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UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

UNITED STATES OF AMERICA *ex rel.* BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC., *et al.*, Defendants.	No. CV 16-08697 MWF (SSx) UNITED STATES' NOTICE OF MOTION AND MOTION FOR REVIEW OF DISCOVERY ORDER Date: April 8, 2019 Time: 10:00 a.m. Court: 5A. Hon. Michael W. Fitzgerald

PLEASE TAKE NOTICE that, on April 8, 2019, at 10:00 a.m., or as soon thereafter as the matter may be heard, in the courtroom of the Honorable Michael W. Fitzgerald, United States District Judge, Courtroom 5A, United States Courthouse, 350 West First Street, Los Angeles, California 90012, the United States of America will and hereby does move for an order reviewing and reversing the Memorandum Decision and Order Granting UnitedHealth Group, Inc.'s Motion to Compel the United States to Produce Documents ("Discovery Order"), filed on December 14, 2018 (Dkt. 324).

This motion is and will be made pursuant to Rule 72(a), Fed. R. Civ. P., and L.R. 72-2 on the grounds that said Discovery Order is clearly erroneous or contrary to law.

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

This motion is made following the conference of counsel pursuant to L.R. 7-3 which took place on December 19, 2018.

Respectfully submitted,

Dated: February 4, 2019

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UNITED STATES OF AMERICA *ex rel.* BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC., *et al.*, Defendants.	No. CV 16-08697 MWF (SSx) UNITED STATES' MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF MOTION FOR REVIEW OF DISCOVERY ORDER Date: April 8, 2019 Time: 10:00 a.m. Court: Hon. Michael W. Fitzgerald

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I. INTRODUCTION

In this False Claims Act ("FCA") case, Plaintiffs allege that Medicare Advantage Organizations ("MAOs") owned by United Health Group, Inc. ("United") knowingly retained payment for millions of *invalid* diagnosis codes submitted to Medicare. To evade liability, United has challenged the entire payment methodology of the Medicare Advantage ("MA") program. United argues that payments to MAOs for *valid* diagnosis codes might have been too low and should have been adjusted using a "fee-for-service" or "FFS" adjuster. United claims that because MAOs might have been underpaid for *valid* diagnoses, it was either entitled to retain payments for *invalid* diagnoses as a form of self-help or is now entitled to relief from any damages resulting from their submission of and failure to delete *invalid* diagnoses. United's attempt to invalidate or recalibrate the entire MA payment model has no place in this FCA action. Nonetheless, United has co-opted discovery to seek documents regarding every aspect of the MA program in an effort to challenge the calculations underlying billions of dollars paid to the thousands of MAOs participating in the MA program over the past decade.

Among the documents encompassed by United's overly broad discovery requests are thousands of documents reflecting internal agency deliberations on a broad range of topics subject to the deliberative process privilege. Although these documents have no relevance to the legitimate claims and defenses in this case, on December 14, 2018, the Magistrate Judge ordered the government to release over 20,000 documents protected by the deliberative process privilege. The Magistrate Judge erred in ordering production.

As a preliminary matter, United's challenge to the MA payment model is not a legally cognizable defense to an FCA action or common law claim. After accepting billions of dollars in payments from CMS, United cannot seek to evade liability for its fraudulent conduct by challenging the validity of the payment model and the regulatory scheme they agreed to follow. Moreover, United itself has conceded that this Court lacks subject-matter jurisdiction to consider its counterclaims asserting that it was underpaid for valid diagnosis codes in its MA claims. Indeed, United has requested

dismissal of these counterclaims and stated that it will pursue its payment grievance in the Court of Federal Claims and other fora. Since this Court lacks jurisdiction to hear such a claim, it also lacks jurisdiction to order discovery on such a claim. The Magistrate Judge's Memorandum Decision (Dkt. 324) compelling the release of internal agency deliberations that are outside the scope of Rule 26(b) discovery is clearly erroneous and must be set aside. *See* Fed. R. Civ. P. 72(a); Local Rule 72-2.

The Magistrate Judge also erred in finding that discovery regarding CMS's consideration of a regulation addressing so-called "one-way" chart reviews was relevant to this case. The obligation to correct diagnosis codes revealed to be unsupported by a beneficiary's medical chart does not turn on whether CMS enacted a regulation addressing one-way chart reviews. Instead, the proper focus of this case is on what United elected to do with information regarding invalid diagnosis codes, regardless of how it obtained that information. As both the Ninth Circuit and this Court have recognized, this case concerns United's failure to delete specific diagnosis codes that it knew were invalid.

The Court should similarly reverse the Magistrate Judge's ruling that internal agency deliberations are relevant to the issue of materiality and damages. The Ninth Circuit made clear that valid diagnosis codes are the foundation of the MA payment process and thus material to Medicare's risk-adjusted MA payments. The damages in this case will be determined based upon the direct, beneficiary-specific, effect of particular invalid diagnosis codes on MA payment amounts. The Magistrate Judge's finding that internal agency deliberations are relevant to these issues is clearly erroneous.

Finally, the Magistrate Judge appears to have incorrectly placed the burden on the government to establish the lack of relevance of documents. As the party seeking the disclosure of privileged information, that burden squarely rests with United. Nonetheless, without regard to the issues presented by this case, United issued overly broad discovery requests spanning all aspects of the MA program and forcing the United States to identify and log thousands of internal deliberative documents having no

relevance to this case. Without appropriate limits on the scope of discovery, United will continue to improperly and strategically use this case as a vehicle for improper discovery into the deliberations of the agency that contracts with and regulates it.

