which United would never have been privy by definition could not have impacted United's thought processes. Given so, United's argument smacks of a *post hoc* exercise in legal sophistry, which plainly does not satisfy the requirement that the objectively reasonable interpretation of the law at issue be formed *at the time of the challenged conduct*. *See Brown*, 226 F. Supp. 3d at 1052 ("*At the time of the alleged violation*, it was simply not the case that 'the statutory text *and relevant court and agency guidance* allow[ed] for more than one reasonable interpretation.'") (quoting *Safeco*, 551 U.S. at 70 n.20) (first emphasis added). Because the "knowingly" standard is evaluated at the time of the alleged violation, a defendant cannot escape FCA liability by developing a *post hoc*

[5] This reading of the FCA is consistent with congressional intent. In amending the FCA, Congress recognized that a claim's falsity may not be clear at the time of the relevant conduct. Rather than foreclose liability in such cases, Congress defined the term "knowingly" to impose liability on defendants that act in bad faith. The legislative history of the amendments explains that Congress sought not only to distinguish "honest mistakes" from "'ostrich-like' conduct" and other forms of bad faith, but also to require defendants to conduct "a limited inquiry" to resolve the uncertainty and "ensure the claims they submit are accurate." S. Rep. No. 99-345, at 7, reprinted in 1986 U.S.C.C.A.N. at 5272.

interpretation of the relevant rule that may, in the abstract, be considered "objectively" reasonable. *See* 31 U.S.C. 3729(a)(1)(A)-(B) (liability exists where a person "knowingly presents, or causes to be presented a false or fraudulent claim," or "knowingly makes, uses, or causes to be made or used a false record or statement").

Indeed, in addressing the required mental state in a different context – liability for statutorily "enhanced damages" for patent infringement – the Supreme Court has rejected the notion that the defendant's liability turns on "the ability of the infringer to muster a reasonable (even though unsuccessful) defense at the infringement trial." *Halo Electronics, Inc. v. Pulse Electronics, Inc.*, 136 S. Ct. 1923, 1933 (2016). The Court noted that, under common law principles, "culpability is generally measured against the knowledge of the actor at the time of the challenged conduct." *Id*. In light of those principles, the Court rejected an "objective recklessness" standard employed by the Federal Circuit, because an "objective" standard of that nature would enable "someone who plunders a patent – infringing it without any reason to suppose his conduct is arguably defensible," to escape liability for enhanced damages "solely on the strength of his attorney's ingenuity" at the time of trial. *Id.*

In the FCA context, other courts of appeals and district courts, like the Ninth Circuit, have squarely rejected the proposition that an "objectively reasonable" *post hoc* interpretation of a statutory or regulatory requirement precludes FCA liability. In *United States ex rel. Phalp v. Lincare Holdings, Inc.*, 857 F.3d 1148 (11th Cir. 2017), for example, the Eleventh Circuit held that the district court erred in concluding that a "defendant's identification of a reasonable interpretation of an ambiguous regulation that would have permitted its conduct" necessarily precluded the FCA "knowledge" requirement from being satisfied. *Id*. at 1155. Under that erroneous standard, the court noted that "a defendant could avoid liability by relying on a 'reasonable' interpretation of an ambiguous regulation manufactured *post hoc*, despite having knowledge of a different authoritative interpretation." *Id*. Instead, the Eleventh Circuit held that FCA knowledge must be based on whether the defendant "actually knew or should have

known that its conduct violated a regulation at the time of the alleged violation." *Id.; see also United States ex rel. Bahnsen v. Boston Sci. Neuromodulation Corp.*, 2017 WL 6403864, at *9 (D.N.J. Dec. 15, 2017) ("[A] claimant cannot avoid liability by manufacturing an after-the-fact reasonable interpretation of an ambiguous provision."); *United States ex rel. Armfield v. Gills*, 2011 WL 13151974, at *15 (M.D. Fla. Mar. 31, 2011) (noting that, even after *Safeco*, an objectively reasonable interpretation does not preclude a finding of scienter if there is evidence "that the proffered interpretation is no more than a post hoc rationalization developed by litigation counsel").

