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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' SUPPLEMENTAL BRIEF IN SUPPORT OF MOTION FOR SCHEDULING ORDER MODIFYING EXTENT OF DISCOVERY Date: April 8, 2019 Time: 10:00 a.m. Court: 5A, Hon. Michael W. Fitzgerald

INTRODUCTION

In this False Claims Act ("FCA") case, Plaintiffs allege that Defendants knowingly retained payments for millions of *invalid* diagnosis codes submitted to Medicare. Although Plaintiffs' claims are limited to Defendants' knowing failure to delete specific *invalid* diagnosis codes, Defendants have coopted discovery in this case to challenge the payment methodology of the entire Medicare Advantage ("MA") program. They argue that the payments they received over the past decade for *valid* diagnosis codes were too low and that they are entitled to retain payments for *invalid* diagnoses to compensate for this. Alternatively, they claim that the damages to Medicare resulting from their knowing failure to delete *invalid* diagnoses should be reduced to compensate them for the purportedly "too low" payments for *valid* diagnoses.

Defendants' challenge to the MA payment model has no relevance to the legitimate claims or defenses in this action. As the government explained in its recent motion for review of the Magistrate Judge's order compelling production of internal agency deliberations (Dkt. 334), such a challenge (i) is not a valid defense to fraud; (ii) was part of Defendants' Counterclaim, which they have already agreed this Court lacks subject matter jurisdiction to adjudicate; and (iii) is not relevant to damages in this FCA action, which rest only upon the submission of invalid (not valid) diagnoses.

To ensure that discovery proceeds in the manner required by Rule 26(b), Plaintiffs sought a threshold ruling on Defendants' legal obligation to correct claims for risk-adjusted payments which were based on *invalid* diagnosis codes (*i.e.*, false claims) (Dkt. 234). Despite the pendency of Plaintiffs' requests for appropriate limitations, Defendants have significantly expanded their burdensome discovery demands on irrelevant issues not only on the government under Rule 34, but also from third-parties under Rule 45. The need for appropriate limits on discovery was made manifest by Defendants' recent motion to compel the production of privileged material, which forced the Centers for Medicare and Medicaid Services ("CMS") to divert considerable resources from running the Medicare Program to logging internal agency documents and

perfecting privilege with respect to inordinately broad categories of material that are irrelevant to Plaintiffs' claims or any legitimate defense.

Plaintiffs therefore renew their request that the Court set appropriate discovery limits in this case and ask the Court enter the accompanying proposed order. The proposed order forecloses discovery on Defendants' improper challenge to the payment process, which challenge is ever expanding and well outside of the scope of permissible Rule 26 (b) discovery. The order also forecloses certain discovery regarding the materiality of diagnosis codes to the MA payment process and the obligation to delete knowingly invalid diagnosis codes that, as explained in previous briefing, are settled issues under this Court's prior rulings and Ninth Circuit precedent.

BACKGROUND

Based on the discovery requests that they have propounded to date, Defendants clearly intend to use this action to litigate their program-level grievances over how Medicare calculates payments to every insurer participating in the MA program based on their submission of valid diagnosis data. Much of Defendants' improper discovery relates to their contention that the payment coefficients for certain risk-adjusting medical conditions were "too low" because they were determined based on unaudited diagnosis data in fee-for-service (FFS) claims submitted to Medicare. Defendants appear to seek this discovery in an attempt to prove that they are entitled to keep payments for *invalid* diagnoses as compensation for the purportedly "too low" payments for *valid* diagnoses. Indeed, United has explicitly stated that it will continue its attempts to litigate its underpayment contentions in multiple "other fora."[1]

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[1] *See* United's Resp. to U.S.' Mot. to Dismiss Counterclaims (Dkt. 249) at 2 ("United . . . has argued that CMS should adopt an 'adjuster' mechanism that would compare the presence of unsupported diagnosis codes in an MA plan's data with the presence of such codes in the traditional Medicare data and account for the difference. . . . It has done so in administrative comments on notice-and-comment rulemakings, in meetings with CMS officials, in its currently pending Administrative Procedure Act challenge to a 2014 CMS regulation, and in its briefs in this case. And United intends to continue asserting that position in other fora, too, because CMS's refusal to adopt an adjuster already has resulted in United being paid less than it should have been under its contracts with CMS and the payment requirements of the Medicare Act.").

To date, United has served the United States with 128 document requests. Many of those requests concern the development, implementation, calibration, and evaluation of the payment model from 2004 to present date. United also seeks documents related to the examination of the possible use of a payment error rate adjuster, referred to as an FFS Adjuster, for administrative Risk Adjustment Data Validation ("RADV") audits conducted by CMS. CMS said that it would use such an adjuster when it decided to extrapolate its audit results to determine contract-level overpayments. Defendants further seek all data used over the last 15 years (i) to calibrate and recalibrate the coefficients for the model (and additional data to perform their own calibrations), and (ii) to evaluate the possible use of the FFS Adjuster for extrapolated audits. All told, Defendants are demanding a vast quantity of documents and a huge volume of data relating to these issues. *See* Declaration of Carol L. Wallack (Attachment 1 hereto) at ¶ 2 (identifying Defendants' document requests relating to the FFS Adjuster issue and the development, evaluation, and calibration of the risk adjustment model).[2]

Defendants recently expanded the scope of discovery relating to this actuarial equivalence/FFS Adjuster issue by seeking documents and data relating to a rule recently proposed by CMS relating to RADV audits and to a study supporting the proposed rule.

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[2] For example, Defendants request all documents regarding:

- "the RADV Medicare fee-for-service ("FFS") error rate adjuster discussed in CMS's Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Feb. 24, 2012)" (Request for Production ["RFP"] 6);
- "the methodology by which the Government calculates Risk Adjustment Factors [i.e., coefficients]" from 1997 to 2017 (RFP 24);
- "the development and operation of the CMS-HCC Risk Adjustment Model [for payment years 2004 to 2017], including but not limited to Documents identifying and explaining the specific data used to calibrate the CMS-HCC Risk Adjustment Model" (RFP 100);
- "how the data were selected and which records were specifically selected to create the 5% Medicare Standard Analytic files . . . used to develop, calibrate, and recalibrate the CMS-HCC Risk Adjustment Model" for payment years 2004 to 2017 (RFP 101); and
- "All data from all fields included in the 5% Fee-For-Service Medicare file used to develop, calibrate, or recalibrate the CMS-HCC Risk Adjustment Model" for payment years 2004 to 2017 (RFP 102).

In October 2018, CMS published a study finding that, contrary to Defendants' speculative contention, any errors in the FFS diagnosis data did not cause the payments to insurers for valid codes to be "too low." *See* Notice of Recent Proposed Medicare Part C Regulation, Exhibit 2, Dkt. 307-2 (*Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* (Oct. 26, 2018)) at 6 (hereinafter "FFS Adjuster Study") (concluding that "diagnosis error in FFS claims data does not lead to systematic payment error in the MA program."). On November 1, 2018, CMS published a notice of proposed rulemaking in which it summarized the FFS Adjuster Study and proposed "not [to] include an FFS Adjuster" in its methodology for calculating overpayments collected through RADV audits. Policy and Technical Changes to the Medicare Advantage Program for 2020 and 2021 Proposed Rule, 83 Fed. Reg. 54,982-01 at 55,041 (Nov. 1, 2018) ("2018 Proposed Rule").

On November 20, 2018, Defendants sent CMS a letter requesting information and data relating to the FFS Adjuster Study. Thereafter, on December 21, 2018, Defendants served the United States with requests in this case for all conceivable documents and data relating to both the FFS Adjuster Study and the proposed rule. Defendants also issued a third-party subpoena demanding similar information from Research Triangle Institute International ("RTI"), a CMS contractor that assisted the agency in developing the risk adjustment model, calibrating the model, and analyzing the RADV FFS Adjuster issue. In addition to information about the proposed rule, Defendants sought a vast quantity of documents and data in RTI's possession from 2002 to the present relating to the risk adjustment model, the calibration of the model, and the FFS Adjuster issue. See Declaration of Carol L. Wallack (Attachment 1 hereto) at ¶ 3. Defendants have sought similar discovery from another CMS contractor named ARDX.

ARGUMENT

Defendants' challenge to the payment methodology and coefficients is not a valid defense to fraud. Defendants have known for many years that the FFS data used to calibrate the coefficients is unaudited and may include diagnoses that are unsupported by

FFS beneficiaries' medical records (over-reporting) and not include all diagnoses that are supported by their records (under-reporting). Prior to each payment year (and before MA insurers submitted bids for Part C contracts), CMS publishes the proposed risk adjustment methodology and coefficients for public comment in an "Advanced Notice" and then publishes the final methodology and coefficients in an "Announcement." 42 U.S.C. § 1395w-23(b)(1)-(3). If Defendants truly objected to the payment model or coefficients, they could have challenged the agency's final Announcements under the Administrative Procedure Act ("APA"), 5 U.S.C. § 700 *et seq*. *Cf. Minuteman Health, Inc. v. U.S. Dep't of Health & Human Servs.*, 291 F. Supp. 3d 174, 179 (D. Mass. 2018) (APA challenge to HHS' risk adjustment model under the Affordable Care Act); *N. Mex. Health Connections v. U.S. Dep't of Health & Human Servs.*, 340 F. Supp. 3d 1112, 1120-21 (D.N.M. 2018) (same). But Defendants never did this. Instead, Defendants voluntarily entered into hundreds of contracts with CMS, agreed to comply with the regulatory and contractual program requirements,[3] and accepted billions of dollars in risk-adjusted payments for years based on the finalized and published coefficients. Defendants cannot knowingly avoid their obligation to delete invalid diagnosis codes and then escape liability for fraud by challenging the payment model. *See Cedars-Sinai Med. Ctr. v. Shalala*, 125 F.3d 765, 769 (9th Cir. 1997) (rejecting argument that APA challenge to Medicare payment rule could be heard as a defense in FCA case); *see also* U.S. Mem. in Supp. of Mot. for Review (Dkt. 334-1), at 10-12. Their payment challenge is not a cognizable defense that can be pursued within the bounds of Rule 26.

In addition, an APA action was the only appropriate means of challenging the

[3] The regulatory requirement that medical records substantiate diagnoses is unambiguous. As discussed at page 12 of Plaintiffs' Reply Memorandum in Support of Joint Motion for Partial Summary Judgment (Dkt. 272), all diagnosis data submitted to CMS for any healthcare programs must comply with the International Classification of Diseases ("ICD") guidelines, 42 C.F.R. § 162.1002(a)(1)(i), (b)(1) & (c)(2)(i), and these guidelines clearly require that the patients' medical records substantiate the diagnoses assigned to them. A CMS risk adjustment data regulation reiterates this by reminding insurers that they must comply with all national standards for the submission of data, which includes the ICD guidelines. 42 C.F.R. § 422.310(d)(1).

coefficients because such an action would have enabled a court to remand to the agency to modify its methodology and recalibrate the coefficients and avoided unnecessary judicial involvement in a complex payment program for which Congress has given the agency significant discretion. In contrast, the use of this FCA action, which concerns only a specific set of invalid diagnosis codes, to recalibrate the entire model and re-determine the coefficients used to pay every MA insurer over the last decade is inappropriate and would vastly and improperly expand the scope of fact and expert discovery, motion practice, and the trial in this action. Similarly, if Defendants want to challenge the recently proposed RADV audit methodology rule, they can pursue an APA action once the rule is finalized, just like any other MA insurer.

Furthermore, Defendants have been clear that they intend to pursue their claim for damages purportedly resulting from any "too low" payments for valid diagnosis codes in the Court of Federal Claims. Defendants initially attempted to file their counterclaims in this Court. In those counterclaims, Defendants explained that their claim for an FSS adjuster 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). Defendants now concede that this Court "lacks jurisdiction" over those claims. *See* Defs.' Opp. to Mot. to Dismiss (Dkt. 249) at 3:25. And this Court has likewise recognized that payments made for valid diagnoses are not part of Plaintiffs' case. *See* Order (Dkt. 212), at 21-22 ("the real issue is the actual invalid codes that were submitted and not deleted"). Thus, this Court lacks subject matter jurisdiction to adjudicate Defendants' counterclaims or to entertain discovery on the challenge.

The FFS Adjuster issue is also irrelevant to Plaintiffs' FCA claim. Plaintiffs allege that Defendants submitted hundreds of thousands of invalid claims for which they were not entitled to payments and wrongfully retained such payments. Unlike RADV audits (for which a payment error rate is extrapolated to an entire contract), Plaintiffs do not rely on extrapolation or seek contract-level overpayments. Instead, each overpayment alleged in this case is tied to a single corresponding invalid diagnosis code,

or false claim for payment. As a result, each separate submission of an invalid diagnosis code and corresponding knowing avoidance of an obligation to delete that invalid diagnosis code is a separate and freestanding FCA violation. In this context, the concept of actuarial equivalence does not change what constitutes a false claim or a violation of the FCA. *See UnitedHealthcare Ins. Co. v. Azar*, 330 F. Supp. 3d 173, 189 (D.D.C. 2018) ("United does not contend that Medicare Advantage insurers should be permitted knowingly or recklessly to bill CMS for erroneous diagnosis codes."). Even if Defendants were correct that the use of unaudited FFS diagnosis data resulted in some of the coefficients being "too low," that would mean *only* that Defendants may not have been paid sufficiently for *valid* diagnoses – *not* that they can knowingly retain payment for *invalid* diagnoses.

Actuarial equivalence and FFS Adjuster arguments are also irrelevant to the determination of the overpayments or damages in this case. The calculation of overpayments or damages resulting from the failure to delete invalid diagnoses is straightforward and does not implicate the payment process for valid codes. If Medicare paid an increased amount to an insurer based on an invalid diagnosis code, that entire amount must be recovered. *See* Pls.' First Am. Compl. ("FAC") (Dkt. 171) at 235-38. *First*, Plaintiffs will re-calculate each individual beneficiary's risk score without the invalid diagnoses identified through Defendants' chart reviews. *Second*, Plaintiffs will calculate the amount that would have been paid to Defendants for that beneficiary based on the revised risk score and published coefficients. The overpayment or damage is the difference between what was paid and what would have been paid for that individual beneficiary based on his or her revised risk score. Payments for valid codes are not affected or implicated in this analysis.

Finally, there is no merit to Defendants' argument that they need internal agency deliberative documents relating to an FFS Adjuster to show that they had a reasonable good-faith belief that they were entitled to a "free pass" for a certain number of false claims based on invalid diagnoses and knowingly retain the amounts Medicare paid

based on these false diagnoses. (Dkt. 310 at 27.) Regulations unambiguously establish that medical record documentation must substantiate all diagnosis data submitted to CMS for all healthcare programs. *See supra* footnote 2. CMS has always been clear that unsubstantiated diagnosis codes are invalid for payment purposes. *See* FAC ¶¶ 89-91 (describing manuals and guides CMS has issued publicly since 2003 consistently stating that diagnosis data submitted for risk-adjusted payments must be supported by patients' medical records). Defendants do not need discovery of internal agency documents to understand their legal obligations, as these obligations were set forth in public documents such as regulations, manuals and guides and incorporated into all of Defendants' Part C contracts.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court enter the proposed order submitted with this supplemental brief.

Respectfully submitted,

Dated: March 20, 2019

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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.

Dated: March 20, 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)

AMENDED [PROPOSED] ORDER GRANTING MOTION FOR SCHEDULING ORDER MODIFYING EXTENT OF DISCOVERY

Date: April 8, 2019
Time: 10:00 a.m.
Court: 5A, Hon. Michael W. Fitzgerald

Upon consideration of Plaintiffs' Motion Pursuant to Rule 16(b)(3) For Issuance of a Scheduling Order Modifying Extent of Discovery (Dkt. 261), Defendants' opposition thereto, and the pleadings and other papers on file herein, and for good cause shown, said motion is GRANTED. IT IS HEREBY ORDERED as follows:

1. Discovery relating to the Risk Adjustment Data Validation ("RADV") Fee-For-Service Adjuster issue, the "actuarial equivalence" requirement in the Medicare Act, the development and implementation of the CMS-HCC risk adjustment model, and the calibration or recalibration of the coefficients for the model, including discovery that the parties have already propounded on each other and third parties, is neither relevant to the claims and defenses in this action nor proportional to the needs of the case and therefore shall not be conducted by the parties.
2. In accordance with the Court's February 12, 2018 Order re Motion to Dismiss (Dkt. 212) at page 21, discovery relating to CMS' general knowledge of one-way chart reviews or general knowledge about problems with the validity of diagnoses submitted by Medicare Advantage Organizations is neither relevant to the claims and defenses in this action nor proportional to the needs of this case and shall be precluded.
3. Discovery relating to matters about which Defendants did not know or could not have had knowledge of is not relevant to Defendants' knowledge of their obligation to delete or withdraw invalid diagnoses or any other relevant issues and is precluded. This includes discovery related to (a) CMS's internal, nonpublic deliberations concerning the obligation to delete invalid diagnoses, (b) communications between CMS and entities other than Defendants about the obligation to delete or the other entities' possible or actual deletions, and (c) investigations by the Department of Health and Human Service's Office of Inspector General or any other government agency concerning whether entities other than Defendants submitted invalid diagnoses or complied with their

obligation to delete invalid diagnoses.