Without limits on discovery, the United States has faced an incredible and unreasonable burden in collecting, reviewing, identifying, and logging responsive (albeit irrelevant) internal agency documents, in addition to obtaining a declaration from a high-level agency official asserting the privilege as to these documents. Agency employees and contractors reviewed over 10,000 of the privileged documents and three high-ranking agency employees provided detailed declarations explaining the basis for the privilege and the harm to the agency if the documents were disclosed. In her Memorandum Decision, the Magistrate Judge placed new demands on the government for perfecting the privilege that is unattainable given the unbounded scope of United's discovery requests. For example, if high-ranking agency officials responsible for the operation of the MA program were, in fact, required to personally review each and every document in order to assert the privilege, such a review would require a year of full-time work given the tens of thousands of documents implicated by United's broad discovery requests. Given the overbreadth of United's discovery requests, the agency cannot comply with the additional demands imposed by the Magistrate Judge's order.

The Court should thus set aside the Magistrate Judge's order and place appropriate limits on discovery so that document production may proceed in the manner contemplated by Rule 26(b) and focus on matters actually at issue in this case.[1]

II. PROCEDURAL HISTORY

A. United Seeks Discovery to Challenge the MA Payment Model

As of this filing, United has served 108 requests for production of documents in this action. The United States objected to many of the requests as outside the scope of

[1] The United States intends to seek to file a Supplemental Brief in support of its Motion pursuant to Rules 16(b)(3)(B) and 26(c)(1)(A) for a scheduling and protective order foreclosing discovery on issues raised by Defendants that are not part of this case.

discovery permitted under Rule 26(b) and sought threshold rulings from this Court to guide discovery. Nonetheless, the government has collected documents from CMS employees implicated by United's overly broad discovery requests and made monthly productions of responsive (and often irrelevant) non-privileged documents. In addition, the unbounded scope of United's discovery requests has caused the United States to identify and log tens of thousands of privileged documents having no relevance to this case.

On May 22, 2018, Plaintiffs filed three motions in an effort to streamline discovery and the resolution of this case. First, Plaintiffs filed a motion for partial summary judgment regarding United's obligation to delete diagnosis codes that it knew were invalid. (Dkt. 234.) This brief addressed the invalidity and irrelevance of United's arguments that the terms "actuarial equivalence" and "same methodology" in a Medicare statute required CMS to adjust Medicare payments to all MAOs for all valid diagnosis codes and that this adjustment could be used to offset any damages resulting from United's knowing failure to delete invalid diagnosis codes that it knew were not supported by the medical record. In addition to the partial summary judgment motion, Plaintiffs filed a motion to strike United's affirmative defenses (Dkt. 235) and a motion to dismiss United's counterclaims (Dkt. 236).

United opposed the motion for partial summary judgment and partially opposed the motion to strike United's affirmative defenses. (Dkts. 248, 250.) However, United did not oppose the motion to dismiss its counterclaims. Instead, United conceded that the Court lacked subject-matter jurisdiction to hear counterclaims premised on the contention that United was underpaid for valid diagnosis codes. (Dkt. 249.) United explained that it had "pressed its argument [regarding underpayment] vocally and consistently over the last decade . . . in administrative comments on notice-and-comment rulemakings, in meetings with CMS officials, [and] in its currently pending Administrative Procedure Act challenge to a 2014 CMS regulation." *Id*. at 2. United further noted that it "intends to continue asserting that position in other fora, too." *Id*.

On August 6, 2018, Plaintiffs further moved for an order limiting discovery under Rules 16 and 26 to account for major issues that have already been resolved as a matter of law or cannot be pursued by Defendants in this forum. (Dkt. 261.) All four of these motions remain pending at this time.

B. United's Motion to Compel Production of Internal Agency Deliberations

Despite the pendency of Plaintiffs' threshold motions seeking appropriate limits on the scope of discovery, United sought to compel the United States to produce thousands of privileged documents reflecting internal agency deliberations on a host of issues unrelated to Plaintiffs' claims or any legitimate defense in this action. On October 3, 2018, the United States sought to stay the Magistrate Judge's consideration of the motion to compel contemplated by United in order to allow the District Court to rule on Plaintiffs' pending motions. (Dkt. 294.) On October 23, 2018, the Magistrate Judge denied the application to stay, but explained that "[a]llowing United to proceed with its motion to compel . . . was not a decision on the merits of the motion." Dkt. 304, at 16.

On November 9, 2018, United filed its motion to compel the production of internal agency deliberations responsive to all of its discovery requests. (Dkt. 310) The Magistrate Judge again refused to defer consideration of the motion to compel until the Plaintiffs' pending motions were resolved on the ground "that the unique circumstances of this case warrant immediate consideration of United's discovery request." *Id.* at 29. Among those "unique circumstances," the Magistrate Judge cited (i) her previous denial of the government's request for a stay; (ii) her finding that, despite its production of tens of thousands of non-privileged documents, the United States was somehow resisting discovery; and (iii) her determination that the motion addressed information that United "considers necessary to prepare its defense." (Dkt. 324.) On December 14, 2018, the Magistrate Judge granted the motion and ordered that the government produce all documents withheld under the deliberative process privilege. *Id.*

In considering the merits of United's motion, the Magistrate Judge held that discovery regarding CMS's methodology for calculating the payment coefficients for

valid diagnosis codes – which establish payments to *every MAO in the MA program* – was relevant to United's defense that it "was not overpaid and did not knowingly and improperly retain an overpayment." *Id*. at 31. The Magistrate Judge also found such discovery to be relevant to whether "United's failure to delete unsupported codes [had] an effect on CMS's decision to keep paying and contracting with United." *Id*. at 31. The Magistrate Judge lastly found such discovery to be relevant to the question of damages. The Magistrate Judge did so notwithstanding that United "seeks *damages* for what [it] contends are CMS's systemic Medicare Advantage underpayments" in a counterclaim it intends to pursue in the Court of Federal Clams under the Tucker Act. *Id*. at 32 (emphasis in original). Although United now concedes that this Court lacks subject-matter jurisdiction to hear any such counterclaim, the Magistrate Judge permitted United to undertake discovery on that claim on the ground that the "[g]overnment [purportedly did] not explain [in opposing the motion to compel] why evidence relating to overpayment, or lack thereof, is not relevant at a minimum to the Government's unjust enrichment claim." *Id*. at 33.

