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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

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

Plaintiff,

v.

UNITEDHEALTH GROUP, INC. *et al.*,

Defendants.

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

NOTICE OF RECENT DEVELOPMENT

Date: N/A
Time: N/A
Courtroom: 5A
Judge: Hon. Michael W. Fitzgerald

UnitedHealth Group Incorporated and the other Defendants in this suit (collectively "United") respectfully submit this Notice of Recent Development to alert the Court to the filing of a consented-to motion for a stay of the government's appeal in *UnitedHealthcare Insurance Co. v. Azar*. *See* Unopposed Motion to Stay Appeal Pending Resolution of the Government's Rule 60(b) Motion in the District Court, *UnitedHealthcare Insurance Co. v. Azar*, No. 18-5326 (D.C. Cir. Dec. 14, 2018), attached hereto as Exhibit 1. If the Court would like briefing on the continued preclusive effect of the district court's decision in *Azar* while the appeal and Rule 60(b) motions are pending, United would be glad to provide it.

Dated: December 17, 2018

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By /s/ David J. Schindler
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EXHIBIT 1

[ORAL ARGUMENT NOT YET SCHEDULED]

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

UNITEDHEALTHCARE INSURANCE CO., et al., Plaintiffs-Appellees, v. ALEX MICHAEL AZAR, II, in his official capacity as Secretary of Health and Human Services, et al., Defendants-Appellants.	No. 18-5326

UNOPPOSED MOTION TO STAY APPEAL PENDING RESOLUTION OF THE GOVERNMENT'S RULE 60(B) MOTION IN THE DISTRICT COURT

Defendants-Appellants Alex Michael Azar, II, the Centers for Medicare & Medicaid Services (CMS), and the United States of America respectfully move to stay the present appeal pending the district court's issuance of an indicative ruling on, or denial of, the government's Rule 60(b) motion for partial reconsideration in the district court. *See* Fed. R. Civ. P. 62.1 (procedure for motions in district court when relief is barred by pending appeal); Fed. R. App. P. 12.1 (procedure in court of appeals). Plaintiffs-appellees consent to this motion in light of the parties' agreement that, if the district court denies the motion, the government will file its opening brief (if any) in this appeal within 30 days of the denial.

STATEMENT

A. Statutory and Regulatory Background

1. Although the present motion is procedural in nature, a brief overview of the case is necessary to explain the relevance of the government's Rule 60(b) motion for reconsideration and why a stay pending resolution of that motion is warranted. This case involves a challenge to a CMS rule governing Medicare Part C, a program that allows Medicare beneficiaries to receive their benefits through Medicare Advantage plans offered by private insurers. CMS pays these insurers a pre-determined amount for each beneficiary, 42 U.S.C. § 1395w-23(a)(1)(A), without regard to the services actually provided. These payments are intended to be actuarially equivalent to the payments CMS would expect to make if the same beneficiaries were covered under "traditional" Medicare (Parts A and B). *Id.* at 1395w-23(a)(1)(C)(1). "[T]o ensure actuarial equivalence," CMS adjusts the amount paid for each beneficiary up or down from a base amount based on that beneficiary's "risk factors," which include age, disability status, gender, and medical conditions. *Id.*

To determine the amount of these adjustments, CMS uses its Hierarchical Condition Category (CMS-HCC) risk adjustment model. The model uses regression analysis of cost and diagnosis data from traditional Medicare to calculate "relative factors" that express, for various condition categories and

demographic factors, how much those conditions or factors are expected to cost Medicare relative to its average per-beneficiary expenditure. D. Ct. Dkt. 74 (Op.), at 5; D. Ct. Dkt. 67 (JA), at 4767-68. For any specific beneficiary, summing the relative factors for that individual's conditions and demographic factors creates a "risk score" that predicts how much Medicare will spend on that beneficiary the following year, relative to the average. JA 4767-68.

To calculate payments to Medicare Advantage insurers, CMS requires insurers to submit diagnosis data for their enrollees. 42 C.F.R. § 422.310(b), (e). CMS uses this data to calculate risk scores for each plan's enrollees; these risk scores in turn determine how much the plan is paid relative to a base rate for each service area. Op. 5. Under this system, reporting that a particular patient has a particular condition—for example, diabetes—will directly increase the risk score for that patient and therefore the insurer's payment.