4. Discovery relating to the issues resolved by the Court's rulings on Plaintiffs' Motions for Partial Summary Judgment (Dkt. 234), to Strike Affirmative Defenses (Dkt. 235), and to Dismiss Defendants' Counterclaims (Dkt. 236), shall not be allowed in this case, including discovery already propounded by the parties on each other and on third parties.

IT IS SO ORDERED.

Dated: _____ _____
UNITED STATES DISTRICT JUDGE

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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) DECLARATION OF CAROL WALLACK IN SUPPORT OF SUPPLEMENTAL BRIEF IN MOTION PURSUANT TO RULE 16(b)(3) FOR ISSUANCE OF A SCHEDULING ORDER Date: April 8, 2019 Time: 10:00 a.m. Court: 5A, Hon. Michael W. Fitzgerald

DECLARATION OF CAROL WALLACK

I, Carol Wallack, declare:

1. I am a trial attorney at the Fraud Section in the Civil Division of the United States Department of Justice ("DOJ"). I represent the United States in the above-captioned action. I have personal knowledge of the matters set forth herein and, if called to testify, could and would testify competently thereto.

2. Defendants' document requests to the government relating to the FFS Adjuster issue and the development, evaluation and calibration of the risk adjustment model are set forth in Exhibits A – D to this declaration. They include the following requests:

- Document Requests Nos. 1, 6, 8, 24, 35, 36, and 37 set forth in Defendants' First Request for Production of Documents to the Government (Set One, Nos. 1–78), served on August 24, 2017, a true and correct copy of which is attached hereto as Exhibit A.
- Document Requests Nos. 9 and 19 set forth in Defendants' Second Request for Production of Documents to the Government (Set Two, Nos. 1 – 19), served on January 19, 2018, a true and correct copy of which is attached hereto as Exhibit B.
- Document Requests Nos. 98, 99, 100, 101, 102, and 103 set forth in Defendants' Third Request for Production of Documents to the Government (Set Three, Nos. 98 – 108), served on July 16, 2018, a true and correct copy of which is attached hereto as Exhibit C.
- Document Requests Nos. 112, 113, 114, 115, 116, 117, 118, 119, and 121 set forth in Defendants' Fourth Request for Production of Documents to the Government (Set Four, Nos. 109 – 121), served on December 21, 2018, a true and correct copy of which is attached hereto as Exhibit D.

3. Defendants' documents requests to Research Triangle Institute International ("RTI") relating to the FFS Adjuster issue and the development, evaluation, and calibration of the risk adjustment model are set forth in Defendants' Subpoena to

Produce Documents to RTI, served on February 2, 2019, a true and correct copy of which is attached hereto as Exhibit E. These include requests nos. 1, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17.

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

Executed on March 20, 2019 at Washington, D.C.

/s/Carol Lynn Wallack
CAROL LYNN WALLACK

EXHIBIT A

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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA *ex rel.* BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC., *et al.*, Defendants.	CASE NO. CV 16-08697 MFW (SSx) DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. ONE) Assigned to Hon. Michael W. Fitzgerald DISCOVERY MATTER

PROPOUNDING PARTY: Defendant UHC of California

RESPONDING PARTY: Plaintiff United States Government

SET NO.: ONE (1)

TO THE RESPONDING PARTY AND TO ITS ATTORNEYS OF RECORD:

Please take notice that pursuant to Rules 26(b)(1) and 34 of the Federal Rules of Civil Procedure and Rule 34-1 of the Local Civil Rules of the United States District Court for the Central District of California, Defendant UHC of California, by and through its undersigned attorneys, submits the following Request for the Production of Documents to the United States Government ("Government"). On or before the thirtieth (30th) day after service of this Request, Plaintiff shall produce and permit the inspection and copying of the documents or things described below at Latham & Watkins, 555 Eleventh Street, Northwest, Suite 1000, Washington, DC 20004. The Definitions and Instructions set forth below shall govern all of the following Requests, as well as responses to the Requests.

DEFINITIONS

As used herein, the following terms and phrases shall have the following meanings:

1. The applicable definitions and rules of construction set forth in the Federal Rules of Civil Procedure and the local rules are incorporated herein by reference.

2. **"Bid(s)"** shall mean and refer to bids and supporting documentation submitted to CMS pursuant to 42 U.S.C. § 1395w-24(a).

3. **"Claim"** shall mean and refer to the definition set forth in the False Claims Act at 31 U.S.C. § 3729(b)(2).

4. **"CMS"** shall mean the United States Centers for Medicare and Medicaid Services, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

5. "**Complaint**" shall mean the complaint filed by the Government in this case on May 16, 2017, and any forthcoming amended complaints filed by the Government in this case.

6. **"Concerning"** shall mean and refer to relating to, referring to, received from, addressed to, sent to, alluding to, responding to, announcing, identifying, explaining, evaluating, discussing, showing, supporting, describing, studying, reflecting, analyzing, or consulting.

7. "**Document**" shall have the full meaning ascribed to it in Federal Rule of Civil Procedure 34 and shall include every writing or record (including Electronically Stored Information) of every type and description such as communications, correspondence, speech, writings, memoranda, stenographic or handwritten notes, language (machine, foreign, or otherwise), studies, publications, books, pamphlets, reports, financial statements, calculations, analyses, films, video tape, photographs, graphs, symbols, signs, voice recordings, sound, radio and/or video signal, telephone, teletype, telecommunication, telegram, facsimile transmission, microfilm, microfiche, photographic film of any type, e-mail, computer electronics of any kind, computer files or all other data compilations from which information can be obtained including electromagnetically sensitive stored media such as floppy discs, hard discs, magnetic disks, and magnetic tapes, any preliminary versions, drafts or revisions of any of the foregoing, and all copies of every such writing or record (or a draft thereof) whenever a copy of a Document is not an identical copy of the original or where such copy contains any commentary, notes or markings whatsoever that do not appear on the original.

8. "**Electronically Stored Information**" or "**ESI**" refers to any designated documents or electronically stored information - including writings, drawings, graphs, charts, photographs, sound recordings, images, e-mails and other data or data compilations stored in any medium (hard drives, disc drives, servers,

lap tops) from which information can be obtained, including all data which may have been deleted, but which can be recovered or retrieved from a back-up system or such other method translated, if necessary, by the party into reasonably usable form. For the avoidance of doubt, any electronic Documents or data shall include its associated metadata.

9. "**Each**" includes the word "every" and "**every**" includes the word "each," "**any**" includes the word "all" and "**all**" includes the word "any," "**and**" includes the word "or" and "**or**" includes the word "and," as necessary to bring within the scope of each Request information which might otherwise be construed to be outside its scope.

10. "**False**" shall mean and refer to "false" or "fraudulent" as those terms are used in the False Claims Act, at 31 U.S.C. §§ 3729(a)(1)(A)-(B).

11. **"Gainshare Arrangements"** refers to agreements whereby Medicare Advantage Plans pay fee-for-service providers additional payments based on revenue, including risk adjustment payments, which Medicare Advantage Plans receive from CMS.

12. "**Government**" shall mean the United States, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf, including but not limited to any component of the United States Department of Justice, the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services and all subdivisions and components thereof.

13. "**HCC**" means a hierarchical condition category associated with one or more diagnosis codes (ICD-9-CM or ICD-10-CM codes) that represent the disease component of the beneficiary risk scores that are applied to Medicare Advantage payments. "RxHCC" means an HCC used for Medicare Part D.

14. **"ICE"** means and refers to the Industry Collaborative Effort for Healthcare, an association of MA Organizations and their Plans as well as provider

groups that service beneficiaries in Plans.

15. **"Identify"** means and refers to the following:

a. when used in reference to a natural person, it means that individual's full name, present or last known residence address and telephone number, business/government affiliation and business/government address and telephone number and e-mail address;

b. when used in reference to an organization, it means to state the organization's full name and, if it is a corporation, partnership or other business entity, the address of its principal place of business;

c. when used in connection with a Document or other recording (written, electronic, or otherwise), it means to state the following, as applicable: the type of document, its date (or approximate date), author, addressee, title, present location, the form in which it is maintained (e.g., written document, computer file, posting on the Internet or World Wide Web, audio or video recording or any other form), the name and address of its custodian, and the substance of the contents thereof. In lieu of identifying any document, copies thereof may be furnished;

d. when used in reference to a communication (whether written, oral, electronic, or otherwise), shall mean to state the form of the communication (e.g., telephone conversation, letter, telegram, teletype, telecopy, electronic mail, posting on the Internet or World Wide Web, facsimile, written memorandum, face-to-face conversation, or any other form), the date (or approximate date) of the communication or the dates (or approximate dates) on which the communication was sent, posted, and/or received (if not the same), the parties to the communication, the party who initiated it, the substance of the communication, and the present location and the name and

address of the custodian if the communication was non-verbal, and/or any written memorialization of the communication; and

e. when used in connection with a location, it means the name of the establishment, the street address, the suite or apartment number if any, the city, state and zip code, and, if applicable, the telephone number.

16. "**Including**" shall be construed as broadly as possible and shall mean "without limitation."

17. **"Limited Data Set Files"** and **"LDS Files"** shall mean and refer to publically available data files containing both institutional and non-institutional Medicare claims and provider information as well as beneficiary level health information.

18. **"Medicare Advantage Plan"** and **"MA Plan"** shall mean and refer to a Medicare Advantage Organization with a contract to provide health benefits coverage that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries in residing in the service area of the MA Plan, in exchange for capitated (i.e., set or fixed), per-member-per-month payments from the federal government, under Parts C and D of the Medicare Program. *See* 42 U.S.C. §§ 1395w-22(a)(1) and 23(a)(1); *see also* 42 U.S.C. § 1395w-28(b)(1).

19. "**Medicare Advantage Organization**" and **"MAO"** shall mean and refer to a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage contract requirements. *See* 42 U.S.C. § 1395w-28(a)(1).

20. "**Person**" shall mean natural persons, proprietorships, corporations, public corporations, municipal corporations, the federal government and all departments and agencies thereof, state governments, local governments, other governmental agencies, political subdivisions, partnerships, groups, associations or organizations.

21. **"RADAR"** shall mean and refer to the Risk Adjustment Data Acquisition and Reporting team within ICE.

22. "**Relating to**" and "**regarding**" or any derivative thereof, in addition to their customary and usual meanings, shall mean concerning, referring to, containing, identifying, monitoring, constituting, reflecting, discussing, pertaining to, assessing, recording, supporting, negating, refuting, touching upon and/or summarizing.

23. "**Relator**" shall mean Benjamin Poehling and all Persons acting on his behalf.

24. "**Risk Adjustment**" shall mean and refer to the method by which CMS adjusts capitation payments to Medicare Advantage Organizations and their health Plans based on enrollees' demographic factors and health status to ensure actuarial equivalence under Parts C and Part D of the Medicare Program, as described in 42 U.S.C. § 1395w-23 and 42 C.F.R. § 422.308(c)(1).

25. **"Risk Adjustment Attestations"** shall mean and refer to the requirement defined in 42 C.F.R. § 422.504(l) that Medicare Advantage organizations must request payment under their contract with CMS on a document that certifies the accuracy, completeness, and truthfulness of relevant data that CMS requests.

26. **"Risk Adjustment Error"** or **"RAE"** shall mean and refer to the estimate that captures error in risk adjustment data (clinical diagnosis data) submitted to CMS by MA plans for risk adjustment payments, based on a national sample of MA beneficiaries. *See* CMS "2011 Medicare Advantage (Part C) Improper Payment Error Rate" Fact Sheet, *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2011-Fact-sheets-items/2011-11-157.html.

27. "***Swoben* Investigation**" shall mean and refer to the Government's investigation related to the case captioned *United States of America ex rel. James*

M. Swoben v. SCAN Health Plan, et al., CV 09-5013 JFW (JEMx), originally filed in the United States District Court for the Central Division of California on July 13, 2009.

28. "**UnitedHealth**" shall mean UnitedHealth Group, Inc.; United Healthcare Services, Inc.; United Healthcare, Inc.; UnitedHealthcare Insurance Company; UHIC Holdings, Inc.; Ovations, Inc.; Optum, Inc.; OptumInsight, Inc.; and Defendant Medicare Advantage Organizations and Plans listed on Exhibit 1 to the United States' Complaint-In-Partial-Intervention and Demand for Jury Trial.

29. "**You**" and "**Your**" shall mean the Government and all Persons acting on its behalf.

INSTRUCTIONS

1. You are to produce all documents, as defined above, that are in the possession, custody or control of You, or in the possession, custody or control of any attorney or agent for You. Without limiting the term "control," a document is deemed to be within Your control if you have ownership, possession or custody of the document, or the right to secure the document or copy thereof from any person or public or private entity having physical possession thereof.

2. Whenever appropriate, the singular form of a word shall be interpreted as plural, and vice versa. Similarly, the use of the present tense of a verb shall be considered to include within its meaning the future and past tense, and vice versa.

3. Each Request should be construed to include the time period from January 1, 2004 through May 16, 2017 (unless stated differently by a specific document request).

4. You are under a duty to supplement Your response to these requests for documents pursuant to Federal Rule of Civil Procedure 26(e)(1).

5. If You know of documents responsive to a particular request that You cannot locate after a reasonable search, describe the documents in Your response to

the particular request and explain the reason for being unable to locate the documents. If a document has been lost or destroyed, state when the document was lost or destroyed and explain the circumstances under which it was lost or destroyed.

6. The documents produced in response to the document requests shall be produced as they are kept in the ordinary course of business and shall be organized so that Defendant can ascertain the files in which they were located, their relative order in such files, and how such files were maintained.

7. Production of Electronically Stored Information ("ESI"), as that phrase is understood in Fed. R. Civ. P. 26, should conform to the instructions contained in the agreed upon "Specifications for Production of ESI and Digitized ('Scanned') Images."

8. If the contention is made that any requested documents are not subject to discovery in whole or part by reason of privilege or otherwise, identify each such document in a log consistent with the requirements of Fed. R. Civ. P. 26(b)(5).

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 1:

All Documents regarding the final Risk Adjustment Data Validation ("RADV") methodology discussed in CMS's *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012), as well as any prior RADV methodologies adopted or suggested by CMS and all comments filed on those methodologies.

REQUEST FOR PRODUCTION NO. 2:

All Documents relating to the standard for evaluating the accuracy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data that CMS and the Office of the Inspector General ("OIG") of the Department

of Health and Human Services ("HHS") apply in RADV audits, including but not limited to, all Documents in which CMS and OIG set forth, discuss, review, and/or revise that standard and all Documents upon which CMS relied to set that standard.

REQUEST FOR PRODUCTION NO. 3:

All Documents relating to any regulations, rules, guidance or other public pronouncements setting forth the Government's standards for evaluating the accuracy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data.

REQUEST FOR PRODUCTION NO. 4:

All Documents relating to any CMS analyses and/or reviews of, and reports on, capitation arrangements and Gainshare Arrangements within the Medicare Advantage program, and any other arrangements that align providers' interests with the interests of MA Plans to provide more efficient and effective care to MA Plan members or that pay for value or quality rather than quantity of services, and their impact on patient outcomes, control of healthcare costs and any other impacts that are measured by these analyses, reviews, and reports.

REQUEST FOR PRODUCTION NO. 5:

All Documents relating to the preliminary or final results of any audits or reviews conducted by or on behalf of the Government, including CMS and the HHS OIG, of diagnosis codes submitted to the Medicare Program for Risk Adjustment payments, including, but not limited to, RADV Audits.

REQUEST FOR PRODUCTION NO. 6:

All Documents regarding the RADV Medicare fee-for-service ("FFS") error rate adjuster discussed in CMS's *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012), including but not limited to, Documents describing any effort by the Government to calculate a Medicare FFS error rate and Documents describing any analysis by the Government related to measuring the

accuracy of diagnoses submitted on Medicare FFS claims.

REQUEST FOR PRODUCTION NO. 7:

All Documents regarding the Risk Adjustment Error ("RAE") rate, including Documents sufficient to show the annual RAE rates calculated by the Government over time.

REQUEST FOR PRODUCTION NO. 8:

All data from all fields included in the following Limited Data Set ("LDS") Files: 1) 100% Denominator File, 2) 5% Carrier Standard Analytic File, 3) 100% Inpatient Standard Analytic File, and 4) 100% Outpatient Standard Analytic File. This request seeks data for dates of service years 2005 through 2015.