Although United failed to explain how the remaining documents implicated by its motion were appropriately within the scope of discovery, the Magistrate Judge generally found them to be relevant to whether MAOs are obligated to delete diagnosis codes that are shown to be invalid by their chart reviews, to United's scienter under the FCA, to the materiality of invalid codes to risk adjusted payments, and to damages. *Id*. at 31-33.

III. BACKGROUND – CLAIMS, DAMAGES, AND DEFENSES

United does not dispute the central factual allegations in this case. For more than a decade, Defendants reviewed the medical charts of millions of beneficiaries enrolled in their MA plans. Those reviews showed that, while some beneficiaries had diagnoses that the physicians had neglected to report to the defendant MAOs ("under-reported" diagnoses), the healthcare providers had reported many diagnoses that were not substantiated by their patients' charts and hence invalid ("over-reported" diagnoses). Defendants promptly submitted the under-reported valid diagnoses to CMS in order to

obtain higher risk-adjusted payments. However, for most years, Defendants did not delete known over-reported, invalid diagnosis codes that they had previously submitted and simply retained the larger payments resulting from those invalid diagnoses.

An insurer is not entitled to *any* payment for an invalid diagnosis. Thus, the calculation of damages resulting from the knowing failure to delete invalid, over-reported diagnoses is straightforward. If Medicare paid an increased amount to an insurer based on an invalid diagnosis code, that entire amount should be recovered. In this case, the Medicare damages are the risk-adjusted payments made to Defendants based on the "over-reported" diagnoses that they submitted to the Medicare Program. *See* Plaintiffs' First Amended Complaint ("FAC") (Dkt. 171) at 235-38.

CMS uses a beneficiary's risk score to calculate the risk-adjusted capitated amount paid to an MAO for insuring that beneficiary. To calculate the risk scores, CMS assigns different multipliers (or "coefficients") to demographic factors (age, sex, institutional status, etc.) and diagnosis groups (known as "hierarchical condition categories" or HCCs). CMS determines these coefficients using payment data from Parts A and B of the Medicare Program (often referred to as the FFS parts of Medicare). Using a regression analysis, CMS associates demographics and diagnoses reported for FFS beneficiaries in one year with FFS payments made by Medicare the following year. Each coefficient estimated by this regression analysis represents the average cost to Medicare associated with a demographic attribute or medical diagnosis group. The process of estimating the coefficients (that is, the costs associated with the demographics and medical diagnoses of Medicare beneficiaries) is often referred to as "calibrating" the HCC model. For each MA beneficiary, the coefficients are added together to form a risk score for that beneficiary each payment year. The beneficiary's risk score is then multiplied against a fixed base payment determined by the MAO's bid.[2]

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[2] To understand how this works, imagine a 72-year-old woman living at home and without a disability. In 2014, such demographic characteristics resulted in a coefficient of 0.348. *See* Announcement of Calendar Year 2014, Table 1 at 67 (Dkt. 234-9, Exhibit

United speculates that the coefficients for some diagnosis groups – which they do not specify – might be too low and that they were underpaid for diagnoses in those groups. United hypothesizes that some diagnoses in the FFS data were unsupported by the patients' medical records and therefore: (1) those patients did not have the medical conditions identified by the diagnoses and (2) the cost of caring for those patients must have been less than for patients whose medical records support the diagnoses. (Dkt. 310 at 13-14.) They claim that this means some coefficients were too low. United argues that CMS cannot recover overpayments to MAOs resulting from *invalid* codes unless it compensates the MAOs for the purported underpayments for *valid* diagnosis codes. In essence, United is claiming that, to compensate for a hypothetical underpayment for valid diagnoses, it is entitled to engage in self-help by knowingly refraining from deleting numerous invalid diagnoses and thereby retaining billions of dollars of false claims. Alternatively, United claims entitlement to a set-off against the overpayments made and damages sustained by Medicare as a result of United's failure to delete invalid diagnosis codes that United knew were unsupported by its beneficiaries' medical records. *See, e.g.*, Counterclaim (Dkt. 223), ¶ 10. Defendants assert that they require broad discovery of privileged agency documents regarding every aspect of the design and implementation of the HCC payment model in order to establish that they were underpaid for valid diagnoses.

A fundamental issue at this juncture of the case is whether United is entitled to litigate – *in this case* – the claim that Medicare's risk adjustment coefficients for valid diagnoses are too low and CMS has therefore underpaid *every MAO participating in the*

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7). If the insurer submitted no diagnoses for this woman, the insurer would be paid 34.8% of the base rate for insuring her. If, however, the insurer submitted a diagnosis for diabetes without complications for her, another 0.118 would be added to her risk score for a total of 0.466. *Id.* If the insurer also submitted a diagnosis of multiple sclerosis, another 0.556 would be added for a total of 1.022. *Id.* Accordingly, if the base payment rate for a year was $10,000, the insurer would receive $10,220 ($10,000 x 1.022). If the insurer deleted the diagnosis for multiple sclerosis, then the payment would be $4,660 ($10,000 x 0.466) and the Medicare Program would not pay or would recover $5,560 based on the invalid diagnoses. *See also* FAC Exhibit 13 (providing additional examples of how the deletion of invalid diagnoses affects payments).