United's FFS coding error rate argument is the epitome of a *post hoc* attempt to justify unlawful conduct. As more fully explained in Plaintiffs' Reply in Support of Motion for Partial Summary Judgment at 32-33 (Dkt. 272), the payment error rate adjuster described in CMS' February 2012 RADV methodology was not based on allowing MAOs to submit a certain number or percentage of unsupported diagnoses based on the number or amount of unsupported diagnoses in FFS claims. The methodology was also limited to the context of an audit with extrapolated results. Even United understood that, outside of the extrapolated contract-level audit context, there was no basis for conditioning the deletion of invalid codes on the promulgation of an adjuster. Indeed, based on its Claims Verification Program and after the February 2012 RADV methodology was issued, United deleted approximately 120,000 unsupported diagnoses for date of service year 2011 (payment year 2012) and approximately 27,000 unsupported diagnoses for date of service year 2012 (payment year 2013). (FAC ¶ 235). It is telling that United did not request an adjuster when it made these deletes. Had it truly thought it was legally entitled to such an adjuster, United most certainly would have made the request that the time. Instead, it has now fashioned this meritless *post hoc* argument to excuse its misconduct.

In summary, any *factual issue* concerning United's scienter under the FCA, hinges on *United's knowledge* of its own invalid diagnosis data that it submitted for payments. What some CMS employee may have thought about coding accuracy, but

which was not heretofore communicated to anyone at United, is not relevant *to United's scienter* at the time it was conducting its Chart Review and RACCR Programs and making decisions about what to do with the coding information brought to light by the chart reviews conducted as part of those programs.

E. United's Other Arguments Are Meritless

United also argues that Plaintiffs, in asserting that discovery should be limited pursuant to Rule 16(b), fail to address other purported evidentiary issues deriving from the claims and allegations in this case. United's arguments lack merit.

First, United argues that the government "ignores its common law claims" and seeks to prevent discovery relevant to "the government's own knowledge of unsupported codes" and asserts that the Rule 16 motion "failed to explain how that evidence could *not* be relevant to the government's claim for Payment By Mistake." Opp. at 8-9. However, United overlooks that the common law claims, including the concept of "mistake," like the FCA claim are based on the fundamental assumption, built into automated claims processing system, that the MAOs are abiding by their obligation to ensure that their diagnosis data is accurate and truthful based on the information available to them and their compliance activities, as mandated by program regulations and contract requirements and as confirmed by MAOs in the certifications they submit. As the Ninth Circuit clearly explained in *Silingo,* "CMS is unable to confirm diagnosis codes before calculating capitation rates" and, "[i]nstead, the agency accepts the diagnosis as submitted . . . ." 895 F.3d at 624. United cannot plausibly contend that CMS reviewed medical charts, or otherwise verified the medical conditions of the many millions of beneficiaries for which MAOs submitted diagnosis data and thereby acquired "knowledge" of the true health status of a given beneficiary before issuing a risk-adjusted payment to an MAO for that beneficiary. Indeed, this is why MAOs' compliance with their obligations to submit valid data and delete invalid data are critical to the integrity of the payment system.

Thus, what is true in the context of the FCA claim is equally true with respect to

the common law claims, with one exception: the common law claims do not require proof of United's scienter. Given this difference between the two types of claims, and the lesser burden involved in proving the common law claims, there is no basis to find that the common law claims give rise to additional discovery that would otherwise be irrelevant to the FCA claim. United fails to identify any such needed discovery and there is none.