REQUEST FOR PRODUCTION NO. 9:

All communications between CMS and Signature Consulting Group regarding RADV audits and/or HCC coding criteria and analysis.

REQUEST FOR PRODUCTION NO. 10:

All Documents related to CMS and any other Government involvement in ICE and RADAR activities, meetings, calls, workshops, conferences and other collaborations regarding any Risk Adjustment issues.

REQUEST FOR PRODUCTION NO. 11:

All Documents related to communications between the Government and ICE and RADAR relating to Risk Adjustment.

REQUEST FOR PRODUCTION NO. 12:

A copy of each signed Medicare Advantage contract between CMS and UnitedHealth and any Documents related to such contracts.

REQUEST FOR PRODUCTION NO. 13:

A copy of each Risk Adjustment Attestation that any Medicare Advantage Organization ("MAO") submitted to CMS pursuant to 42 C.F.R. § 422.504(l), and any Documents submitted by Medicare Advantage Organizations to qualify or explain their Risk Adjustment Attestations.

REQUEST FOR PRODUCTION NO. 14:

All Documents relating to the annual Risk Adjustment Attestation of accuracy submitted by MAOs pursuant to 42 C.F.R. § 422.504(l), including Documents relating to the specific data and information MA Plans must certify as accurate, complete, and truthful.

REQUEST FOR PRODUCTION NO. 15:

All Documents relating to the Government's review, analysis, or acceptance of the Risk Adjustment Attestations submitted by any MAO pursuant to 42 C.F.R. § 422.504(l).

REQUEST FOR PRODUCTION NO. 16:

All Documents relating to CMS's issuance or decision to issue risk adjustment payments, including final reconciliation payments, to UnitedHealth after receiving UnitedHealth's Risk Adjustment Attestations.

REQUEST FOR PRODUCTION NO. 17:

All Documents relating to the Government's knowledge as to whether MA Plans were validating the accuracy of diagnosis codes submitted on claims data to CMS for purposes of Risk Adjustment.

REQUEST FOR PRODUCTION NO. 18:

All Documents relating to the Government's knowledge as to whether MA Plans were deleting diagnosis codes submitted on claims data to CMS for purposes of Risk Adjustment that were not supported by a medical record.

REQUEST FOR PRODUCTION NO. 19:

All Documents relating to the Government's knowledge as to whether MA Plans "look both ways."

REQUEST FOR PRODUCTION NO. 20:

All Documents relating to the Government's knowledge of MA Plans' efforts to exercise "reasonable diligence" to report and return overpayments to CMS as described in 79 Fed Reg. 29,844, 29,923.

REQUEST FOR PRODUCTION NO. 21:

All Documents relating to the Government's, review, analysis, or receipt of the Bids submitted by UnitedHealth pursuant to 42 U.S.C. § 1395w-24(a), including but not limited to Documents relating to (a) any actions that the Government took in response to those Bids, (b) questions posed by the Government, (c) any evidence of the Government's concerns with the UnitedHealth Bids, (d) any conclusions reached by the Government in the course of evaluating the UnitedHealth Bids, and (e) any analysis or reviews or conclusions regarding the appropriateness of any of the assumptions set forth or relied by United in its Bids.

REQUEST FOR PRODUCTION NO. 22:

All Documents relating to instructions and guidelines for CMS employees responsible for reviewing MA Plans' bids and associated material.

REQUEST FOR PRODUCTION NO. 23:

All Documents regarding the requirement mandated by 42 U.S.C. § 1395w-23(a)(l)(C)(ii) that CMS apply a coding intensity adjustment to MA Plans, including but not limited to all Documents relating to the calculation of the coding intensity adjustment.

REQUEST FOR PRODUCTION NO. 24:

Documents sufficient to show the methodology by which the Government calculates Risk Adjustment Factors, including but not limited to, all Documents regarding consideration of whether CMS's calculation of Risk Adjustment Factors and development of a risk model from other than inpatient settings should be based on diagnoses from claims data or medical charts. *See* 42 U.S.C. § 1395w-23. This request seeks documents from June 1, 1997 through May 1, 2017.

REQUEST FOR PRODUCTION NO. 25:

All Documents relating to the statement contained in "*Medicare Program; Medicare+Choice Program*" that MA Organizations "undertake 'due diligence' to

ensure the accuracy, completeness, and truthfulness of encounter data" they submit to CMS, and make "good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted" to CMS, 65 Fed. Reg. 40,170, 40,268 (June 29, 2000), including, but not limited to, any Documents discussing or describing any obligations created by this statement. This request seeks documents from June 1, 1997 through May 1, 2017.

REQUEST FOR PRODUCTION NO. 26:

All Documents regarding CMS's proposal in proposed rule "*Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" to add 42 C.F.R. § 422.310(e)(1) requiring that "[a]ny medical record reviews conducted by a MA organization ... be designed to determine the accuracy of diagnoses submitted under § 422.308(c) and § 422.310(g)," 79 Fed. Reg. 1918,2053 (Jan. 10, 2014), including, but not limited to, any and all reasons, analyses, or considerations regarding why CMS did not adopt this proposal in the final rule. 79 Fed. Reg. 29,844, 29,921; 29,926 (May 23, 2014).

REQUEST FOR PRODUCTION NO. 27:

All Documents regarding CMS's "*Reporting and Returning of Overpayments*" proposal in its proposed rule "*Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" to add 42 C.F.R. § 422.326 to "clarify the statutory definition of overpayment" 79 Fed. Reg. 1918, 2055-56 (Jan. 10, 2014), including, but not limited to, any comments submitted to CMS about the proposed rule.

REQUEST FOR PRODUCTION NO. 28:

All Documents regarding CMS's "*Reporting and Returning of Overpayments"* final rule in *"Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" 79 Fed. Reg. 29,844, 29,921; 29,926 (May 23, 2014).

REQUEST FOR PRODUCTION NO. 29:

All Documents containing unique versions of Chapter 7 and Chapter 21 of CMS's "*Medicare Managed Care Manual*" dating from 1999 to the present.

REQUEST FOR PRODUCTION NO. 30:

All Documents related to internal discussions, analyses and/or calculations regarding the preparation of the Regulatory Impact Statement for HCFA, Medicare Program: Medicare + Choice Program Final Rule, 65 Fed. Reg. 40170 (June 29, 2000).

REQUEST FOR PRODUCTION NO. 31:

All Documents regarding whether Section 6.4.1 of CMS's *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide* requires MAOs to delete unsupported codes.

REQUEST FOR PRODUCTION NO. 32:

All Documents regarding whether Section 7.2.4.1 of CMS's *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide* applies to contexts other than CMS's RADV audits.

REQUEST FOR PRODUCTION NO. 33:

All Documents reflecting discussion or analysis of CMS's overpayment standard, requiring Plans to exercise "reasonable diligence" in reporting and returning overpayments, including but not limited to Documents explaining or analyzing the "reasonable diligence" standard. *See* 79 Fed Reg. 29,844, 29,923.

REQUEST FOR PRODUCTION NO. 34:

All Documents regarding CMS's "*Guidance for Reporting and Returning Medicare Advantage Organization and/or Sponsor Identified Overpayments to the Centers for Medicare & Medicaid Services (CMS)*" (February 18, 2015).

REQUEST FOR PRODUCTION NO. 35:

All Documents regarding any Government efforts to review, validate or otherwise evaluate the accuracy of Medicare FFS diagnosis codes that it received

on claims data as part of its process of calculating risk-adjusted reimbursement rates or calculating annual risk scores, including, but not limited to, any Documents related to whether the Government reviews or otherwise evaluates corresponding medical records as part of any such validation activities.

REQUEST FOR PRODUCTION NO. 36:

All Documents regarding the Government's forecasting, budgeting and/or appropriating payments or funds to CMS related to insuring the Medicare FFS population.

REQUEST FOR PRODUCTION NO. 37:

All Documents relating to the methodology CMS used to calculate its annual county-level average risk score and per capita costs for Calendar Years 2005 through 2015. *See, e.g.*, County Fee-for-Service Expenditure Data for Calendar Year 2012, *available at* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html.

REQUEST FOR PRODUCTION NO. 38:

All Documents reflecting or relating to whether MA Plans validate or validated the accuracy of diagnosis codes submitted on claims data to CMS for purposes of Risk Adjustment and whether MA Plans "look both ways" when reviewing medical charts.

REQUEST FOR PRODUCTION NO. 39:

All Documents regarding any obligation or requirement that MA Plans validate the accuracy of diagnosis codes submitted on claims data before they submit claims data to CMS for purposes of Risk Adjustment, including but not limited to any such obligation or requirement that appears in CMS's *2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide*.

REQUEST FOR PRODUCTION NO. 40

All Documents relating to discussions between the Government and MA Plans regarding the voluntary retention or return of potential or actual overpayments as a result of MA Plan review of Risk Adjustment data.

REQUEST FOR PRODUCTION NO. 41:

All Documents relating to discussions between the Government and MA Plans regarding Chart Reviews, compliance obligations with respect to Risk Adjustment, diagnosis coding and medical record document as those issues pertain to Risk Adjustment, and RADV Audits, including but not limited to Documents relating to discussions with UnitedHealth in 2014.

REQUEST FOR PRODUCTION NO. 42:

All training-related Documents that the Government provided coders (or contractors coding on behalf of the Government) to instruct them on evaluating the accuracy and adequacy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data.

REQUEST FOR PRODUCTION NO. 43:

All Documents regarding coding for purposes of evaluating the accuracy and adequacy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data, including but not limited to coding chronic conditions.

REQUEST FOR PRODUCTION NO. 44:

All Documents related to instructions and guidelines CMS has issued regarding coding and reporting using Revisions 9 and 10 of the International Classification of Diseases ("ICD"), including all Documents related to the creation and development of any such instructions and guidelines.

REQUEST FOR PRODUCTION NO. 45:

All Documents related to the coding convention that "[t]he assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists." *See* "ICD-10-CM Official Guidelines for Coding and Reporting FY 2017 (October 1, 2016 – September 30, 2017)," *available at*

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf.

REQUEST FOR PRODUCTION NO. 46:

All Documents related to the response to the question from the Coding Clinic Fourth Quarter 2016 that reads in part: "Please explain the intent of the new ICD-10-CM guideline regarding code assignment and clinical criteria that reads as follows: 'The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists.'" *See* AHA Coding Clinic for ICD-10-CM and ICD-10-PCS at 147 (Fourth Quarter 2016), *available at* www.CodingClinicAdvisor.com.

REQUEST FOR PRODUCTION NO. 47:

Documents sufficient to show the dollar value of diagnosis codes deleted by all MA Plans including, but not limited to, UnitedHealth.

REQUEST FOR PRODUCTION NO. 48:

All Documents related to the deletion of emails from any email accounts maintained by Ms. Marilyn Tavenner or to her use of a private email address to correspond regarding Risk Adjustment.

REQUEST FOR PRODUCTION NO. 49:

All Documents relating to any March and/or April 2014 meetings or discussions involving Mr. Larry Renfro and Mr. Jonathan Blum and/or Ms. Marilyn Tavenner.

REQUEST FOR PRODUCTION NO. 50:

All Documents relating to the April 29, 2014 meeting between Mr. Sean Cavanaugh, Ms. Cynthia Tudor, Ms. Cheri Rice, Mr. Dan Farmer, and Ms. Julie Grover from CMS and UnitedHealth executives Mr. Dan Schumacher, Mr. Steve Nelson, Ms. Karen Erickson, and Mr. Thad Johnson. This request includes any Documents relating to the preparation for and follow-up from this meeting.

REQUEST FOR PRODUCTION NO. 51:

All Documents relating to the May 2, 2014 email from Ms. Cheri Rice to Mr. Steve Nelson regarding "[UnitedHealth's] 2012 Attestation and follow-up from yesterday's meeting."

REQUEST FOR PRODUCTION NO. 52:

All Documents relating to the July 30, 2015 email from Ms. Cheri Rice to Mr. Steve Nelson regarding "[UnitedHealth's] 2013 CMS RAF Attestation."

REQUEST FOR PRODUCTION NO. 53:

All Documents relating to the June 15, 2016 email from Ms. Cheri Rice to Mr. Steve Nelson regarding "[UnitedHealth's] 2014 CMS RAF Attestation."

REQUEST FOR PRODUCTION NO. 54:

All Documents regarding any interviews or depositions of current and/or former CMS officials related to any matter (litigation or investigation) involving Risk Adjustment and MA Plans.

REQUEST FOR PRODUCTION NO. 55

All Documents relating to Your Complaint's allegations that UnitedHealth submitted false and fraudulent claims to the Government.

REQUEST FOR PRODUCTION NO. 56:

All Documents relating to Your Complaint's allegations that UnitedHealth received payments from the Government based on allegedly false HCC or RxHCC diagnoses.

REQUEST FOR PRODUCTION NO. 57:

All Documents provided by the Relator to the Government that the Government has not already provided to UnitedHealth.

REQUEST FOR PRODUCTION NO. 58:

All Documents relating to meetings between the Relator and the Government.

REQUEST FOR PRODUCTION NO. 59:

All Documents relating to Government litigation hold(s) related to this case and/or the *Swoben* Investigation, including but not limited to copies of the litigation hold(s) and documents sufficient to show who received the hold, what the hold covers, and when it was issued.

REQUEST FOR PRODUCTION NO. 60:

All Documents relating to Government document retention policies, including but not limited to its policies for retaining data, electronic documents and emails, as well as copies of the document retention policies and documents sufficient to show what the policy covers, and to what timeframe it applies.

REQUEST FOR PRODUCTION NO. 61:

Documents sufficient to show what steps the Government took to preserve ESI, including email and any other information created or maintained by former Government personnel (including but not limited to CMS employees) related to this case and/or the *Swoben* Investigation.

REQUEST FOR PRODUCTION NO. 62:

All Documents that are facially marked with any claim of privilege or as to which UnitedHealth has asserted a claim of privilege in connection with Your *Poehling* Investigation to the extent any of the Documents were read, reviewed, analyzed or shared with any individual at the Department of Justice ("DOJ"), OIG or CMS, or any non-governmental individual, who was or is involved in any way in the litigation or investigation of allegations in this matter.

REQUEST FOR PRODUCTION NO. 63:

All Documents relating to any efforts the Government undertook in connection with receiving, reviewing, or analyzing UnitedHealth Documents that are facially marked with any claim of privilege or to which UnitedHealth has asserted a claim of privilege in connection with Your *Poehling* Investigation, to the extent any of the Documents were read, reviewed, analyzed, or shared with any

individual at DOJ, OIG, or CMS, or any non-governmental individual, who was or is involved in any way in the litigation or investigation of allegations in this matter.

REQUEST FOR PRODUCTION NO. 64:

All Documents relating to whether any representative of the Government (including any investigator) reviewed, analyzed, or discussed any privileged UnitedHealth information, including UnitedHealth Documents that are facially marked with any claim of privilege or as to which UnitedHealth has asserted a claim of privilege in connection with Your Poehling Investigation, including UnitedHealth Documents provided to the Government by Mr. Poehling or his counsel, to the extent any of the Documents were read, reviewed, analyzed or shared with any individual at DOJ, OIG or CMS, or any non-governmental individual, who was or is involved in any way in the litigation or investigation of the allegations in this case.

REQUEST FOR PRODUCTION NO. 65:

All Documents relating to the Government's handling of UnitedHealth's clawback requests, including confirmation that Documents that were clawed back were, in fact, deleted from all Government computers and other data recording devices.

REQUEST FOR PRODUCTION NO. 66:

All Documents relating to any efforts the Government undertook in connection with receiving, reviewing, or analyzing potentially privileged UnitedHealth documents in this case to the extent Your Complaint is based in any part on the *Poehling* Investigation, including any Documents designated privileged on their face.

REQUEST FOR PRODUCTION NO. 67:

All Documents relating to whether any representative of the Government (including any investigator) reviewed, analyzed, or discussed any privileged

UnitedHealth information, including privileged UnitedHealth Documents provided to the Government by Mr. Poehling or his counsel.

REQUEST FOR PRODUCTION NO. 68:

All Documents relating to any steps the Government took to prevent any individual at DOJ, OIG or CMS, or any non-governmental individual, who was or is involved in any way in the litigation or investigation of the allegations in this case and who had or has access to UnitedHealth Documents that are facially marked with any claim of privilege or as to which UnitedHealth has asserted a claim of privilege in connection with Your *Poehling* Investigation, including UnitedHealth Documents provided to the Government by Mr. Poehling or his counsel, from revealing, using, or otherwise conveying privileged UnitedHealth information to any Person.