MA program for over a decade. Resolution of this threshold but important question regarding the scope of this litigation will have an enormous impact on the length, complexity, and scope of discovery now underway.

IV. ARGUMENT

Discovery is limited to information "that is relevant to any party's claims or defense." Fed. R. Civ. P. 26(b)(1). By extension, a party need only assert privilege over information that is "otherwise discoverable" under Rule 26(b)(1). Fed. R. Civ. P. 26(b)(5). Thus, before privilege questions may be addressed in this case, United – not the government – has the initial burden of demonstrating that the internal agency deliberations it seeks to compel are in fact relevant to the claims or defenses in this case. *See, e.g.*, *Freeman v. Seligson*, 405 F.2d 1326, 1338 (D.C. Cir. 1968) ("matters of privilege can appropriately be deferred for definitive ruling until after the production demand has been adequately bolstered by a general showing of relevance and good cause"); *Gill v. Gulfstream Park Racing Ass'n Inc.*, 399 F.3d 391, 400 (1st Cir. 2005) ("Discovery of both privileged and unprivileged information may be limited by Rule 26(b)(2)."); *Miller v. Pancucci*, 141 F.R.D. 292, 295 (C.D. Cal. 1992) (holding that "[p]rior to reaching the privilege questions," "[t]he first analysis, by necessity, encompasses relevance"). In this case, United seeks discovery into internal agency deliberations regarding every aspect of the MA program and has not – and cannot – establish the relevancy of the documents it seeks in this case. The Magistrate Judge erred by ordering the release of privileged internal agency deliberations that are irrelevant to any legitimate claims or defenses at issue. The order should be set aside.[3]

[3] A party can challenge a non-dispositive order by a Magistrate Judge that is clearly erroneous or is contrary to law. Fed. R. Civ. P. 72(a); *see also* Local Rule 72-2. "The 'clearly erroneous' standard applies to the magistrate judge's findings of fact; legal conclusions are freely reviewable *de novo* to determine whether they are contrary to law." *Wolpin v. Philip Morris Inc.*, 189 F.R.D. 418, 422 (C.D. Cal. 1999).

A. United is Not Entitled to Internal Agency Deliberations Pertaining to an Invalid Defense That Is Not Part of this Action

Discovery cannot proceed based upon defenses and claims for relief that are neither cognizable nor within the subject-matter jurisdiction of the Court. *Oppenheimer Fund, Inc. v. Sanders*, 437 U.S. 340, 352 (1978) ("Thus, it is proper to deny discovery of matter that is relevant only to claims or defenses that have been stricken, … unless the information sought is otherwise relevant to issues in the case."); *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 94 (1998) ("Without jurisdiction the court cannot proceed at all in any cause."). In this case, United's challenge to the MA payment methodology is not a legally cognizable defense to an FCA or common law claim. The Magistrate Judge ignored Supreme Court and Ninth Circuit law in concluding otherwise.

In *Dennis v. United States*, 384 U.S. 855 (1966), the Supreme Court rejected defendants' attempt to assert a defense challenging the legality of a statute that they had violated. Defendants were convicted of conspiracy to obtain NLRB services by filing false non-Communist affidavits required under the Taft-Hartley Act. Defendants sought to overturn their convictions based upon their challenge to the constitutionality of the statute. The Supreme Court flatly rejected this defense, stating:

> It is no defense to a charge based upon this sort of enterprise that the statutory scheme sought to be evaded is somehow defective. Ample opportunities exist in this country to seek and obtain judicial protection. There is no reason for this Court to consider the constitutionality of a statute at the behest of petitioners who have been indicted for conspiracy by means of falsehood and deceit to circumvent the law which they now seek to challenge. This is the teaching of the cases.

Id. at 866 (citations omitted). In *Dennis*, the Supreme Court made clear that one cannot evade a requirement through fraud and deceit and then later challenge the requirement:

> The governing principle is that a claim of unconstitutionality will not be heard to excuse a voluntary, deliberate and calculated course of fraud and

> deceit. One who elects such a course as a means of self-help may not escape the consequences by urging that his conduct be excused because the statute which he sought to evade is unconstitutional. *This is a prosecution directed at petitioners' fraud*. It is not an action to enforce the statute claimed to be unconstitutional.

Id. at 867 (emphasis added); *see also Bryson v. United States*, 396 U.S. 64, 72 (1969) ("Our legal system provides methods for challenging the Government's right to ask questions – lying is not one of them."); *Kay v. United States*, 303 U.S. 1, 6 (1938) ("When one undertakes to cheat the Government or to mislead its officers, or those acting under its authority, by false statements, he has no standing to assert that the operations of the Government in which the effort to cheat or mislead is made are without constitutional sanction."); *United States v. Weiss*, 914 F.2d 1514, 1522-23 (2d Cir.1990) (Medicare fraud case stating that "it is no defense to a charge of filing false statements that the government document that prescribed the details of filing had not been approved . . . as [a statute] allegedly required").

In *Cedars-Sinai Med. Ctr. v. Shalala*, 125 F.3d 765 (9th Cir. 1997), the Ninth Circuit adopted the reasoning of *Dennis*, *Bryson*, and *Weiss* in an FCA context. There, the defendant hospitals in an FCA case brought a separate declaratory judgment action arguing that a Medicare coverage rule was not issued in accordance with APA requirements. *Id*. at 767. The Ninth Circuit followed the above line of cases in rejecting the declaratory judgment sought, stating:

> Even if the Hospitals succeed in having the rule declared invalid, however, that will be *no defense to the Relator's claims under the False Claims Act*. If the Hospitals did indeed knowingly submit false claims in order to receive payment for devices not covered under the [Medicare coverage] rule, the invalidity of the rule will be no defense.