Second, United contends that "the discovery that 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 [and] Motion for Partial Summary Judgment." Opp. at 16. Relatedly, United claims that Plaintiffs are wrong to assert that decisions by the Ninth Circuit and this Court have "decided contested issues as a matter of law." *Id*. at 17. In their summary judgment briefs, as well as the brief filed in support of the Motion to Dismiss Defendants' Counterclaim, Plaintiffs have already explained that the requirement of accurate coding is being enforced pursuant to federal regulations, the MA contracts, and Managed Care Manual provisions incorporated into the MA contracts. There is no factual issue associated with the Court's interpretation of these legal requirements. Thus, any proposed discovery premised on the false assertion that the accuracy requirement flows from ambiguous legal sources is improper and irrelevant. Further, the same discussions in Plaintiffs' brief addressing how the Ninth Circuit and this Court resolved core legal issues in this case are also pertinent here. Plaintiffs incorporate those discussions and do not repeat them here.

Third, United faults Plaintiffs for not having established "any undue burden" stemming from its discovery. There is no such requirement. The issue now before the Court is relevancy. Discovery of irrelevant information is simply not permitted under the Federal Rules. *See* Fed. R. Civ. Proc. 26(b). Irrelevant discovery need not also be shown to be unduly burdensome to be properly precluded.[6]

[6] Nonetheless, if the Court requires, the government can make such a showing.

F. United's Comparison Of The Purportedly Disproportionate Volume Of Documents Produced By Each Side Is Irrelevant And Misleading

Finally, by suggesting a disparity in the volume of material collected and produced between the parties in the course of formal document productions, United attempts to create a sense of inequity that it hopes will influence the Court's ruling on the Rule 16 motion. At the outset, even if true, such a disparity would not excuse irrelevant discovery. In any event, there is no meaningful disparity here. Unlike a private entity like United, CMS formulates, announces, and administers program requirements, procedures and policies on a public record, and has done so since the inception of the Medicare Advantage Program and the risk adjustment payment program. Those materials, which are relevant to this Parts C and D case and which contain the obligations that CMS seeks to enforce through the FCA, have always been available to United without the need for any formal discovery request. To suggest that access to information from a federal agency is remotely comparable to the need for discovery of non-public information held by a corporate entity like United – much of which is typically guarded as proprietary and confidential – is to peddle a false sense of equivalency. United has for decades had access to the complete body of information and guidance needed from CMS throughout all the years it has participated in Parts C and D. This includes, for example, federal regulations, Federal Register notices, as well as a substantial body of program information, such as Medicare Advantage Participant Guides.

Moreover, there is no basis to expect that the volume of the production by the government in an FCA case would necessarily be equivalent to that of the defendant – especially in a case such as this. As much as United may wish to shift the focus of discovery to the government's deliberations within particular components of the Medicare Program, the relevant focus in an FCA case is on United's conduct and scienter. Thus, United's productions should be substantial, given that the company has perennially engaged in extensive chart review programs designed to generate additional

Medicare income by making coding "adds" and failing to delete invalid diagnoses. Ultimately, United attempted, at the highest levels of the company, to engineer a facile justification to excuse its decision to abandon compliance with the most fundamental requirement of the Medicare Program – accurate, chart based coding – in order to retain enormous inflated risk-adjusted payments.

Under these circumstances, the production totals referenced in United's brief attempt to create a misleading sense of inequity where there is none. The volume of materials produced by an FCA defendant naturally may exceed that produced by the government. Such a result is an unexceptional feature of most FCA cases.

Furthermore, United was required to begin collecting and producing documents in response to the government's investigative requests. The first such request was made in 2012. Additional requests were made in 2015 and 2016. United produced most of the documents over a three-year time period, from 2014 through 2016. Collection and production of material from CMS is now ongoing and there is no reason to expect that the government would, in a matter of months, catch up to United given the three-year time period it took to produce documents during the investigation.

III. CONCLUSION

For the foregoing reasons, the United States and relator Poehling respectfully request that their motion be granted and that the Court impose appropriate limits on the scope of discovery pursuant to Rule 16(b)(3)(B).

Respectfully submitted,

Dated: September 4, 2018

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Attestation

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

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