2. As part of the Patient Protection and Affordable Care Act, Congress enacted a statutory provision providing that a person—including a Medicare Advantage insurer—that "has received an overpayment" must "report and return the overpayment" no later than "60 days after the date on which the overpayment was identified." 42 U.S.C. § 1320a-7k(d). The statute defines "overpayment" to mean "any funds that a person receives or retains under" the Medicare statute "to

which the person, after applicable reconciliation, is not entitled." *Id.* § 1320a-7k(d)(4)(B).

In 2014, the Secretary of Health and Human Services promulgated the Overpayment Rule, 42 C.F.R. § 422.326, to implement these statutory provisions. As relevant here, the rule defines "overpayment" using language that echoes the statute. 79 Fed. Reg. 29,921, 29,844 (2014) (JA 1313). The preamble to the rule further states that "a risk adjustment diagnosis that has been submitted for payment but is found to be invalid because it does not have supporting medical record documentation would result in an overpayment." *Id*. Thus, if a plan discovers that it reported a diagnosis for a patient that was not supported by the patient's medical record, the plan would have to correct the error and return any payment received as a result of the error.

B. District Court Ruling

Plaintiffs-appellees, a group of Medicare Advantage plans in the UnitedHealth Group (UnitedHealth), challenged the Overpayment Rule in the district court. One ground for the challenge was that the rule's definition of "overpayment" would violate the Medicare statute's requirement that payments to Medicare Advantage plans be actuarially equivalent to those CMS would expect to make in traditional Medicare. The Overpayment Rule would cause plans to be underpaid, UnitedHealth claimed, because it requires Medicare Advantage plans to

correct errors they identify, whereas CMS purportedly does not correct errors in the traditional Medicare data on which the risk adjustment model is based. D. Ct. Dkt. 47-1 (UnitedHealth Br.), at 11-12. UnitedHealth's theory starts with the premise that some reported diagnoses for any particular condition—say, diabetes—are presumably erroneous due to physician coding error or for other reasons. On this theory, non-diabetics erroneously coded as having diabetes would not have actually incurred the costs associated with that condition. *Id.* Counting these patients as diabetics in calculating the relative factor for diabetes would therefore tend to make the condition appear less costly than it actually is, leading to underpayment of Medicare Advantage insurers for their diabetic patients. *Id.* However, Medicare Advantage insurers can make up for this alleged underpayment, UnitedHealth's theory goes, if they *also* report a similar proportion of erroneous diabetes diagnoses. *Id.* On this theory, these erroneous diagnoses simply compensate for the improperly low relative factor for diabetes.

The district court granted summary judgment for UnitedHealth and vacated the Overpayment Rule. Op. 2. The district court struck down both the Overpayment Rule's definition of "overpayment" and another rule provision—the rule's definition of when an insurer has "identified" an overpayment—that is not at issue in the government's Rule 60(b) motion. Op. 21, 26-29.

In striking down the definition of "overpayment," the court held that CMS's interpretation was contrary to the Medicare statute's actuarial equivalence requirement. Op. 20-21. The court believed that, by requiring the correction of erroneous diagnoses in Medicare Advantage plans but not in traditional Medicare, it was "inevitable" that CMS would pay less to a Medicare Advantage plan than it would expect to pay in traditional Medicare for an equivalent patient. Op. 20-21. The court therefore concluded that the rule "establishes a system where 'actuarial equivalence' cannot be achieved." Op. 21. For similar reasons, the court concluded that CMS failed to comply with the statutory requirement that it annually publish county-by-county risk scores for traditional Medicare patients "using the same methodology as is expected to be applied in making payments" to Medicare Advantage plans. 42 U.S.C. § 1395w-23(b)(4)(D); Op. 21.

The court also held the rule's interpretation of "overpayment" was arbitrary and capricious because CMS failed to adequately explain its purported reversal from a decision, in the context of a separate audit program, to implement an "adjuster" to account for differences in how diagnoses would be validated in traditional Medicare and Medicare Advantage. Op. 22-26. That holding is not at not at issue in the government's Rule 60(b) motion.