Id. (emphasis added, quotations omitted, citing *Weiss*, *Bryson*, and *Dennis*); *see also City and County of San Francisco v. Tutor-Saliba Corp.*, 2005 WL 645389, at *8 (N.D. Cal.

Mar. 17, 2005) (rejecting argument in state FCA case that "allegedly fraudulent conduct should be excused because part of the contract [in which fraud occurred] is invalid" and that "invalid portion of the contract is no excuse for fraudulent behavior").

Here, the Ninth Circuit has already found that an MAO's obligation to delete known unsupported diagnosis codes is sufficiently "clear." *United States ex rel. Swoben v. United HealthCare Group, Inc*, 848 F.3d 1161, 1166, 1174 (9th Cir. 2016). Having knowingly retained payment for invalid diagnosis codes, United may not use this FCA action to challenge CMS's payment model and rules as being in violation of the Medicare Statute. United knew about the payment model (including how the coefficients were calculated) and the payment rules (including the obligation to delete invalid diagnosis codes) when it entered into its Part C contracts with CMS and thereafter claimed and received billions of dollars from Medicare. As in *Bryson*, if United had truly disagreed with its regulatory and contractual obligation to delete invalid codes or if United thought it would be underpaid by complying with the longstanding medical record requirement, it was free to forego participation in a program governed by terms it found objectionable. Alternatively, United could have pursued a separate APA action raising the purported statutory violation, that is, the calibration of the payment coefficients (which CMS published in the Federal Register each year) based on unaudited FFS diagnosis data in light of the MAOs' obligation to delete known invalid diagnoses. In fact, during the government's investigation of this matter, United brought a separate APA action making such a challenge and advised the Court it would continue to press the payment issue "in other fora, too." *See* Dkt. 249, at 2.

However, United cannot agree to participate in the MA program with knowledge of its payment requirements and the manner in which the coefficients were determined, accept payment under the program, violate the requirements, and then challenge them when caught. Acceptance of United's contention – that it may violate requirements it agreed to honor and then litigate its program grievance only when its misconduct is exposed – would not only permit a defendant to engage in the very self-help prohibited

under the authority above, it would create a perverse incentive and set a dangerous precedent for others participating in the program. Such entities could claim payment from Medicare with knowledge of contractual and regulatory obligations and then violate those obligations so as to enhance profits expecting that the violation may go unnoticed or, if exposed, that they would assert a legal challenge to the requirements with which they had expressly agreed to comply or as to which they had knowledge.

United has been clear, moreover, that it intends to pursue its claim for a damages purportedly resulting from any payment disparity it claims exists with respect to valid diagnosis codes in the Court of Federal Claims. As discussed above, United initially attempted to file its counterclaims in this Court. In those counterclaims, United explained that its claim for an FSS adjustment pertains to the "lower payment to an MA plan for a patient who *does* have that condition (and a supported diagnosis code to go with it)." Counterclaim, ¶ 10 (emphasis original). United now concedes that this Court "lacks jurisdiction" over those claims. *See* Dkt. 249 at 3:25. And this Court has recognized that payments made for valid diagnoses are not part of Plaintiffs' case. *See also* Order on Motion to Dismiss (Dkt. 212), at 21-22 ("the real issue is the actual invalid codes that were submitted and not deleted"). United's assertion that it was somehow underpaid for valid diagnosis codes is a distinct and separate issue and has no relevance to the damages resulting from its failure to delete invalid diagnosis codes. Since the Court lacks subject-matter jurisdiction to adjudicate United's counterclaims, it also lacks jurisdiction to order discovery on any such claims or defenses.

Although the United States made these fundamental points to the Magistrate Judge, they are largely ignored in her Memorandum Decision. The decision briefly touches upon the jurisdictional question in Footnote 3, where the Magistrate Judge acknowledges that United had asked the District Court to find it lacked jurisdiction over the counterclaims. *See* Mem. Decision, at 3, n.3. Nonetheless, the Magistrate suggested that the jurisdictional question could be side-stepped if she assumed that the "only claims in this litigation are the Government's [claims]." *Id.*

In concluding that United may "challenge[] whether, by failing to delete known unsupported diagnosis codes, it was overpaid," Mem. Dec. at 29, the Magistrate Judge appears to be proceeding from the unstated premise that the calculation of coefficients for valid diagnosis codes is somehow relevant to quantifying damages caused by Defendants' failure to delete invalid diagnosis codes. But such a premise is simply incorrect. United is not entitled to retain any payment for a medical condition that a beneficiary did not have. Thus, the damage calculation in this case is straightforward. First, Plaintiffs will remove the invalid diagnoses that were identified through United's own chart reviews and recalculate each individual beneficiary's risk score without those invalid codes. This first step does not involve an audit or sampling or extrapolation or any speculation about what additional review United could or should have done to identify invalid diagnosis codes. Instead, this first step relies entirely on diagnosis codes that United, in the course of its own chart reviews, found to be unsupported. Second, Plaintiffs will calculate the amount that Medicare would have paid United for each beneficiary based on the beneficiary's corrected risk score. To determine how much United would be have been paid based on a corrected risk score, Plaintiffs will apply the published risk adjustment coefficients that were in place at the time United actually was paid based on the inflated risk score. The damage calculation relies entirely on (1) information about invalid diagnosis codes from United's own chart reviews, (2) information in United's possession about its beneficiaries' risk scores, and (3) publicly-available payment information. The identification and quantification of overpayments and damages in this FCA action has nothing to do with the use of an FFS Adjuster.