REQUEST FOR PRODUCTION NO. 69:

All Documents on which You intend to rely to support the claims that UnitedHealth knew that many provider-reported diagnosis codes were invalid, as alleged in paragraphs 81 through 120 of Your Complaint.

REQUEST FOR PRODUCTION NO. 70:

All Documents on which You intend to rely to support the claims that UnitedHealth knew that it was obligated to undertake good faith efforts to identify and delete invalid provider-reported diagnosis codes, as alleged in paragraphs 81 through 120 of Your Complaint.

REQUEST FOR PRODUCTION NO. 71:

All Documents on which You intend to rely to support the claim that UnitedHealth is not entitled to a significant amount of Risk Adjustment payments it has received from Medicare, as alleged in paragraph 115 of Your Complaint.

REQUEST FOR PRODUCTION NO. 72:

All Documents on which You intend to rely to support the claim that UnitedHealth avoided "looking both ways," as alleged in paragraphs 121 through 134 of Your Complaint.

REQUEST FOR PRODUCTION NO. 73:

All Documents on which You intend to rely to support the claims that UnitedHealth engaged in a "Recode Project" designed to "liberalize[] its coding policies to enable the coders to identify more diagnosis codes purportedly supported by the beneficiaries' medical records" as alleged in paragraph 133 of Your Complaint.

REQUEST FOR PRODUCTION NO. 74:

All Documents on which You intend to rely to support the claims that UnitedHealth knew it was obligated to "look both ways" at the results of its Chart Reviews and to delete invalid diagnoses as alleged in paragraphs 135 through 152 of Your Complaint.

REQUEST FOR PRODUCTION NO. 75:

All Documents on which You intend to rely to support the claims that UnitedHealth's "look both way" Claims Verification program was insufficient and short-lived, as alleged in paragraphs 153 through 193 of Your Complaint.

REQUEST FOR PRODUCTION NO. 76:

All Documents on which You intend to rely to support the claims that UnitedHealth failed to delete at least over one billion dollars of invalid diagnoses, as alleged in paragraphs 194 through 197 of Your Complaint.

REQUEST FOR PRODUCTION NO. 77:

All Documents on which You intend to rely to support the claims that UnitedHealth avoided repaying Medicare for invalid diagnoses reported by its financially-incentivized providers, as alleged in paragraphs 198 through 229 of Your Complaint.

REQUEST FOR PRODUCTION NO. 78:

All Documents on which You intend to rely to support the claims related to UnitedHealth's Risk Adjustment Attestations, as alleged in paragraphs 230 through 233 of Your Complaint.

Dated: August 24, 2017

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

By _____
Daniel Meron
Attorneys for UnitedHealth Defendants

PROOF OF SERVICE

I am employed in the County of Los Angeles, State of California. I am over the age of 18 years and not a party to this action. My business address is Latham & Watkins LLP, 355 South Grand Avenue, Suite 100, Los Angeles, CA 90071-1560.

On **August 24, 2017**, I served the following document described as:

DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. ONE)

by serving a true copy of the above-described document in the following manner:

BY ELECTRONIC MAIL

The above-described document was transmitted via electronic mail to the following party pursuant to written consent under Federal Rule of Civil Procedure 5(b)(2)(E) on **August 24, 2017**:

SEE ATTACHED SERVICE LIST

I declare that I am employed in the office of a member of the Bar of, or permitted to practice before, this Court at whose direction the service was made and declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on **August 24, 2017**, at Los Angeles, California.

Josephine Osei-Tutu

SERVICE LIST

United States District Court
Case No. CV 09-5013 JFW(JEMx)

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EXHIBIT B

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Attorneys for Defendants

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA *ex rel.* BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC., *et al.*, Defendants.	CASE NO. CV 16-08697 MFW (SSx) DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. TWO) Assigned to Hon. Michael W. Fitzgerald DISCOVERY MATTER

PROPOUNDING PARTY: Defendant UHC of California

RESPONDING PARTY: Plaintiff United States Government

SET NO.: TWO (2)

TO THE RESPONDING PARTY AND TO ITS ATTORNEYS OF RECORD:

Please take notice that pursuant to Rules 26(b)(1) and 34 of the Federal Rules of Civil Procedure and Rule 34-1 of the Local Civil Rules of the United States District Court for the Central District of California, Defendant UHC of California, by and through its undersigned attorneys, submits the following Request for the Production of Documents to the United States Government ("Government"). On or before the thirtieth (30th) day after service of this Request, Plaintiff shall produce and permit the inspection and copying of the documents or things described below at Latham & Watkins, 555 Eleventh Street, Northwest, Suite 1000, Washington, DC 20004. The Definitions and Instructions set forth below shall govern all of the following Requests, as well as responses to the Requests.

DEFINITIONS

As used herein, the following terms and phrases shall have the following meanings:

1. The applicable definitions and rules of construction set forth in the Federal Rules of Civil Procedure and the local rules are incorporated herein by reference.

2. **"Beneficiary"** or **"Member"** shall mean an individual enrolled in a Medicare Advantage Plan.

3. **"Capitation"** shall mean any fee arrangement where payment is based in whole or in part on a set percentage of revenue from CMS.

4. **"Claim"** shall mean and refer to the definition set forth in the False Claims Act at 31 U.S.C. § 3729(b)(2).

5. "**CMS"** shall mean the United States Centers for Medicare and

Medicaid Services, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

6. "**Complaint**" shall mean the complaint filed by the Government in this case on November 17, 2017, and any forthcoming amended complaints filed by the Government in this case.

7. **"Concerning"** shall mean and refer to relating to, referring to, received from, addressed to, sent to, alluding to, responding to, announcing, identifying, explaining, evaluating, discussing, showing, supporting, describing, studying, reflecting, analyzing, or consulting.

8. **"Delete"** means the deletion of a Diagnosis Code from RAPS or EDS that was previously submitted to RAPS or EDS or otherwise withdrawing or correcting data that was previously submitted to RAPS or EDS.

9. **"Diagnosis Code"** means an ICD-9 or ICD-10 diagnosis code.

10. "**Document**" shall have the full meaning ascribed to it in Federal Rule of Civil Procedure 34 and shall include every writing or record (including Electronically Stored Information) of every type and description such as communications, correspondence, speech, writings, memoranda, stenographic or handwritten notes, language (machine, foreign, or otherwise), studies, publications, books, pamphlets, reports, financial statements, calculations, analyses, films, video tape, photographs, graphs, symbols, signs, voice recordings, sound, radio and/or video signal, telephone, teletype, telecommunication, telegram, facsimile transmission, microfilm, microfiche, photographic film of any type, e-mail, computer electronics of any kind, computer files or all other data compilations from which information can be obtained including electromagnetically sensitive stored media such as floppy discs, hard discs, magnetic disks, and magnetic tapes, any preliminary versions, drafts or revisions of any of the foregoing, and all copies of every such writing or record (or a draft thereof) whenever a copy of a Document is not an identical copy of the original or

where such copy contains any commentary, notes or markings whatsoever that do not appear on the original.

11. "**Each**" includes the word "every" and "**every**" includes the word "each," "**any**" includes the word "all" and "**all**" includes the word "any," "**and**" includes the word "or" and "**or**" includes the word "and," as necessary to bring within the scope of each Request information which might otherwise be construed to be outside its scope.

12. "**Electronically Stored Information**" or "**ESI**" refers to any designated documents or electronically stored information - including writings, drawings, graphs, charts, photographs, sound recordings, images, e-mails and other data or data compilations stored in any medium (hard drives, disc drives, servers, lap tops) from which information can be obtained, including all data which may have been deleted, but which can be recovered or retrieved from a back-up system or such other method translated, if necessary, by the party into reasonably usable form. For the avoidance of doubt, any electronic Documents or data shall include its associated metadata.

13. **"Encounter Data"** shall mean data generated by healthcare providers and submitted by MAOs to CMS that documents both a Beneficiary's health conditions and diagnoses and the services and items delivered to the Beneficiary to treat these conditions.

14. **"Encounter Data System"** or **"EDS"** or **"Encounter Data Processing System"** or **"EDPS"** means a system used by MAOs and/or MA Plans to submit Risk Adjustment data to CMS.

15. "**False**" shall mean and refer to "false" or "fraudulent" as those terms are used in the False Claims Act, at 31 U.S.C. §§ 3729(a)(1)(A)-(B).

16. "**Fee-for-Service Medicare**" or "**FFS Medicare**" shall mean traditional Medicare, under Parts A and B of the Medicare Program. Fee-for-Service or FFS Medicare uses a reimbursement methodology under which CMS

reimburses healthcare providers and suppliers a fee for each item or service actually rendered to a patient based on payment rates pre-determined by the Government.

17. **"Gainshare Arrangements"** refers to agreements whereby Medicare Advantage Plans pay fee-for-service providers additional payments based on revenue, including risk adjustment payments, which Medicare Advantage Plans receive from CMS.

18. "**Government**" shall mean the United States, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf, including but not limited to any component of the United States Department of Justice, the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services and all subdivisions and components thereof.

19. "**HCC"** means a hierarchical condition category associated with one or more diagnosis codes (ICD-9-CM or ICD-10-CM codes) that represent the disease component of the beneficiary risk scores that are applied to Medicare Advantage payments. "RxHCC" means an HCC used for Medicare Part D.

20. **"Identify"** means and refers to the following:

a. when used in reference to a natural person, it means that individual's full name, present or last known residence address and telephone number, business/government affiliation and business/government address and telephone number and e-mail address;

b. when used in reference to an organization, it means to state the organization's full name and, if it is a corporation, partnership or other business entity, the address of its principal place of business;

c. when used in connection with a Document or other recording (written, electronic, or otherwise), it means to state the following, as applicable: the type of document, its date (or approximate date),

author, addressee, title, present location, the form in which it is maintained (e.g., written document, computer file, posting on the Internet or World Wide Web, audio or video recording or any other form), the name and address of its custodian, and the substance of the contents thereof. In lieu of identifying any document, copies thereof may be furnished;

d. when used in reference to a communication (whether written, oral, electronic, or otherwise), shall mean to state the form of the communication (e.g., telephone conversation, letter, telegram, teletype, telecopy, electronic mail, posting on the Internet or World Wide Web, facsimile, written memorandum, face-to-face conversation, or any other form), the date (or approximate date) of the communication or the dates (or approximate dates) on which the communication was sent, posted, and/or received (if not the same), the parties to the communication, the party who initiated it, the substance of the communication, and the present location and the name and address of the custodian if the communication was non-verbal, and/or any written memorialization of the communication; and

e. when used in connection with a location, it means the name of the establishment, the street address, the suite or apartment number if any, the city, state and zip code, and, if applicable, the telephone number.

21. "**Including**" shall be construed as broadly as possible and shall mean "without limitation."

22. **"Medicare Advantage Plan"** and **"MA Plan"** shall mean and refer to a Medicare Advantage Organization with a contract to provide health benefits coverage that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries in residing in the service area of the MA Plan, in exchange for capitated (i.e., set or fixed),

per-member-per-month payments from the federal government, under Parts C and D of the Medicare Program. *See* 42 U.S.C. §§ 1395w-22(a)(1) and 23(a)(1); *see also* 42 U.S.C. § 1395w-28(b)(1).

23. "**Medicare Advantage Organization"** and **"MAO**" shall mean and refer to a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage contract requirements. *See* 42 U.S.C. § 1395w-28(a)(1).

24. **"Medical Loss Ratio"** and **"MLR"** shall mean the standard set forth in the Affordable Care Act of 2010 ("ACA") and codified in the regulations at 42. C.F.R. Part 422, Subpart X and 42 C.F.R. Part 423, Subpart X, which requires MAOs to spend at least 85%, of their premium income on medical services, medications, and certain quality improvement activities for Beneficiaries, leaving the remaining 15% for administrative expenses and profit.

25. **"Medical Loss Ratio Rebate"** and **"MLR Rebate"** shall mean the annual rebate certain MAOs are required under 42 C.F.R. § 422.2470(a) to remit to CMS if the MAO does not meet the minimum Medical Loss Ratio or MLR standard set forth in the regulations at 42. C.F.R. Part 422, Subpart X and 42 C.F.R. §§ 422.2410 and 423.2410.

26. "**Person**" shall mean natural persons, proprietorships, corporations, public corporations, municipal corporations, the federal government and all departments and agencies thereof, state governments, local governments, other governmental agencies, political subdivisions, partnerships, groups, associations or organizations.

27. **"Provider"** shall mean any provider of healthcare services including individual providers such as physicians, physicians assistants, laboratories, medical equipment providers, and nurse practitioners; institutional providers such as hospitals and clinics; provider groups such as groups of physicians or associations of physicians with other provider types; and any other type of providers of

healthcare services or items. "Provider" includes fee-for-service Providers, Providers with Gainshare Arrangements, and Providers with Capitation arrangements. "Provider" also includes any past or present employee, contractor, or agent of any Provider. The term "Provider" shall be given the broadest possible meaning when responding to these Requests.

28. **"Risk Adjustment Processing System"** or **"RAPS"** means a system used by MAOs and/or MA Plans to submit Risk Adjustment data to CMS.

29. "**Relating to**" and "**regarding**" or any derivative thereof, in addition to their customary and usual meanings, shall mean concerning, referring to, containing, identifying, monitoring, constituting, reflecting, discussing, pertaining to, assessing, recording, supporting, negating, refuting, touching upon and/or summarizing.

30. "**Relator**" shall mean Benjamin Poehling and all Persons acting on his behalf.

31. "**Risk Adjustment**" shall mean and refer to the method by which CMS adjusts capitation payments to Medicare Advantage Organizations and their health Plans based on enrollees' demographic factors and health status to ensure actuarial equivalence under Parts C and Part D of the Medicare Program, as described in 42 U.S.C. § 1395w-23 and 42 C.F.R. § 422.308(c)(1).

32. "Risk Adjustment Data Validation" or **"RADV**" shall mean the process by which CMS audits the diagnosis codes submitted for payment by an MAO to determine if the diagnosis codes are supported by medical record documentation for a Beneficiary. *See* 42 C.F.R. § 422.310(e).

33. **"UnitedHealth**" shall mean all the Defendants listed in Your Complaint.

34. "**You**" and "**Your**" shall mean the Government and all Persons acting on its behalf.

INSTRUCTIONS

1. You are to produce all documents, as defined above, that are in the possession, custody or control of You, or in the possession, custody or control of any attorney or agent for You. Without limiting the term "control," a document is deemed to be within Your control if you have ownership, possession or custody of the document, or the right to secure the document or copy thereof from any person or public or private entity having physical possession thereof.

2. Whenever appropriate, the singular form of a word shall be interpreted as plural, and vice versa. Similarly, the use of the present tense of a verb shall be considered to include within its meaning the future and past tense, and vice versa.

3. Each Request should be construed to include the time period from January 1, 2004 through May 16, 2017 (unless stated differently by a specific document request).

4. You are under a duty to supplement Your response to these requests for documents pursuant to Federal Rule of Civil Procedure 26(e)(1).

5. If You know of documents responsive to a particular request that You cannot locate after a reasonable search, describe the documents in Your response to the particular request and explain the reason for being unable to locate the documents. If a document has been lost or destroyed, state when the document was lost or destroyed and explain the circumstances under which it was lost or destroyed.

6. The documents produced in response to the document requests shall be produced as they are kept in the ordinary course of business and shall be organized so that Defendant can ascertain the files in which they were located, their relative order in such files, and how such files were maintained.

7. Production of Electronically Stored Information ("ESI"), as that phrase is understood in Fed. R. Civ. P. 26, should conform to the instructions

contained in the agreed upon "Specifications for Production of ESI and Digitized ('Scanned') Images."

8. If the contention is made that any requested documents are not subject to discovery in whole or part by reason of privilege or otherwise, identify each such document in a log consistent with the requirements of Fed. R. Civ. P. 26(b)(5).

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 1:

All Documents disclosed by CMS in response to the Freedom of Information Act ("FOIA") request by Mr. Fred Schulte dated May 21, 2013, including all documents described in the Joint Status Report in Civil Action 14-887 in the U.S. District Court for the District of Columbia, filed November 15, 2016.

REQUEST FOR PRODUCTION NO. 2:

All Documents relating to CMS policies, guidance or procedures regarding the acceptance and processing of Deletes submitted by an MAO, including but not limited to Documents regarding CMS's adjustment of payments to MAOs based on the MAO's submission of Deletes.

REQUEST FOR PRODUCTION NO. 3:

All Documents relating to CMS policies, guidance or procedures regarding the acceptance of, or refusal to accept, MAOs' submission of Deletes, including but not limited to Documents relating to CMS's refusal to accept Deletes more than seven years after the date of the initial submission of the code(s), Documents relating to CMS's refusal to accept Deletes for 2008 DOS, and Documents regarding whether CMS views these codes as overpayments even if an MAO has made reasonable efforts to delete these codes but CMS has refused to accept the Deletes.