C. Rule 60(b) Motion

After judgment, CMS published a study and notice of proposed rulemaking addressing whether it would implement, in the context of the separate audit program described above, an adjuster to account for differences between traditional Medicare and Medicare Advantage in how they validate diagnoses. *See* 83 Fed. Reg. 54,982, 55,040-41 (Nov. 1, 2018). The study concluded through empirical analysis "that errors in [traditional Medicare] claims data do not have any systematic effect on the risk scores calculated by the CMS–HCC risk adjustment model, and therefore do not have any systematic effect on the payments made to [Medicare Advantage] organizations." *Id.* at 55,040. To the extent that the errors had an effect, the study found that it led to a slight *overpayment* to Medicare Advantage plans. D. Ct. Dkt. 76-1, at 4. CMS therefore proposed "not to include an . . . Adjuster in any final" audit methodology. 83 Fed. Reg. at 55,041.

Based on this new evidence, the government filed a Rule 60(b) motion in the district court asking the court to reconsider its holding that the Overpayment Rule's definition of "overpayment" would inevitably lead to violation of the Medicare statute. D. Ct. Dkt. 76, at 3. The government argued that the study's conclusion—that erroneous diagnoses in traditional Medicare did not lead to systematic underpayment in Medicare Advantage—contradicted the district court's assertion that underpayment would be "inevitable" if CMS corrected errors in

Medicare Advantage but not in traditional Medicare. The motion did not seek reconsideration of any of the court's other holdings. *Id.* Under the district court's current briefing schedule, briefing on the motion will be complete by January 21, 2019.

ARGUMENT

A stay of the present appeal pending a district court indicative ruling on, or denial of, the government's Rule 60(b) motion is warranted, for three reasons.

First, a stay would give the district court the opportunity to reconsider its conclusion regarding actuarial equivalence in light of significant contrary evidence not previously available to the court. As explained above, UnitedHealth's theory is that erroneous diagnoses in traditional Medicare data cause Medicare Advantage insurers to be underpaid, but that insurers can make up for this alleged underpayment if their reimbursements also are not adjusted to exclude erroneous diagnoses. However, UnitedHealth argues, the Overpayment Rule necessarily puts insurers at a financial disadvantage by requiring them to correct any erroneous diagnoses they identify. The district court concluded that, under the Overpayment Rule, it was "inevitable" that CMS would underpay Medicare Advantage plans and that "'actuarial equivalence' cannot be achieved." Op. 20-21. The study cited in the government's Rule 60(b) motion calls this conclusion into question by suggesting that erroneous diagnoses in traditional Medicare do not lead to

systematic underpayment (indeed, they appear to produce a slight overpayment), and therefore that Medicare Advantage insurers do not need to report erroneous diagnoses of their own to compensate.

It is appropriate for the district court to address this issue in the first instance and to consider how the study affects the court's prior conclusions. The district court's reasoning on this front may help illuminate the issues in advance of any consideration by this Court.

Second, if the district court were to issue an indicative ruling indicating that it would reconsider that holding, Fed. R. Civ. P. 62.1, and if this Court were to remand for the district court to enter such an order, Fed. R. App. P. 12.1, such an order may impact the government's need to pursue this appeal.

Third, a stay would not prejudice UnitedHealth, which consents to this motion. As a condition of that consent, the parties have agreed that, in the event the district court denies the government's motion, the government will file its opening brief in this appeal (if any) within 30 days of the denial. Any delay to the present proceedings would therefore be minimal.

CONCLUSION

For the foregoing reasons, the government respectfully requests that the Court stay the present appeal pending the district court's issuance of an indicative ruling on, or denial of, the government's Rule 60(b) motion for partial reconsideration.

Respectfully submitted,

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s/ Weili J. Shaw

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DECEMBER 2018

CERTIFICATE OF COMPLIANCE

I hereby certify that this motion complies with the type-volume limitation of Fed. R. App. P. 27(d)(2)(A) because it contains **1,888** words, according to the count of Microsoft Word.

s/ Weili J. Shaw
WEILI J. SHAW

CERTIFICATE OF SERVICE

I hereby certify that on December 14, 2018, I electronically filed the foregoing with the Clerk of the Court using the appellate CM/ECF system. Counsel for all parties to the case are registered CM/ECF users and will be served by the CM/ECF system.

s/ Weili J. Shaw
WEILI J. SHAW