The Magistrate Judge stated that "the Government does not explain why evidence relating to overpayment, or the lack thereof, is not relevant *at a minimum* to the Government's unjust enrichment claim." Mem. Dec. at 33 (emphasis in original). However, the common law damages are not conceptually different from the FCA damages – both causes of action are specific to the unsupported diagnostic codes in the claims for the beneficiaries whose medical records were reviewed by United. Dkt. 310,

at 56-60. Because United was not entitled to any payment for a condition a beneficiary did not actually have based on his or her medical record, United was unjustly enriched in the amount such an invalid code increased payment. *Id.* at 56. Indeed, Plaintiffs noted that the District Court also had already addressed this specific feature of the common law claims. Dkt. 212, at 21 ("the common law claims for Unjust Enrichment and Payment by Mistake are premised on the invalid diagnosis codes"). Thus, the Memorandum Decision is incorrect in stating that the government had not addressed the unjust enrichment claim.

The irrelevance of Defendants' statutory arguments to this case is not a trivial issue. Allowing United to expand the scope of this case to encompass its arguments regarding underpayment for valid diagnosis codes would dramatically expand the scope of fact and expert discovery, motions practice, and trial and would impact the entire MA program and the payments made to every one of the thousands of MAOs insuring millions of beneficiaries. In addition to requesting documents and information from custodians and offices across HHS, United has sought from HHS and its contractor all data underlying the agency's calculation of coefficients each year, presumably with the intention of recalculating those coefficients as part of this case. Such an endeavor is not necessary or appropriate to resolve the issues in this case.

The Court should thus set aside the Magistrate Judge's order requiring the disclosure of internal agency deliberations pertaining to the agency's annual promulgation of HCC risk-adjustment coefficients, United's actuarial equivalence defense, and United's other arguments that it was underpaid. Such discovery is outside the scope of relevant information permitted under Rule 26(b).

B. The Magistrate Judge Erred in Relying on United's Mischaracterization of this Case As Premised on One-Way Chart Reviews

United's chart review program clearly plays a central role in this litigation. It is the mechanism by which United acquired actual knowledge that it had submitted invalid diagnosis codes. However, Plaintiffs' claims are not premised on whether one-way chart

reviews meet the contractual and regulatory requirement that MAOs have an effective compliance program. Instead, as both the Ninth Circuit and this Court have recognized, the critical issue in a case such as this is what United did with the information about invalid, unsupported codes by whatever means it acquired that information. Thus, discovery into the agency's internal communications regarding whether and how chart review programs might satisfy compliance program requirements is not necessary or appropriate.

In *Swoben*, United litigated the issue of whether it was required to correct unsupported codes based on information it acquired via its one-way chart reviews. 848 F.3d at 1169. In that case, the Ninth Circuit noted that MAOs "may, but are not required to, conduct retrospective reviews of their enrollees' medical records to ensure the accuracy of the diagnosis codes." *Id*. The court clearly explained that "this [FCA case] is not a case about whether [MAOs] have to take affirmative steps to verify risk adjustment data," but that when MAOs "adopt[] affirmative verification procedures, [they] have to conduct them in good faith" and submit accurate codes. *Id.* at 1179; *see also United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672-73 (9th Cir. 2018) ("With data for millions of people being submitted each year, CMS is unable to confirm diagnoses before calculating capitation rates . . . . Every diagnosis code submitted to CMS must be based on a 'face-to-face' visit that is documented in the medical record.").

The Memorandum Decision briefly mentions the *Swoben* decision, noting that the Ninth Circuit was aware that CMS had considered, but ultimately decided not to finalize, a proposed rule that would have prohibited MAOs from performing one-sided reviews. Mem. Dec. at 32. The Memorandum Decision then states that "it is not unreasonable to anticipate that the reasons why CMS did not finalize that proposed rule may be helpful to its defense." *Id.* Why or how the agency's reasons could be helpful to United's defense, the Memorandum Decision does not say. The legal obligation of an MAO to submit valid diagnoses – which is the central issue in this case – is resolved by reference to the regulations and contract that were actually in place and which govern the rights and

obligations of the parties. *See Oliver v. The Parsons Co.*,195 F.3d 457, 463 (9th Cir. 1999) (meaning of "technical and complex" regulatory terms in FCA case "is ultimately the subject of judicial interpretation"). In this case, the obligation to submit valid diagnoses has already been resolved as matter of law, as reflected in the *Swoben* and *Silingo* decisions.

The statement in the Memorandum Decision ignores the fulsome discussion by the Ninth Circuit about the very regulation referenced by the Magistrate: "Although CMS decided not to finalize the proposed [chart review] rule . . . [CMS] reiterated that it has always expected that a [MAO] . . . implement, during the routine course of business, appropriate payment evaluation procedures" and that the agency had finalized another regulation requiring the deletion of invalid diagnosis codes. *Swoben*, 848 F.3d. at 1169 (discussing the notices of proposed and final rulemaking at 79 Fed. Reg. 2000 and 29,923). Thus, the Ninth Circuit construed the obligations of MAOs based on the formally-issued public record. If the appellate court had determined that the issue of whether an MAO is required to submit valid diagnosis codes needed to be informed by consideration of non-public agency documents – for example, documents relating to a proposed rule on one-way chart reviews that was later withdrawn by CMS – it could have remanded the case with that direction. But it did not. It reversed the district court and issued its holding, which is now the law of this Circuit. *Accord, United States v. Lachman*, 387 F.3d 42, 54 (1st Cir. 2004) (holding that any interpretive issue relating to a regulation is resolved through reference to the official public record and explaining that "non-public or informal understandings of agency officials concerning the meaning of a regulation are . . . not relevant"). Notwithstanding that Plaintiffs extensively covered the doctrine of *stare decisis* in briefs now under submission with the District Court and in the opposition to the motion to compel, the Memorandum Decision simply ignores it.