REQUEST FOR PRODUCTION NO. 4:

All Documents relating to MAOs' submission of closed period deletes to CMS, including but not limited to Documents relating to correspondence between MAOs and CMS regarding the submission of closed period deletes, Documents relating to CMS's requirement that MAOs obtain and submit remedy tickets with any closed period delete submissions, Documents relating to CMS's requirement that MAOs respond to questions regarding the submission of closed period deletes (e.g., what payment year(s) are involved in the data submission issue(s), how many records are affected, an impact estimate of the error in dollars, a detailed technical explanation of the cause of the problem, whether a submission deadline was missed and the reason why, and a narrative of the steps the MAO has taken to ensure the issue does not reoccur), and MAOs' responses to CMS's questions regarding closed period deletes.

REQUEST FOR PRODUCTION NO. 5:

All Documents related to the Medical Loss Ratio or MLR, including but not limited to Documents regarding the development of the MLR standard set forth in 42. C.F.R. Part 422, Subpart X and 42 C.F.R. Part 423, Subpart X, CMS's guidance regarding the same, Documents regarding the MLR reports MAOs are required to submit to CMS for each contract year pursuant to 42 C.F.R. §§ 422.2460 and 423.2460, CMS's MLR reporting tool and Documents relating to CMS's analysis and acceptance of MAOs' MLR reports.

REQUEST FOR PRODUCTION NO. 6:

All Documents related to the Medical Loss Ratio Rebate or MLR Rebate, including but not limited to Documents regarding the development of the MLR Rebate set forth in 42 C.F.R. § 422.2470, CMS's guidance regarding the same and Documents relating to CMS's analysis and acceptance of MAOs' MLR reports and MLR Rebates.

REQUEST FOR PRODUCTION NO. 7:

All Documents related to any MLR Rebates paid by UnitedHealth to CMS, including but not limited to Documents regarding CMS's acceptance and analysis of UnitedHealth's payment of any MLR Rebates to CMS.

REQUEST FOR PRODUCTION NO. 8:

All Documents related to CMS's guidance to MAOs on Encounter Data submission, including but not limited to "*Guidance for Encounter Data Submission*" from Jennifer Harlow, Deputy Director, Medicare Plan Payment Group (October 30, 2017).

REQUEST FOR PRODUCTION NO. 9:

All Documents relating to CMS policies, guidance or procedures regarding FFS Medicare encounter data CMS later determines is false, fraudulent or unsupported by a medical record, including but not limited to Documents relating to CMS's deletion of diagnoses codes from FFS Medicare encounter data when CMS determines that encounter never occurred and Documents regarding CMS's removal of the costs associated with that false, fraudulent or unsupported encounter from the base of expenses attributed to each HCC.

REQUEST FOR PRODUCTION NO. 10:

All Documents relating to the Government litigation hold(s) issued on or around December 9, 2016 titled "Litigation Hold – Component Survey for United Health Group (C.D. Cal.)," related to this case and/or the *Swoben* Investigation, including but not limited to copies of the litigation hold(s) and Documents sufficient to show who received the hold, who confirmed receipt, read and/or accepted the hold, what the hold covers, and when it was issued.

REQUEST FOR PRODUCTION NO. 11:

All Documents relating to the Government litigation hold(s) issued on or around January 6, 2017 titled "Litigation Hold for United Health Group (C.D. Cal.)," related to this case and/or the *Swoben* Investigation, including but not

limited to copies of the litigation hold(s) and Documents sufficient to show who received the hold, who confirmed receipt, read and/or accepted the hold, what the hold covers, and when it was issued.

REQUEST FOR PRODUCTION NO. 12:

All Documents relating to the reissuance or reminders of Government litigation hold(s) related to this case and/or the *Swoben* Investigation, including but not limited to copies of the litigation hold(s) and documents sufficient to show who received the hold, who confirmed receipt, read and/or accepted the hold, what the hold covers, and when it was issued.

REQUEST FOR PRODUCTION NO. 13:

All Documents relating to guidance, instructions and/or directions the Government provided to coders (or contractors coding on behalf of the Government) to instruct them on evaluating the accuracy and adequacy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data, including but not limited to such guidance, instructions and/or directions related to Risk Adjustment Data Validation or RADV audits.

REQUEST FOR PRODUCTION NO. 14:

All Documents related to CMS's guidance to coders (or contractors coding on behalf of the Government) on evaluating the accuracy of diagnoses reported by MA Plans in connection with MA Plan Risk Adjustment data, including but not limited to "*Contract-Level Risk Adjustment Data Validation Medical Record Reviewer Guidance*" published by CMS (September 27, 2017) and earlier versions.

REQUEST FOR PRODUCTION NO. 15:

All documents related to discussion, commentary or analysis of CMS's estimation of the paperwork and information collection burden imposed on MAOs by the information collection requirements ("ICRs") as described in 79 Fed. Reg. 29,844, 29,942 (May 23, 2014).

REQUEST FOR PRODUCTION NO. 16:

All Documents relating to CMS' receipt of complaints regarding UnitedHealth's Risk Adjustment programs, including but not limited to correspondence between CMS and any Person regarding such complaints (e.g., letters/complaints/submissions from physicians, medical associations, or individuals setting forth concerns about UnitedHealth's Risk Adjustment programs) and any action CMS has taken to respond to, address, and/or resolve such complaints.

REQUEST FOR PRODUCTION NO. 17:

Any Documents relating to CMS guidance to MA Plans regarding oversight of Providers, including those Providers with Capitation arrangements, including but not limited to Documents relating to MA Plans' obligations to oversee Providers' submission of accurate risk adjustment data.

REQUEST FOR PRODUCTION NO. 18:

Any Documents relating to any meetings between CMS and any Person related to Risk Adjustment, any MA Plan's Risk Adjustment Program, and/or to the submission of Risk Adjustment data to CMS, including but not limited to calendar invites, meeting agendas, notes and/or memoranda from such meetings, talking points, and correspondence related to such meetings.

REQUEST FOR PRODUCTION NO. 19:

Any documents relating to CMS policies, guidance or procedures relating to the requirement under 42 U.S.C. § 1395w-23(a)(1)(C)(i) (2016) that CMS pay MAOs in a manner that "ensures actuarial equivalence" between traditional Medicare plans and MAOs, including but not limited to Documents regarding CMS's analyses and evaluation of the frequency and cost of particular conditions within traditional FFS Medicare to determine the amounts paid to MAOs for particular conditions.

Dated: January 19, 2018

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

By _____
Daniel Meron
Attorneys for UnitedHealth Defendants

PROOF OF SERVICE

I am employed in the County of Los Angeles, State of California. I am over the age of 18 years and not a party to this action. My business address is Latham & Watkins LLP, 355 South Grand Avenue, Suite 100, Los Angeles, CA 90071-1560.

On **January 19, 2018**, I served the following document described as:

DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. TWO)

by serving a true copy of the above-described document in the following manner:

BY ELECTRONIC MAIL

The above-described document was transmitted via electronic mail to the following party pursuant to written consent under Federal Rule of Civil Procedure 5(b)(2)(E) on **January 19, 2018**:

SEE ATTACHED SERVICE LIST

I declare that I am employed in the office of a member of the Bar of, or permitted to practice before, this Court at whose direction the service was made and declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on **January 19, 2018**, at Los Angeles, California.

Josephine Osei-Tutu

SERVICE LIST

United States District Court
CASE NO. CV 16-08697 MFW (SSx)

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EXHIBIT C

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Attorneys for Defendants

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA *ex rel*. BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC., *et al.*, Defendants.	CASE NO. CV 16-08697 MFW (SSx) DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. THREE) Assigned to Hon. Michael W. Fitzgerald DISCOVERY MATTER

PROPOUNDING PARTY: Defendant UHC of California

RESPONDING PARTY: Plaintiff United States Government

SET NO.: THREE (3)

TO THE RESPONDING PARTY AND TO ITS ATTORNEYS OF RECORD:

Please take notice that pursuant to Rules 26(b)(1) and 34 of the Federal Rules of Civil Procedure and Rule 34-1 of the Local Civil Rules of the United States District Court for the Central District of California, Defendant UHC of California, by and through its undersigned attorneys, submits the following Request for the Production of Documents to the United States Government ("Government"). On or before the thirtieth (30th) day after service of this Request, Plaintiff shall produce and permit the inspection and copying of the documents or things described below at Latham & Watkins, 555 Eleventh Street, Northwest, Suite 1000, Washington, DC 20004. The Definitions and Instructions set forth below shall govern all of the following Requests, as well as responses to the Requests.

DEFINITIONS

As used herein, the following terms and phrases shall have the following meanings:

1. The applicable definitions and rules of construction set forth in the Federal Rules of Civil Procedure and the local rules are incorporated herein by reference.

2. **"Beneficiary"** or **"Member"** shall mean an individual enrolled in a Medicare Advantage Plan.

3. **"Capitation"** shall mean any fee arrangement where payment is based in whole or in part on a set percentage of revenue from CMS.

4. "**CMS**" shall mean the United States Centers for Medicare and Medicaid Services, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

5. **"CMS-HCC Risk Adjustment Model"** shall refer to the regression model used to calculate risk scores for payment under the Medicare Advantage Program. This term refers to all iterations and recalibrations of the model that were used to determine payments for payment years 2004 through 2017, including the CMS-HCC base model (introduced in payment year 2004), the CMS-HCC V12 model (introduced in payment year 2009) and the CMS HCC V21 model (introduced in payment year 2013) and the CMS V22 Model (introduced in payment year 2014) and any other revisions or recalibrations of the model used for payment years 2004 through 2017.

6. "**Complaint**" shall mean the complaint filed by the Government in this case on November 17, 2017, and any forthcoming amended complaints filed by the Government in this case.

7. **"Concerning"** shall mean and refer to relating to, referring to, received from, addressed to, sent to, alluding to, responding to, announcing, identifying, explaining, evaluating, discussing, showing, supporting, describing, studying, reflecting, analyzing, or consulting.

8. **"Diagnosis Code"** means an ICD-9 or ICD-10 diagnosis code.

9. "**Document**" shall have the full meaning ascribed to it in Federal Rule of Civil Procedure 34 and shall include every writing or record (including Electronically Stored Information) of every type and description such as communications, correspondence, speech, writings, memoranda, stenographic or handwritten notes, language (machine, foreign, or otherwise), studies, publications, books, pamphlets, reports, financial statements, calculations, analyses, films, video tape, photographs, graphs, symbols, signs, voice recordings, sound, radio and/or video signal, telephone, teletype, telecommunication, telegram, facsimile transmission, microfilm, microfiche, photographic film of any type, e-mail, computer electronics of any kind, computer files or all other data compilations from which information can be obtained including electromagnetically sensitive stored

media such as floppy discs, hard discs, magnetic disks, and magnetic tapes, any preliminary versions, drafts or revisions of any of the foregoing, and all copies of every such writing or record (or a draft thereof) whenever a copy of a Document is not an identical copy of the original or where such copy contains any commentary, notes or markings whatsoever that do not appear on the original.

10. "**Each**" includes the word "every" and "**every**" includes the word "each," "**any**" includes the word "all" and "**all**" includes the word "any," "**and**" includes the word "or" and "**or**" includes the word "and," as necessary to bring within the scope of each Request information which might otherwise be construed to be outside its scope.

11. "**Electronically Stored Information**" or "**ESI**" refers to any designated documents or electronically stored information - including writings, drawings, graphs, charts, photographs, sound recordings, images, e-mails and other data or data compilations stored in any medium (hard drives, disc drives, servers, lap tops) from which information can be obtained, including all data which may have been deleted, but which can be recovered or retrieved from a back-up system or such other method translated, if necessary, by the party into reasonably usable form. For the avoidance of doubt, any electronic Documents or data shall include its associated metadata.

12. "**Fee-for-Service Medicare**" or "**FFS Medicare**" shall mean traditional Medicare, under Parts A and B of the Medicare Program. Fee-for-Service or FFS Medicare uses a reimbursement methodology under which CMS reimburses healthcare providers and suppliers a fee for each item or service actually rendered to a patient based on payment rates pre-determined by the Government.

13. **"Gainshare Arrangements"** refers to agreements whereby Medicare Advantage Plans pay fee-for-service providers additional payments based on revenue, including risk adjustment payments, which Medicare Advantage Plans receive from CMS.

14. "**Government**" shall mean the United States, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf, including but not limited to any component of the United States Department of Justice, the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services and all subdivisions and components thereof.

15. "**HCC**" means a hierarchical condition category associated with one or more Diagnosis Codes (ICD-9-CM or ICD-10-CM codes) that represent the disease component of the Beneficiary risk scores that are applied to Medicare Advantage payments. "RxHCC" means an HCC used for Medicare Part D.

16. "**HHS-OIG**" shall mean the Office of the Inspector General for the United States Department of Health and Human Services, its departments, components, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

17. **"Identify"** means and refers to the following:

a. when used in reference to a natural person, it means that individual's full name, present or last known residence address and telephone number, business/government affiliation and business/government address and telephone number and e-mail address;

b. when used in reference to an organization, it means to state the organization's full name and, if it is a corporation, partnership or other business entity, the address of its principal place of business;

c. when used in connection with a Document or other recording (written, electronic, or otherwise), it means to state the following, as applicable: the type of document, its date (or approximate date), author, addressee, title, present location, the form in which it is maintained (e.g., written document, computer file, posting on the Internet or World Wide Web, audio or video recording or any other form), the name and address of

its custodian, and the substance of the contents thereof. In lieu of identifying any document, copies thereof may be furnished;

d. when used in reference to a communication (whether written, oral, electronic, or otherwise), shall mean to state the form of the communication (e.g., telephone conversation, letter, telegram, teletype, telecopy, electronic mail, posting on the Internet or World Wide Web, facsimile, written memorandum, face-to-face conversation, or any other form), the date (or approximate date) of the communication or the dates (or approximate dates) on which the communication was sent, posted, and/or received (if not the same), the parties to the communication, the party who initiated it, the substance of the communication, and the present location and the name and address of the custodian if the communication was non-verbal, and/or any written memorialization of the communication; and

e. when used in connection with a location, it means the name of the establishment, the street address, the suite or apartment number if any, the city, state and zip code, and, if applicable, the telephone number.

18. "**Including**" shall be construed as broadly as possible and shall mean "without limitation."

19. "**Limited Data Set Files**" and "**LDS Files**" shall mean and refer to publicly available data files containing both institutional and non-institutional Medicare claims and provider information as well as beneficiary level health information.

20. **"Medicare Advantage Plan"** and **"MA Plan"** shall mean and refer to a Medicare Advantage Organization with a contract to provide health benefits coverage that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries in residing in the service area of the MA Plan, in exchange for capitated (i.e., set or fixed), per-member-per-month payments from the federal government, under Parts C and D of

the Medicare Program. *See* 42 U.S.C. §§ 1395w-22(a)(1) and 23(a)(1); *see also* 42 U.S.C. § 1395w-28(b)(1).

21. "**Medicare Advantage Organization"** and **"MAO**" shall mean and refer to a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage contract requirements. *See* 42 U.S.C. § 1395w-28(a)(1).

22. "**Person**" shall mean natural persons, proprietorships, corporations, public corporations, municipal corporations, the federal government and all departments and agencies thereof, state governments, local governments, other governmental agencies, political subdivisions, partnerships, groups, associations or organizations.

23. **"Provider"** shall mean any provider of healthcare services including individual providers such as physicians, physicians assistants, laboratories, medical equipment providers, and nurse practitioners; institutional providers such as hospitals and clinics; provider groups such as groups of physicians or associations of physicians with other provider types; and any other type of providers of healthcare services or items. "Provider" includes fee-for-service Providers, Providers with Gainshare Arrangements, and Providers with Capitation arrangements. "Provider" also includes any past or present employee, contractor, or agent of any Provider. The term "Provider" shall be given the broadest possible meaning when responding to these Requests.

24. "**Relating to**" and "**regarding**" or any derivative thereof, in addition to their customary and usual meanings, shall mean concerning, referring to, containing, identifying, monitoring, constituting, reflecting, discussing, pertaining to, assessing, recording, supporting, negating, refuting, touching upon and/or summarizing.

25. "**Risk Adjustment**" shall mean and refer to the method by which CMS adjusts capitation payments to Medicare Advantage Organizations and their health Plans based on enrollees' demographic factors and health status to ensure actuarial

equivalence under Parts C and Part D of the Medicare Program, as described in 42 U.S.C. § 1395w-23 and 42 C.F.R. § 422.308(c)(1).

26. "Risk Adjustment Data Validation" or **"RADV"** shall mean the process by which CMS audits the Diagnosis Codes submitted for payment by an MAO to determine if the Diagnosis Codes are supported by medical record documentation for a Beneficiary. *See* 42 C.F.R. § 422.310(e).