The subject of United's one-way chart reviews came up again in this Court's Order on United's motion to dismiss the First Amended Complaint in this case. Consistent with the Ninth Circuit's decision in *Swoben*, this Court found that even if

"CMS continued to make risk adjusted payments despite generalized knowledge of Defendants' 'one–way' chart reviews . . . the issue here . . . is the specific invalid diagnosis codes that Defendants submitted and failed to delete despite the information available to them." Dkt. 212, at 21.

Notwithstanding that decisions by both the Ninth Circuit and this Court, concluding that whether or not United was obligated to conduct chart reviews, it had an obligation to correct any invalid codes revealed by those reviews, the Memorandum Decision inexplicably ignores these rulings and expressly reopens the door to United litigating them anew. *See, e.g., Morrow v. Balaski*, 719 F.3d 160, 181 (3d Cir. 2013) ("the very point of *stare decisis* is to forbid us from revisiting a debate every time there are reasonable arguments to be made on both sides").

C. Non-Public, Privileged Material Is Not Relevant to Materiality and Scienter Issues In This Case

The Magistrate Judge found that internal agency deliberations were relevant to United's defenses because they might show that "United's failure to delete unsupported codes did not have an effect on CMS's decision to keep paying and contracting with United" and that "evidence showing that CMS knew about one-way chart reviews but took no action would also support the argument that the failure to delete unsupported codes was not material." Mem. Dec. at 32. The Memorandum Decision does not discuss the points briefed by the government, which demonstrated that each premise is incorrect, and that both the Ninth Circuit and this District Court have already addressed these arguments.

This Court has recognized that the proper focus of the materiality question is not United's one-way chart reviews, but the unsupported diagnosis codes that United refrained from deleting. Dkt. 212, at 20-22. And diagnosis codes are material to the amount CMS paid for each beneficiary enrolled in United's plans. *See id*. at 15 ("not only do various contractual and regulatory materials require Defendants to submit accurate diagnostic data, but that data is central to the calculation of the amount of

money CMS pays to Defendants"). The Ninth Circuit reached a similar conclusion in *Swoben*. 848 F.3d at 1167-68 ("diagnosis codes contribute to an enrollee's risk score, which is used to adjust a base payment rate").

Furthermore, as this Court explained, the "Government may have had general suspicions about whether Defendants were complying with requirements for submitting diagnostic data and truthful attestations, but because of the allegedly fraudulent representations that Defendants made, [the Government] could not identify which diagnoses were valid and which were not." Dkt. 212, at 21. More recently, in *Silingo*, the Ninth Circuit again noted that "CMS is unable to confirm diagnoses before calculating capitation rates" and "[i]nstead accepts the diagnoses as submitted." 904 F.3d at 672. United cannot plausibly contend that discovery of internal, deliberative communications within CMS has any potential to reveal that CMS could have determined that any particular code for any one of the millions of claims submitted by United was unsupported by the beneficiary's chart – *i.e.* precisely the type of claim-specific information that United was, in fact, developing via its chart review program. The only way for CMS to have had such information is if United had provided it to CMS – and United does not purport to have done so.

Additionally, the government is not estopped from enforcing the plain language of the MA contracts and regulations simply because it had not debarred United or suspended its MA contracts based on the one-way chart reviews. As explained at length in the opposition to the motion to compel and in the briefs filed in support of Plaintiffs' motion to strike Defendants' affirmative defenses (Dkt. 235), estoppel against the government does not follow from the type of agency conduct referenced in United's motion to compel. The evidence sought by United cannot be used to estop the government's attempt to recover public funds as a matter of law.

The Magistrate Judge accepted United's argument that whether non-public deliberative communications between agency officials regarding "overpayments" are consistent or inconsistent with unspecified interpretations by unidentified officials at

United somehow is relevant to United' scienter. However, the issue of scienter in this case focuses on whether *United knew* that the diagnosis codes it submitted to CMS were unsupported by patient charts. Evidence pertaining to that issue can come only *from United*. Internal agency deliberations that were never made public or shared with United will not shed light on what the *United knew* about the diagnosis codes that were unsubstantiated by patient charts *that only United had reviewed*. Similarly, to the extent that scienter focuses on United's knowledge of its legal obligation to delete unsupported diagnosis codes, United's internal documents – not those of the agency – are potentially relevant.

The Memorandum Decision fails to address the points stated in opposition to the motion to compel. The internal agency deliberations sought by United are not relevant to materiality or scienter.

D. Information Sought by the Motion to Compel is Publicly-Available

Furthermore, even if any of the information sought by United were relevant, it has failed to establish any "good faith" basis to obtain privileged information. CMS announces and implements program policy and guidance on a public record. United made no attempt to explain what questions were unanswered by publicly available information or why it required the agency's internal deliberations. And the Magistrate Judge likewise failed to address whether United could establish a need for internal agency documents. *See Fed. Trade Comm'n v. Warner Commc'ns Inc.*, 742 F.2d 1156, 1161 (9th Cir. 1985) ("availability of other evidence" as a factor in whether to order production of privileged information).