27. **"UnitedHealth"** shall mean all the Defendants listed in Your Complaint.

28. "**You**" and "**Your**" shall mean the Government and all Persons acting on its behalf.

INSTRUCTIONS

1. You are to produce all documents, as defined above, that are in the possession, custody or control of You, or in the possession, custody or control of any attorney or agent for You. Without limiting the term "control," a document is deemed to be within Your control if you have ownership, possession or custody of the document, or the right to secure the document or copy thereof from any person or public or private entity having physical possession thereof.

2. Whenever appropriate, the singular form of a word shall be interpreted as plural, and vice versa. Similarly, the use of the present tense of a verb shall be considered to include within its meaning the future and past tense, and vice versa.

3. Each Request should be construed to include the time period from January 1, 2004 through May 16, 2017 (unless stated differently by a specific document request).

4. You are under a duty to supplement Your response to these requests for documents pursuant to Federal Rule of Civil Procedure 26(e)(1).

5. If You know of documents responsive to a particular request that You cannot locate after a reasonable search, describe the documents in Your response to the particular request and explain the reason for being unable to locate the

documents. If a document has been lost or destroyed, state when the document was lost or destroyed and explain the circumstances under which it was lost or destroyed.

6. The documents produced in response to the document requests shall be produced as they are kept in the ordinary course of business and shall be organized so that Defendant can ascertain the files in which they were located, their relative order in such files, and how such files were maintained.

7. Production of Electronically Stored Information ("ESI"), as that phrase is understood in Fed. R. Civ. P. 26, should conform to the instructions contained in the agreed upon "Specifications for Production of ESI and Digitized ('Scanned') Images."

8. If the contention is made that any requested documents are not subject to discovery in whole or part by reason of privilege or otherwise, identify each such document in a log consistent with the requirements of Fed. R. Civ. P. 26(b)(5).

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 98:

All data from all fields included in the following Limited Data Set ("LDS") Files: 1) 100% Master Beneficiary Summary File, 2) 5% Carrier Standard Analytic File, 3) 100% Inpatient Standard Analytic file, 4) 100% Outpatient Standard Analytic File; and 5) 100% Hospice File. This request seeks data for date of service year 2016.

REQUEST FOR PRODUCTION NO. 99:

All data from all fields included in the 100% Hospice File LDS File. This request seeks data for dates of service years 2005 through 2015.

REQUEST FOR PRODUCTION NO. 100:

All Documents related to the development and operation of the CMS-HCC Risk Adjustment Model, including but not limited to Documents identifying and explaining the specific data used to calibrate the CMS-HCC Risk Adjustment Model.

REQUEST FOR PRODUCTION NO. 101:

All Documents sufficient to show how the data were selected and which records were specifically selected to create the 5% Medicare Standard Analytic files (or 5 % sample of the relevant Fee-For-Service Medicare datasets) used to develop, calibrate, and recalibrate the CMS-HCC Risk Adjustment Model, including but not limited to business requirements Documents, technical requirements Documents, listing of assumptions, listing of inputs, log files created during execution, work plans and listing of work steps related to whether the sample was random or customized.

REQUEST FOR PRODUCTION NO. 102:

All data from all fields included in the 5% Fee-For-Service Medicare file used to develop, calibrate, or recalibrate the CMS-HCC Risk Adjustment Model.

REQUEST FOR PRODUCTION NO. 103:

All programming logic used to generate the 5% Fee-For-Service Medicare files (or 5% sample of the relevant Fee-For-Service Medicare datasets) used to calibrate the CMS-HCC Risk Adjustment Model, including but not limited to programming logic Documents, business requirements Documents, technical requirements Documents, listing of assumptions, listing of inputs, log files created during execution, work plans and listing of work steps sufficient to show any filtering of the Medicare fee-for-serve data prior to calibration of the CMS-HCC Risk Adjustment Model.

REQUEST FOR PRODUCTION NO. 104:

All Documents related to internal discussions, analyses, and/or calculations regarding the preparation of the Collection of Information Requirements for "*Establishment of the Medicare+Choice Program*" Final Rule, 63 Fed. Reg. 34,968, 35,061 (June 26, 1998).

REQUEST FOR PRODUCTION NO. 105:

All Documents related to interviews, discussions, meetings, and/or communications between UnitedHealth and HHS-OIG related to HHS-OIG's "Risk Adjustment Data Validation of Payments Made to PacifiCare of California for Calendar Year 2007 (Contract Number H0543)," including but not limited to notes and/or memoranda from such meetings – including but not limited to December 2–3, 2009 meetings between UnitedHealth and HHS-OIG – talking points, and correspondence related to such meetings.

REQUEST FOR PRODUCTION NO. 106:

All Documents related to interviews, discussions, meetings, and/or communications between UnitedHealth and HHS-OIG related to HHS-OIG's "Risk Adjustment Data Validation of Payments Made to PacifiCare of Texas for Calendar Year 2007 (Contract Number H4590)," including but not limited to notes and/or memoranda from such meetings – including but not limited to December 2–3, 2009 meetings between UnitedHealth and HHS-OIG – talking points, and correspondence related to such meetings.

REQUEST FOR PRODUCTION NO. 107:

All Documents on which You intend to rely on to response to each paragraph of UnitedHealth's Counterclaim filed on March 23, 2018.

REQUEST FOR PRODUCTION NO. 108:

All Documents on which You intend to rely to defend against each of UnitedHealth's affirmative defenses set forth on pages 81 to 83 of UnitedHealth's Answer to the Government's Amended Complaint (except, as set forth in Dan Meron's May 18, 2018 email, affirmative defenses 12, 15, and the second sentence of 16).

Dated: July 16, 2018

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

By 
David J. Schindler
Attorneys for UnitedHealth Defendants

PROOF OF SERVICE

I am employed in the County of Los Angeles, State of California. I am over the age of 18 years and not a party to this action. My business address is Latham & Watkins LLP, 355 South Grand Avenue, Suite 100, Los Angeles, CA 90071-1560.

On **July 16, 2018**, I caused the service of a true copy of the following document described as:

DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. THREE)

to be served in the following manner:

BY ELECTRONIC MAIL

The above-described document was transmitted via electronic mail to the following party pursuant to written consent under Federal Rule of Civil Procedure 5(b)(2)(E) on **July 16, 2018**:

SEE ATTACHED SERVICE LIST

I declare that I am employed in the office of a member of the Bar of, or permitted to practice before, this Court at whose direction the service was made and declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on **July 16, 2018**, at Los Angeles, California.

David J. Schindler

SERVICE LIST

United States District Court
CASE NO. CV 16-08697 MFW (SSx)

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Meng Xi Catriona Lavery *UHG-RelatorsCounsel@Lists.SusmanGodfrey.com* **Susman Godfrey L.L.P.** 1900 Avenue of the Americas, Suite 1400 Los Angeles, CA 90067 Tel: (310) 789-3100 Arun S. Subramanian William C. Carmody Geng Chen *UHG-RelatorsCounsel@Lists.SusmanGodfrey.com* **Susman Godfrey L.L.P.** 1301 Avenue of the Americas, 32nd Fl. New York, NY 100 19-6023 Tel: (212) 336-8330 John P. Lahad Weston L. O'Black *UHG-RelatorsCounsel@Lists.SusmanGodfrey.com*	Attorneys for Relator Benjamin Poehling

Susman Godfrey L.L.P. 1000 Louisiana Street, 51st Fl. Houston, TX 77002 Tel: (713) 654-6666 Matthew R. Berry *UHG-RelatorsCounsel@Lists.SusmanGodfrey.com* **Susman Godfrey L.L.P.** 1201 Third Avenue, Suite 3800 Seattle, WA 98101 Tel: (206) 373-7394	

EXHIBIT D

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Attorneys for Defendants

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA *ex rel.* BENJAMIN POEHLING, Plaintiffs, v. UNITEDHEALTH GROUP, INC., *et al.*, Defendants.	CASE NO. CV 16-08697 MFW (SSx) DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. FOUR) Assigned to Hon. Michael W. Fitzgerald DISCOVERY MATTER

PROPOUNDING PARTY: Defendant UHC of California

RESPONDING PARTY: Plaintiff United States Government

SET NO.: FOUR (4)

TO THE RESPONDING PARTY AND TO ITS ATTORNEYS OF RECORD:

Please take notice that pursuant to Rules 26(b)(1) and 34 of the Federal Rules of Civil Procedure and Rule 34-1 of the Local Civil Rules of the United States District Court for the Central District of California, Defendant UHC of California, by and through its undersigned attorneys, submits the following Request for the Production of Documents to the United States Government ("Government"). On or before the thirtieth (30th) day after service of this Request, Plaintiff shall produce and permit the inspection and copying of the documents or things described below at Latham & Watkins, 555 Eleventh Street, Northwest, Suite 1000, Washington, DC 20004. The Definitions and Instructions set forth below shall govern all of the following Requests, as well as responses to the Requests.

DEFINITIONS

As used herein, the following terms and phrases shall have the following meanings:

1. The applicable definitions and rules of construction set forth in the Federal Rules of Civil Procedure and the local rules are incorporated herein by reference.

2. **"Beneficiary"** or **"Member"** shall mean an individual enrolled in a Medicare Advantage Plan.

3. **"Capitation"** shall mean any fee arrangement where payment is based in whole or in part on a set percentage of revenue from CMS.

4. **"Claim"** shall mean and refer to the definition set forth in the False Claims Act at 31 U.S.C. § 3729(b)(2).

5. "**CMS**" shall mean the United States Centers for Medicare and

Medicaid Services, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

6. **"CMS-HCC Risk Adjustment Model"** shall refer to the regression model used to calculate risk scores for payment under the Medicare Advantage Program. This term refers to all iterations and recalibrations of the model that were used to determine payments for payment years 2004 through 2017, including the CMS-HCC base model (introduced in payment year 2004), the CMS-HCC V12 model (introduced in payment year 2009) and the CMS HCC V21 model (introduced in payment year 2013) and the CMS V22 Model (introduced in payment year 2014) and any other revisions or recalibrations of the model used for payment years 2004 through 2017.

7. "**Complaint**" shall mean the complaint filed by the Government in this case on November 17, 2017, and any forthcoming amended complaints filed by the Government in this case.

8. **"Concerning"** shall mean and refer to relating to, referring to, received from, addressed to, sent to, alluding to, responding to, announcing, identifying, explaining, evaluating, discussing, showing, supporting, describing, studying, reflecting, analyzing, or consulting.

9. **"Department of Justice"** shall mean the United States Department of Justice, its agencies, departments, agents, components, offices, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

10. **"Diagnosis Code"** means an ICD-9 or ICD-10 diagnosis code.

11. "**Document**" shall have the full meaning ascribed to it in Federal Rule of Civil Procedure 34 and shall include every writing or record (including Electronically Stored Information) of every type and description such as communications, correspondence, speech, writings, memoranda, stenographic or handwritten notes, language (machine, foreign, or otherwise), studies, publications, books, pamphlets, reports, financial statements, calculations,

analyses, films, video tape, photographs, graphs, symbols, signs, voice recordings, sound, radio and/or video signal, telephone, teletype, telecommunication, telegram, facsimile transmission, microfilm, microfiche, photographic film of any type, e-mail, computer electronics of any kind, computer files or all other data compilations from which information can be obtained including electromagnetically sensitive stored media such as floppy discs, hard discs, magnetic disks, and magnetic tapes, any preliminary versions, drafts or revisions of any of the foregoing, and all copies of every such writing or record (or a draft thereof) whenever a copy of a Document is not an identical copy of the original or where such copy contains any commentary, notes or markings whatsoever that do not appear on the original.

12. "**Each**" includes the word "every" and "**every**" includes the word "each," "**any**" includes the word "all" and "**all**" includes the word "any," "**and**" includes the word "or" and "**or**" includes the word "and," as necessary to bring within the scope of each Request information which might otherwise be construed to be outside its scope.

13. "**Electronically Stored Information**" or "**ESI**" refers to any designated documents or electronically stored information - including writings, drawings, graphs, charts, photographs, sound recordings, images, e-mails and other data or data compilations stored in any medium (hard drives, disc drives, servers, lap tops) from which information can be obtained, including all data which may have been deleted, but which can be recovered or retrieved from a back-up system or such other method translated, if necessary, by the party into reasonably usable form. For the avoidance of doubt, any electronic Documents or data shall include its associated metadata.

14. "**Face-To-Face Encounter**" shall have the meaning ascribed to it by the 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide, Sections 4.3 and 4.11.

15. "**Dollar Coefficients**" refers to the estimated dollar amounts or incremental dollar costs associated with each demographic and HCC variable in the CMS-HCC Risk Adjustment Model before normalization and conversion into Relative Factors, and shall have the same meaning as is ascribed to the term "estimated coefficient" on pages 13–14 of the Technical Appendix to CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits*.

16. "**Fee-for-Service Adjuster**" or "**FFS Adjuster**" shall refer to the RADV Fee-For-Service Medicare error rate adjuster discussed in CMS's Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Feb. 24, 2012), CMS's proposed rule, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, 83 Fed. Reg. 54982 (Nov. 1, 2018), CMS's October 26, 2018 report titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* and accompanying Technical Appendix, or any calculation to account for unsupported codes in the FFS data used to calibrate the CMS-HCC Risk Adjustment model when calculating potential overpayments to MA plans.

17. "**Fee-for-Service Medicare**" or "**FFS Medicare**" shall mean traditional Medicare, under Parts A and B of the Medicare Program. Fee-for-Service or FFS Medicare uses a reimbursement methodology under which CMS reimburses healthcare providers and suppliers a fee for each item or service actually rendered to a patient based on payment rates pre-determined by the Government.

18. **"Gainshare Arrangements"** refers to agreements whereby Medicare Advantage Plans pay fee-for-service providers additional payments based on

revenue, including risk adjustment payments, which Medicare Advantage Plans receive from CMS.

19. "**Government**" shall mean the United States, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf, including but not limited to any component of the United States Department of Justice, the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services and all subdivisions and components thereof.

20. "**HCC"** means a hierarchical condition category associated with one or more diagnosis codes (ICD-9-CM or ICD-10-CM codes) that represent the disease component of the beneficiary risk scores that are applied to Medicare Advantage payments. "RxHCC" means an HCC used for Medicare Part D.

21. "**HHS-OIG**" shall mean the Office of the Inspector General for the United States Department of Health and Human Services, its departments, components, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

22. **"Identify"** means and refers to the following:

a. when used in reference to a natural person, it means that individual's full name, present or last known residence address and telephone number, business/government affiliation and business/government address and telephone number and e-mail address;

b. when used in reference to an organization, it means to state the organization's full name and, if it is a corporation, partnership or other business entity, the address of its principal place of business;

c. when used in connection with a Document or other recording (written, electronic, or otherwise), it means to state the following, as applicable: the type of document, its date (or approximate date), author, addressee, title, present location, the form in which it is

maintained (e.g., written document, computer file, posting on the Internet or World Wide Web, audio or video recording or any other form), the name and address of its custodian, and the substance of the contents thereof. In lieu of identifying any document, copies thereof may be furnished;

d. when used in reference to a communication (whether written, oral, electronic, or otherwise), shall mean to state the form of the communication (e.g., telephone conversation, letter, telegram, teletype, telecopy, electronic mail, posting on the Internet or World Wide Web, facsimile, written memorandum, face-to-face conversation, or any other form), the date (or approximate date) of the communication or the dates (or approximate dates) on which the communication was sent, posted, and/or received (if not the same), the parties to the communication, the party who initiated it, the substance of the communication, and the present location and the name and address of the custodian if the communication was non-verbal, and/or any written memorialization of the communication; and

e. when used in connection with a location, it means the name of the establishment, the street address, the suite or apartment number if any, the city, state and zip code, and, if applicable, the telephone number.

23. "**Including**" shall be construed as broadly as possible and shall mean "without limitation."

24. **"Medicare Advantage Plan"** and **"MA Plan"** shall mean and refer to a Medicare Advantage Organization with a contract to provide health benefits coverage that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries in residing in the service area of the MA Plan, in exchange for capitated (i.e., set or fixed), per-member-per-month payments from the federal government, under Parts C and

D of the Medicare Program. *See* 42 U.S.C. §§ 1395w-22(a)(1) and 23(a)(1); *see also* 42 U.S.C. § 1395w-28(b)(1).

25. "**Medicare Advantage Organization"** and **"MAO**" shall mean and refer to a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage contract requirements. *See* 42 U.S.C. § 1395w-28(a)(1).

26. "**Person**" shall mean natural persons, proprietorships, corporations, public corporations, municipal corporations, the federal government and all departments and agencies thereof, state governments, local governments, other governmental agencies, political subdivisions, partnerships, groups, associations or organizations.

27. **"Provider"** shall mean any provider of healthcare services including individual providers such as physicians, physicians assistants, laboratories, medical equipment providers, and nurse practitioners; institutional providers such as hospitals and clinics; provider groups such as groups of physicians or associations of physicians with other provider types; and any other type of providers of healthcare services or items. "Provider" includes fee-for-service Providers, Providers with Gainshare Arrangements, and Providers with Capitation arrangements. "Provider" also includes any past or present employee, contractor, or agent of any Provider. The term "Provider" shall be given the broadest possible meaning when responding to these Requests.

28. "**Relating to**" and "**regarding**" or any derivative thereof, in addition to their customary and usual meanings, shall mean concerning, referring to, containing, identifying, monitoring, constituting, reflecting, discussing, pertaining to, assessing, recording, supporting, negating, refuting, touching upon and/or summarizing.

29. "**Relative Factor**" shall have the meaning ascribed to that term in CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and*

Payment Recovery for Contract Level Risk Adjustment Data Validation Audits and accompanying Technical Appendix.

30. "**Relator**" shall mean Benjamin Poehling and all Persons acting on his behalf.

31. "**Risk Adjustment**" shall mean and refer to the method by which CMS adjusts Capitation payments to Medicare Advantage Organizations and their health Plans based on enrollees' demographic factors and health status to ensure actuarial equivalence under Parts C and Part D of the Medicare Program, as described in 42 U.S.C. § 1395w-23 and 42 C.F.R. § 422.308(c)(1).

32. "**Risk Adjustment Data**" shall mean all data that are used in the development and application of a risk adjustment payment model, as defined in 42 C.F.R. § 422.310(a).

33. **"Risk Adjustment Data Validation"** or **"RADV**" shall mean the process by which CMS audits the diagnosis codes submitted for payment by an MAO to determine if the diagnosis codes are supported by medical record documentation for a Beneficiary. *See* 42 C.F.R. § 422.310(e).

34. "**Risk Score**" shall have the meaning ascribed to that term in CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* and accompanying Technical Appendix.

35. **"UnitedHealth**" shall mean all the Defendants listed in Your Complaint.

36. "**You**" and "**Your**" shall mean the Government and all Persons acting on its behalf.

INSTRUCTIONS

1. You are to produce all documents, as defined above, that are in the possession, custody or control of You, or in the possession, custody or control of any attorney or agent for You. Without limiting the term "control," a document is

deemed to be within Your control if you have ownership, possession or custody of the document, or the right to secure the document or copy thereof from any person or public or private entity having physical possession thereof.

2. Whenever appropriate, the singular form of a word shall be interpreted as plural, and vice versa. Similarly, the use of the present tense of a verb shall be considered to include within its meaning the future and past tense, and vice versa.

3. Each Request should be construed to include the time period from January 1, 2004 through May 16, 2017 (unless stated differently by a specific document request).

4. You are under a duty to supplement Your response to these requests for documents pursuant to Federal Rule of Civil Procedure 26(e)(1).

5. If You know of documents responsive to a particular request that You cannot locate after a reasonable search, describe the documents in Your response to the particular request and explain the reason for being unable to locate the documents. If a document has been lost or destroyed, state when the document was lost or destroyed and explain the circumstances under which it was lost or destroyed.

6. The documents produced in response to the document requests shall be produced as they are kept in the ordinary course of business and shall be organized so that Defendant can ascertain the files in which they were located, their relative order in such files, and how such files were maintained.

7. Production of Electronically Stored Information ("ESI"), as that phrase is understood in Fed. R. Civ. P. 26, should conform to the instructions contained in the agreed upon "Specifications for Production of ESI and Digitized ('Scanned') Images."

8. If the contention is made that any requested documents are not subject to discovery in whole or part by reason of privilege or otherwise, identify each

such document in a log consistent with the requirements of Fed. R. Civ. P. 26(b)(5).

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 109:

All Documents related to internal discussions, analyses, and/or calculations regarding the preparation of the Regulatory Impact Statement and/or the Collection of Information Requirements Statement for "*Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" Proposed Rule, 79 Fed. Reg. 1918, 2027, 2030–2049 (Jan. 10, 2014).

REQUEST FOR PRODUCTION NO. 110:

All Documents related to internal discussions, analyses, and/or calculations regarding the preparation of the Regulatory Impact Statement for "*Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" Final Rule, 79 Fed. Reg. 29,844, 29,952–29,955 (May 23, 2014).

REQUEST FOR PRODUCTION NO. 111:

All Documents related to HHS-OIG's "Risk Adjustment Data Validation of Payments Made to PacifiCare of California for Calendar Year 2007 (Contract Number H0543)" and/or "Risk Adjustment Data Validation of Payments Made to PacifiCare of Texas for Calendar Year 2007 (Contract Number H4590)," including but not limited to Documents and Communications related to (i) Brian Lund's (UnitedHealth Group) May 5, 2009 email to Lisa Lara (HHS-OIG) regarding UnitedHealth's "current policy regarding the risk adjustment process for PacifiCare of CA and TX"; (ii) Lisa Lara's June 18, 2009 email to Brian Lund that in part states: "Also, can you tell me when we should be expecting the rest of the answers to the questions we sent you on June 5, 2009," *see* MARA778592; (iii) the "questions" Lisa Lara references in her June 18, 2009 email and UnitedHealth's

responses to these questions; (iv) Lisa Lara's October 30, 2009 email to Brian Lund, stating in part, "[w]e are working on the follow-up questions for the RADV audits concerning PacifiCare of CA and TX," *see* MARA778592; and (v) Lisa Lara's November 3, 2009 email to Brian Lund regarding follow-up questions. This request includes but is not limited to internal HHS-OIG discussions, notes, analyses, and/or memoranda and HHS-OIG notes and/or memoranda from follow-up discussions and/or meetings between UnitedHealth and HHS-OIG regarding these Documents and Communications.

REQUEST FOR PRODUCTION NO. 112:

All Documents or Communications developed, authored, modified, sent, considered, analyzed, received, or relied upon by CMS related to CMS's proposed rule, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, 83 Fed. Reg. 54982 (Nov. 1, 2018), or CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* and accompanying Technical Appendix, including but not limited to Documents or Communications regarding any effort by the Government to analyze, compute, or measure the impact of unsupported Diagnosis Codes in FFS Medicare claims data on the amount, magnitude, or value of the Dollar Coefficients or Relative Factors in the CMS-HCC Risk Adjustment Model or the Risk Scores generated by the CMS-HCC Risk Adjustment Model. This request should be construed to include the time period January 1, 2004 to the present.

REQUEST FOR PRODUCTION NO. 113:

All data created, modified, sent, considered, analyzed, received, or relied upon by CMS related to CMS's proposed rule, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription*

Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54982 (Nov. 1, 2018), or CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* and accompanying Technical Appendix, including but not limited to, the "the 2004-2005 [FFS] file used for model calibration" referred to on page 5 of the Technical Appendix, the "2011 overpayment run" and the "MA sample" selected from the "2011 overpayment run" referred to on page 5 of the Technical Appendix, and the Comprehensive Error Rate Testing audit data and "sample of FFS claims and associated medical records . . . collected from the (CERT) audit" referred to on pages 5–6 of the Technical Appendix. This request should be construed to include the time period January 1, 2004 to the present.

REQUEST FOR PRODUCTION NO. 114:

All Documents, Communications, or data and programming logic sufficient to show what, if any, exclusions and/or filtering logic was applied to the data used in CMS's study described in the October 26, 2018 Technical Appendix accompanying the Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits*, including but not limited to programming logic, business requirements Documents, technical requirements Documents, database schema, listing of assumptions, listing of inputs, log files created during execution, work plans and listing of work steps. This request should be construed to include the time period January 1, 2004 to the present.

REQUEST FOR PRODUCTION NO. 115:

All Communications between CMS and the Department of Justice related to CMS's proposed rule, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit,*

Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, 83 Fed. Reg. 54982 (Nov. 1, 2018), CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* and accompanying Technical Appendix, or any effort by the Government to calculate a FFS Adjuster. This request should be construed to include the time period January 1, 2004 to the present.

REQUEST FOR PRODUCTION NO. 116:

All Documents regarding the RADV Medicare fee-for-service ("FFS") error rate adjuster discussed in CMS's *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012), including but not limited to, Documents describing any effort by the Government to calculate a Medicare FFS error rate, Documents describing any analysis by the Government related to measuring the accuracy of diagnoses submitted on Medicare FFS claims, or Documents regarding any effort by the Government to analyze, compute, or measure the impact of unsupported Diagnosis Codes in FFS Medicare claims data on the amount, magnitude, or value of the Dollar Coefficients or Relative Factors in the CMS-HCC Risk Adjustment Model or the Risk Scores generated by the CMS-HCC Risk Adjustment Model. This request should be construed to include the time period January 1, 2004 to the present.

REQUEST FOR PRODUCTION NO. 117:

All Communications, or Documents reflecting Communications, between CMS and the American Academy of Actuaries (the "Academy") regarding RADV methodology or a FFS Adjuster, including but not limited to Communications regarding the Academy's January 21, 2011 *Comment on RADV Sampling and Error Calculation Methodology* addressed to Cheri Rice at CMS, the Academy's December 17, 2018 letter to CMS *Re: CMS-4285-P—Medicare and Medicaid*

Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, the RADV Fee-For-Service Medicare error rate adjuster discussed in CMS's Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits (Feb. 24, 2012), CMS's proposed rule, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, 83 Fed. Reg. 54982 (Nov. 1, 2018), or CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* and accompanying Technical Appendix. This request should be construed to include the time period January 1, 2004 to the present.

REQUEST FOR PRODUCTION NO. 118:

All data from all fields included in the following Limited Data Set ("LDS") Files: 1) 100% Denominator File, 2) 5% Carrier Standard Analytic File, 3) 100% Inpatient Standard Analytic file, 4) 100% Outpatient Standard Analytic File, and 5) 100% Hospice File. This request seeks data for dates of service year 2004.

REQUEST FOR PRODUCTION NO. 119:

All Documents, Communications, data and programming logic sufficient to show what, if any, exclusions and/or filtering logic was applied to the 5% Medicare Standard Analytic files (or 5% sample of the relevant Fee-For-Service Medicare datasets) or any other data files to create the dataset used to develop, calibrate, and recalibrate the CMS-HCC Risk Adjustment Model, including but not limited to programming logic, business requirements Documents, technical requirements Documents, database schema, listing of assumptions, listing of

inputs, log files created during execution, work plans and listing of work steps. This request should be construed to include the time period January 1, 2004 to the present.

REQUEST FOR PRODUCTION NO. 120:

All Documents and Communications relating to the Government's knowledge as to whether MA Plans were filtering out or excluding certain Provider types and non-Face-To-Face Encounters from Risk Adjustment Data MA Plans submitted to CMS.

REQUEST FOR PRODUCTION NO. 121:

All Documents and Communications regarding a paper authored by Henry Miller and Kathleen Schneider and prepared for CMS regarding Medicare Part B diagnosis coding and assignment of diagnoses to HCCs, including but not limited to analyses performed in connection with the paper. This request should be construed to include the time period from January 1, 2000 to the present.

Dated: December 21, 2018

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

By _____
David J. Schindler
Attorneys for UnitedHealth Defendants

PROOF OF SERVICE

I am employed in the County of Los Angeles, State of California. I am over the age of 18 years and not a party to this action. My business address is Latham & Watkins LLP, 355 South Grand Avenue, Suite 100, Los Angeles, CA 90071-1560.

On **December 21, 2018**, I caused the service of a true copy of the following document described as:

DEFENDANT UHC OF CALIFORNIA'S REQUESTS FOR PRODUCTION OF DOCUMENTS TO THE GOVERNMENT (SET NO. FOUR)

to be served in the following manner:

BY ELECTRONIC MAIL

The above-described document was transmitted via electronic mail to the following party pursuant to written consent under Federal Rule of Civil Procedure 5(b)(2)(E) on **December 21, 2018**:

SEE ATTACHED SERVICE LIST

I declare that I am employed in the office of a member of the Bar of, or permitted to practice before, this Court at whose direction the service was made and declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on **December 21, 2018**, at Los Angeles, California.

David J. Schindler

SERVICE LIST

United States District Court
CASE NO. CV 16-08697 MFW (SSx)

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EXHIBIT E

AO 88B (Rev. 02/14) Subpoena to Produce Documents, Information, or Objects or to Permit Inspection of Premises in a Civil Action

UNITED STATES DISTRICT COURT

for the

Central District of California

United States of America
Plaintiff
v.
UnitedHealth Group, Inc. et al.
Defendant

Civil Action No. 2:16-cv-08697-MWF-SS

SUBPOENA TO PRODUCE DOCUMENTS, INFORMATION, OR OBJECTS OR TO PERMIT INSPECTION OF PREMISES IN A CIVIL ACTION

To: Research Triangle Institute International
3040 East Cornwallis Road, P.O. Box 12194, Research Triangle Park, NC 27709-2194
(Name of person to whom this subpoena is directed)

☑ *Production:* **YOU ARE COMMANDED** to produce at the time, date, and place set forth below the following documents, electronically stored information, or objects, and to permit inspection, copying, testing, or sampling of the material: See Attachment A, attached hereto.

Place:	Date and Time:
First Legal Records c/o Diamond Eye Legal 21 E Smoketree Ct. Clayton, NC 27527	02/22/2019 6:00 pm

☐ *Inspection of Premises:* **YOU ARE COMMANDED** to permit entry onto the designated premises, land, or other property possessed or controlled by you at the time, date, and location set forth below, so that the requesting party may inspect, measure, survey, photograph, test, or sample the property or any designated object or operation on it.

Place:	Date and Time:

The following provisions of Fed. R. Civ. P. 45 are attached – Rule 45(c), relating to the place of compliance; Rule 45(d), relating to your protection as a person subject to a subpoena; and Rule 45(e) and (g), relating to your duty to respond to this subpoena and the potential consequences of not doing so.

Date: 02/01/2019

CLERK OF COURT

OR

Signature of Clerk or Deputy Clerk *Attorney's signature*

The name, address, e-mail address, and telephone number of the attorney representing *(name of party)* UnitedHealth Group, Inc., et al., who issues or requests this subpoena, are:

David J. Schindler, Latham & Watkins LLP, 355 South Grand Ave, Suite 100, Los Angeles, CA 90071-1560 david.schindler@lw.com, 1.213.891.8415

Notice to the person who issues or requests this subpoena

If this subpoena commands the production of documents, electronically stored information, or tangible things or the inspection of premises before trial, a notice and a copy of the subpoena must be served on each party in this case before it is served on the person to whom it is directed. Fed. R. Civ. P. 45(a)(4).

Civil Action No. 2:16-cv-08697-MWF-SS

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 45.)

I received this subpoena for *(name of individual and title, if any)* _____

on *(date)* _____ .

❒ I served the subpoena by delivering a copy to the named person as follows: _____

_____

_____ on *(date)* _____ ; or

❒ I returned the subpoena unexecuted because: _____

_____ .

Unless the subpoena was issued on behalf of the United States, or one of its officers or agents, I have also tendered to the witness the fees for one day's attendance, and the mileage allowed by law, in the amount of $ _____ .

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc.:

Federal Rule of Civil Procedure 45 (c), (d), (e), and (g) (Effective 12/1/13)

(c) Place of Compliance.

(1) ***For a Trial, Hearing, or Deposition.*** A subpoena may command a person to attend a trial, hearing, or deposition only as follows:

(A) within 100 miles of where the person resides, is employed, or regularly transacts business in person; or

(B) within the state where the person resides, is employed, or regularly transacts business in person, if the person

(i) is a party or a party's officer; or

(ii) is commanded to attend a trial and would not incur substantial expense.

(2) ***For Other Discovery.*** A subpoena may command:

(A) production of documents, electronically stored information, or tangible things at a place within 100 miles of where the person resides, is employed, or regularly transacts business in person; and

(B) inspection of premises at the premises to be inspected.

(d) Protecting a Person Subject to a Subpoena; Enforcement.

(1) ***Avoiding Undue Burden or Expense; Sanctions.*** A party or attorney responsible for issuing and serving a subpoena must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. The court for the district where compliance is required must enforce this duty and impose an appropriate sanction—which may include lost earnings and reasonable attorney's fees—on a party or attorney who fails to comply.

(2) ***Command to Produce Materials or Permit Inspection.***

(A) *Appearance Not Required.* A person commanded to produce documents, electronically stored information, or tangible things, or to permit the inspection of premises, need not appear in person at the place of production or inspection unless also commanded to appear for a deposition, hearing, or trial.