For example, in its motion to compel, United seeks "documents related to (1) the Risk Adjustment error rate in CMS's data, (2) a RADV Medicare FFS adjuster, and (3) the RADV audit methodology." Dkt. 310 at 25. In its response, the Government explained that CMS has already published and produced an abundance of information on each of these points. *Id.* at 45-47 (of 75). Most significantly, in October 2018, CMS published a technical paper on its website in association with the agency's issuance of

proposed revisions to its Medicare Part C Risk Adjustment Data Validation ("RADV") audit regulations. In an appendix to the technical paper, CMS set out the error or "discrepancy" rates in FSS claims data that was reviewed as part of the study of the FFS Adjuster issue.[4] (Dkt. 301-3.) Thus, CMS published precisely the information that is the focus of United's motion to compel.

With respect to the other items of interest to United, the government explained that CMS had previously published copiously on the subject of RADV audits (*see, e.g.*, Policy and Technical Changes to the Medicare Advantage Program, 74 Fed. Reg. 54,634, 54,674 (Oct. 22, 2009); 75 Fed. Reg. at 19,748 (Apr. 15, 2010)) as well as with respect to virtually every other feature of the MA program. *See, e.g.*, Program Instructions and Guidance cited in Dkt. 261-1, at 12-13. However, the Magistrate Judge appears to have ignored the issue and made no effort to assess the responsiveness of the public information with respect to the topics identified by United.

E. A Decision on the Motion to Compel Should Have Awaited Resolution of the Plaintiffs' Motion for a Protective Order

Rule 26 provides a means by which a party may limit or avoid the burden associated with asserting privilege claims. Fed. R. Civ. P. 26, advisory committee's note to 1993 amendment ("A party can seek relief through a protective order under subdivision (c) if compliance with the requirement of providing this information would be an unreasonable burden."); *see also Burlington N. & Santa Fe R.R. Co. v. U.S. Dist. Court for the Dist. of Mont.*, 408 F.3d 1142, 1149 n.3 (9th Cir. 2005) (holding that when subject to "exhaustive" discovery requests covering privileged documents, a litigant "is not without recourse" and may "apply for a discovery or protective order"); *United States ex rel. Philip Morris*, 347 F.3d 951, 954 (D.C. Cir. 2003) ("if a party's pending

[4] The proposed revisions to the regulations can also be found at https://s3.amazonews.com/publicinspection.federalregister.gov/ 2018-23599.pdf and at 83 Fed. Reg. 54982 (Nov. 1, 2018)). The Executive Summary and Technical Paper are at https://www.cms.gov/Research-Statistics-Data-and Systems/MonitoringPrograms/Medicare-Risk-Adjustment-Data-Validation-Program/Resources.html.

objections to the scope of discovery apply to allegedly privileged documents, the party need not log the documents until the court rules on its scope objection"); *Freeman v. Seligson*, 405 F.2d at 1338.

In August 2018, the United States did precisely what is contemplated by the Federal Rules and the Ninth Circuit and sought relief under both Rule 16(b) and Rule 26(c) from the burdens associated with United's irrelevant discovery requests. *See* Dkt. 261-1, at 1. The relief sought was premised on Plaintiffs having filed three substantive and partially dispositive motions on core legal issues. The points argued in the motions taken under submission by the District Court are integral to the government's opposition to United's motion to compel. The Magistrate Judge's ruling on United's motion to compel has worked as a denial of the United States' motion for a protective order pending before the District Court.

With respect to this point, the Magistrate Judge found that her ruling on the earlier request to stay United's motion to compel essentially disposed of the Protective Order issue. Mem. Dec. (Dkt. 324) at 29 (explaining that the "Magistrate Judge ultimately denied a request for a stay, and the District Judge has not reversed that ruling.") But as noted above, the denial of the application for a stay was based on the finding that the government had "failed to meet the standard for *ex parte* relief." Dkt. 304 at 17. The Memorandum Decision addressing the stay motion explicitly stated the ruling on the stay would "not deprive the Government of the opportunity to raise . . . all of its substantive arguments against discovery." *Id* at 16. With that assurance in hand, the government did not move for a review of the stay decision. The Magistrate Judge subsequently found that, despite the limited ruling she issued when denying the stay and because the District Court had not *sua sponte* reversed that outcome, the primary argument raised by the government in opposition to the motion to compel could be disposed of summarily.

The points and authorities presented by the government in opposition to the Motion to Compel along with those stated in support of the four motions pending with this Court should have controlled the outcome. The Ninth Circuit and other appellate

courts have specified that resolution of discovery disputes should follow a logical sequence. The fundamental issues of relevancy and scope should precede the consideration of privilege assertions for documents or categories of documents. The Memorandum Decision should be set aside and the Court should resolve which claims and contentions by United are properly within this case pursuant to Rules 16 and 26.

V. CONCLUSION

The Memorandum Decision should be set aside. The Court should reject United's attempt to compel the production of internal agency documents regarding aspects of the MA program having no relevance to the legitimate claims and defenses in this case.

Respectfully submitted,

Dated: February 4, 2019

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UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

UNITED STATES OF AMERICA *ex rel.* BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC., *et al.*, Defendants.	No. CV 16-08697 MWF (SSx) [PROPOSED] ORDER GRANTING UNITED STATES' NOTICE OF MOTION AND MOTION FOR REVIEW OF DISCOVERY ORDER Date: April 8, 2019 Time: 10:00 a.m. Court: 5A. Hon. Michael W. Fitzgerald

Upon motion of the United States of America for and order reviewing and reversing the Memorandum Decision and Order Granting UnitedHealth Group, Inc.'s Motion to Compel the United States to Produce Documents ("Discovery Order"), filed on December 14, 2018 (Dkt. 324), and good cause appearing, said motion is hereby GRANTED.

Accordingly, IT IS HEREBY ORDERED that said Discovery Order is REVERSED and the Motion to Compel is DENIED.

IT IS SO ORDERED.

Dated: _____ _____
UNITED STATES DISTRICT JUDGE