(B) *Objections.* A person commanded to produce documents or tangible things or to permit inspection may serve on the party or attorney designated in the subpoena a written objection to inspecting, copying, testing, or sampling any or all of the materials or to inspecting the premises—or to producing electronically stored information in the form or forms requested. The objection must be served before the earlier of the time specified for compliance or 14 days after the subpoena is served. If an objection is made, the following rules apply:

(i) At any time, on notice to the commanded person, the serving party may move the court for the district where compliance is required for an order compelling production or inspection.

(ii) These acts may be required only as directed in the order, and the order must protect a person who is neither a party nor a party's officer from significant expense resulting from compliance.

(3) ***Quashing or Modifying a Subpoena.***

(A) *When Required.* On timely motion, the court for the district where compliance is required must quash or modify a subpoena that:

(i) fails to allow a reasonable time to comply;

(ii) requires a person to comply beyond the geographical limits specified in Rule 45(c);

(iii) requires disclosure of privileged or other protected matter, if no exception or waiver applies; or

(iv) subjects a person to undue burden.

(B) *When Permitted.* To protect a person subject to or affected by a subpoena, the court for the district where compliance is required may, on motion, quash or modify the subpoena if it requires:

(i) disclosing a trade secret or other confidential research, development, or commercial information; or

(ii) disclosing an unretained expert's opinion or information that does not describe specific occurrences in dispute and results from the expert's study that was not requested by a party.

(C) *Specifying Conditions as an Alternative.* In the circumstances described in Rule 45(d)(3)(B), the court may, instead of quashing or modifying a subpoena, order appearance or production under specified conditions if the serving party:

(i) shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship; and

(ii) ensures that the subpoenaed person will be reasonably compensated.

(e) Duties in Responding to a Subpoena.

(1) ***Producing Documents or Electronically Stored Information.*** These procedures apply to producing documents or electronically stored information:

(A) *Documents.* A person responding to a subpoena to produce documents must produce them as they are kept in the ordinary course of business or must organize and label them to correspond to the categories in the demand.

(B) *Form for Producing Electronically Stored Information Not Specified.* If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

(C) *Electronically Stored Information Produced in Only One Form.* The person responding need not produce the same electronically stored information in more than one form.

(D) *Inaccessible Electronically Stored Information.* The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.

(2) ***Claiming Privilege or Protection.***

(A) *Information Withheld.* A person withholding subpoenaed information under a claim that it is privileged or subject to protection as trial-preparation material must:

(i) expressly make the claim; and

(ii) describe the nature of the withheld documents, communications, or tangible things in a manner that, without revealing information itself privileged or protected, will enable the parties to assess the claim.

(B) *Information Produced.* If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial-preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information under seal to the court for the district where compliance is required for a determination of the claim. The person who produced the information must preserve the information until the claim is resolved.

(g) Contempt.

The court for the district where compliance is required—and also, after a motion is transferred, the issuing court—may hold in contempt a person who, having been served, fails without adequate excuse to obey the subpoena or an order related to it.

For access to subpoena materials, see Fed. R. Civ. P. 45(a) Committee Note (2013).

ATTACHMENT A TO SUBPOENA

DEFINITIONS

Notwithstanding any definition below, each word, term or phrase used in this Subpoena is intended to have the broadest meaning under the Federal Rules of Civil Procedure.

1. **"Beneficiary"** or **"Member"** shall mean an individual enrolled in a Medicare Advantage Plan.

2. "**Capitation"** shall mean any fee arrangement where payment is based in whole or in part on a set percentage of revenue from CMS.

3. "**CMS"** shall mean the United States Centers for Medicare and Medicaid Services, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

4. **"CMS-HCC Risk Adjustment Model"** shall refer to the regression model used to calculate risk scores for payment under the Medicare Advantage Program. This term refers to all iterations and recalibrations of the model that were used to determine payments for payment years 2004 through 2017, including the CMS-HCC base model (introduced in payment year 2004), the CMS-HCC V12 model (introduced in payment year 2009) and the CMS HCC V21 model (introduced in payment year 2013) and the CMS V22 Model (introduced in payment year 2014) and any other revisions or recalibrations of the model used for payment years 2004 through 2017.

5. "**Communication"** shall mean and refers to correspondence, discussions, conversations, interviews, negotiations, telephone calls, emails, instant messages, text messages, voice mail messages, cablegrams, mailgrams, telegrams, telexes, cables, and all other transmissions of information, thoughts, documents, or ideas between two or more persons.

6. "**Complaint**" shall mean any and all of the United States' Amended Complaint-In-Partial-Intervention filed in this case on November 17, 2017, the

Relator's Second Amended Complaint filed in this case on May 16, 2017, and any forthcoming amended complaints filed by the United States or the Relator in this case.

7. **"Diagnosis Code"** means an ICD-9 or ICD-10 diagnosis code.

8. **"Document**" shall have the full meaning ascribed to it in Federal Rule of Civil Procedure 34 and shall include all written, printed, typewritten, electronic, photographic, recorded or graphic materials, however produced or reproduced, in whatever form (e.g. final versions, draft versions and non-duplicate copies), which relate or pertain in any way to the subject matter to which the below Document Requests refer. "Document" includes, without limitation, all originals, copies and drafts of all notes, memoranda, correspondence, electronic mail, ledgers, journals, minutes, books, telephone slips, expense accounts, time sheets, telegrams, cables, publications, photographs, microfilm prints, contracts, insurance policies, manuals, recordings, tapes, transcriptions of records and recordings, business records, desk calendars, diaries, transcripts, affidavits, bills, receipts, checks, reports, audit materials, memoranda of telephone or other conversations by or with any Person(s) and any other pertinent information set forth in written language or any electronic or magnetic representation thereof, and shall not be limited in any way with respect to the process by which any document was created, generated or reproduced, or with respect to the medium in which the document is embodied. "Documents" as used herein shall also include any and all metadata, including but not limited to: author name and initials, company or organization name, identification of computer or network server or hard disk where the document is stored, names of previous document authors, revisions and version, date created, date last modified, hidden text or cells, other file properties and summary information, non-visible portions or embedded objects, personalized views and comments.

9. "**Dollar Coefficients**" refers to the estimated dollar amounts or incremental dollar costs associated with each demographic and HCC variable in the

CMS-HCC Risk Adjustment Model before normalization and conversion into Relative Factors, and shall have the same meaning as is ascribed to the term "estimated coefficient" on pages 13–14 of the Technical Appendix to CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits.*

10. "**Each**" includes the word "every" and "**every**" includes the word "each," "**any**" includes the word "all" and "**all**" includes the word "any," "and" includes the word "or" and "or" includes the word "and," as necessary to bring within the scope of each Request information which might otherwise be construed to be outside its scope.

11. "**Electronically Stored Information**" or "**ESI**" refers to any designated documents or electronically stored information – including writings, drawings, graphs, charts, photographs, sound recordings, images, e-mails and other data or data compilations stored in any medium (hard drives, disc drives, servers, lap tops) from which information can be obtained, including all data which may have been deleted, but which can be recovered or retrieved from a back-up system or such other method translated, if necessary, by the party into reasonably usable form. For the avoidance of doubt, any electronic Documents or data shall include its associated metadata.

12. "**Fee-for-Service Medicare**" or "**FFS Medicare**" shall mean traditional Medicare, under Parts A and B of the Medicare Program. Fee-for-Service or FFS Medicare uses a reimbursement methodology under which CMS reimburses healthcare providers and suppliers a fee for each item or service actually rendered to a patient based on payment rates pre-determined by the Government.

13. **"Gainshare Arrangements"** refers to agreements whereby Medicare Advantage Plans pay fee-for-service providers additional payments based on revenue, including risk adjustment payments, which Medicare Advantage Plans receive from CMS.

14. **"Government"** shall mean the United States, its agencies, departments, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf, including but not limited to any component of the United States Department of Justice, the United States Department of Health and Human Services, the Centers for Medicare & Medicaid Services and all subdivisions and components thereof.

15. **"HCC"** means a hierarchical condition category associated with one or more Diagnosis Codes (ICD-9-CM or ICD-10-CM codes) that represents the disease component of the Beneficiary risk scores that are applied to Medicare Advantage payments. "RxHCC" means an HCC used for Medicare Part D.

16. **"HHS"** shall mean the United States Department of Health and Human Services, its departments, components, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

17. **"HHS-OIG"** shall mean the Office of the Inspector General for the United States Department of Health and Human Services, its departments, components, agents, representatives, contractors, attorneys, consultants, and all other Persons acting on its behalf.

18. **"Identify"** means and refers to the following:

a. when used in reference to a natural person, it means that individual's full name, present or last known residence address and telephone number, business/government affiliation and business/government address and telephone number and e-mail address;

b. when used in reference to an organization, it means to state the organization's full name and, if it is a corporation, partnership or other business entity, the address of its principal place of business;

c. when used in connection with a Document or other recording (written, electronic, or otherwise), it means to state the following, as applicable: the type of document, its date (or approximate date),

author, addressee, title, present location, the form in which it is maintained (e.g., written document, computer file, posting on the Internet or World Wide Web, audio or video recording or any other form), the name and address of its custodian, and the substance of the contents thereof. In lieu of identifying any document, copies thereof may be furnished;

d. when used in reference to a communication (whether written, oral, electronic, or otherwise), shall mean to state the form of the communication (e.g., telephone conversation, letter, telegram, teletype, telecopy, electronic mail, posting on the Internet or World Wide Web, facsimile, written memorandum, face-to-face conversation, or any other form), the date (or approximate date) of the communication or the dates (or approximate dates) on which the communication was sent, posted, and/or received (if not the same), the parties to the communication, the party who initiated it, the substance of the communication, and the present location and the name and address of the custodian if the communication was non-verbal, and/or any written memorialization of the communication; and

e. when used in connection with a location, it means the name of the establishment, the street address, the suite or apartment number if any, the city, state and zip code, and, if applicable, the telephone number.

19. "**Including**" shall be construed as broadly as possible and shall mean "without limitation."

20. "**Medicare Advantage**" and **"MA"** shall mean a type of health insurance that provides coverage to beneficiaries under Part C of the Medicare Program. *See* 42 U.S.C. §§ 1395w-21 through 1395w-29.

21. **"Medicare Advantage Plan"** and **"MA Plan"** shall mean and refer to a Medicare Advantage Organization with a contract to provide health benefits coverage that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA Plan, in exchange for capitated (i.e., set or fixed), per-member-per-month payments from the federal government, under Parts C and D of the Medicare Program. *See* 42 U.S.C. §§ 1395w-22(a)(1) and 23(a)(1); *see also* 42 U.S.C. § 1395w-28(b)(1).

22. "**Medicare Advantage Organization"** and **"MAO**" shall mean and refer to a public or private entity organized and licensed by a state as a risk-bearing entity that is certified by CMS as meeting the Medicare Advantage contract requirements. *See* 42 U.S.C. § 1395w-28(a)(1).

23. "**Person**" shall mean any natural person, proprietorship, corporation, public corporation, municipal corporation, partnership, group, association, union, company, establishment, the federal government and all departments and agencies thereof, state governments, local governments, other governmental agencies, political subdivisions, or any other organization or entity.

24. **"Provider"** shall mean any provider of healthcare services including individual providers such as physicians, physician assistants, laboratories, medical equipment providers, and nurse practitioners; institutional providers such as hospitals and clinics; provider groups such as groups of physicians or associations of physicians with other provider types; and any other type of providers of healthcare services or items. "Provider" includes fee-for-service Providers, Providers with Gainshare Arrangements, and Providers with Capitation arrangements. "Provider" also includes any past or present employee, contractor, or agent of any Provider. The term "Provider" shall be given the broadest possible meaning when responding to these Requests.

25. "**Relating to**" and "**regarding**" or any derivative thereof, in addition to

their customary and usual meanings, shall mean concerning, referring to, containing, identifying, monitoring, constituting, reflecting, discussing, pertaining to, assessing, recording, supporting, negating, refuting, touching upon and/or summarizing.

26. "**Relative Factor**" shall have the meaning ascribed to that term in CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* and accompanying Technical Appendix.

27. "**Risk Adjustment**" shall mean and refer to the method by which CMS adjusts capitation payments to Medicare Advantage Organizations and their health Plans based on enrollees' demographic factors and health status to ensure actuarial equivalence under Parts C and Part D of the Medicare Program, as described in 42 U.S.C. § 1395w-23 and 42 C.F.R. § 422.308(c)(1).

28. **"Risk Adjustment Data Validation"** or **"RADV"** shall mean the process by which CMS audits the Diagnosis Codes submitted for payment by an MAO to determine if the Diagnosis Codes are supported by medical record documentation for a Beneficiary. *See* 42 C.F.R. § 422.310(e).

29. "**Risk Score**" shall have the meaning ascribed to that term in CMS's October 26, 2018 Executive Summary titled Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits and accompanying Technical Appendix.

30. **"Two-Way Looks"** shall mean reviewing a Member's medical records to both identify diagnoses submitted in the claims data to CMS that are not supported by the medical record, as well as identify additional diagnoses that are supported by the medical record and that were not previously reported in claims data to CMS.

31. **"Under-Coding"** shall mean the failure to capture all present conditions or diagnoses on a claim or medical record.

32. **"UnitedHealth**" shall mean UnitedHealth Group Incorporated, United HealthCare Services, Inc., UnitedHealthcare, Inc., UnitedHealthcare Insurance

Company, Ovations, Inc., Optum, Inc., OptumInsight, Inc., AmeriChoice of New Jersey, Inc., AmeriChoice of New York, Inc., Arizona Physicians IPA, Inc., Care Improvement Plus of Maryland, Inc., Care Improvement Plus of Texas Insurance Company, Care Improvement Plus South Central Insurance Company, Care Improvement Plus Wisconsin Insurance Company, Optum Insurance Co., Citrus Health Care, Inc., Health Plan of Nevada, Inc., Medica HealthCare Plans, Inc., Oxford Health Plans (CT), Inc., Oxford Health Plans (NJ), Inc., Oxford Health Plans (NY), Inc., PacifiCare Life and Health Insurance Company, PacifiCare of Arizona, Inc., PacifiCare of Colorado, Inc., PacifiCare of Nevada, Inc., Physicians Health Choice of Texas, LLC, Preferred Care Partners, Inc., Rocky Mountain Health Maintenance Organization, Incorporated, Sierra Health and Life Insurance Company, Inc., Symphonix Health Insurance, Inc., UHC of California (f.k.a. PacifiCare of California), United Health Care Ins. Co. and United New York, Unison Health Plan of Tennessee, Inc., UnitedHealthcare Benefits of Texas, Inc. (f.k.a. PacifiCare of Texas, Inc.), UnitedHealthcare Community Plan of Ohio, Inc. (f.k.a. Unison Health Plan of Ohio, Inc.), UnitedHealthcare Community Plan of Texas, L.L.C. (f.k.a. Evercare of Texas, L.L.C.), UnitedHealthcare Community Plan, Inc. (f.k.a. UnitedHealthcare of the Great Lakes Health Plan, Inc.), UnitedHealthcare Insurance Company of New York, UnitedHealthcare of Alabama, Inc., UnitedHealthcare of Arizona, Inc., UnitedHealthcare of Arkansas, Inc., UnitedHealthcare of Florida, Inc., UnitedHealthcare of Georgia, Inc., UnitedHealthcare of New England, Inc., UnitedHealthcare of New York, Inc., UnitedHealthcare of North Carolina, Inc., UnitedHealthcare of Ohio, Inc., UnitedHealthcare of Oklahoma, Inc. (f.k.a. PacifiCare of Oklahoma, Inc.), UnitedHealthcare of Oregon, Inc. (f.k.a. PacifiCare of Oregon, Inc.), UnitedHealthcare of Pennsylvania, Inc. (f.k.a. Unison Health Plan of Pennsylvania, Inc.), UnitedHealthcare of Tennessee, Inc., UnitedHealthcare of the Midlands, Inc., UnitedHealthcare of the Midwest, Inc., UnitedHealthcare of Utah, Inc.,

UnitedHealthcare of Washington, Inc. (f.k.a. PacifiCare of Washington, Inc.), UnitedHealthcare of Wisconsin, Inc., and UnitedHealthcare Plan of the River Valley, Inc.

33. **"UnitedHealth Risk Adjustment Programs"** shall mean anything involving one or more of the following UnitedHealth programs: Chart Review, Chart Audits, Claims Verification, Internal Data Validation, or Risk Adjustment Coding Compliance Review (RACCR).

34. "**You**," and "**Your**" shall mean Research Triangle Institute International ("RTI") and all Persons acting on its behalf.

INSTRUCTIONS

1. The instructions set forth in Fed. R. Civ. P. 45 are adopted and incorporated by reference herein.

2. You are to produce all Documents, as defined above, that are in the possession, custody or control of You, or in the possession, custody or control of any attorney or agent for You. Without limiting the term "control," a Document is deemed to be within Your control if you have ownership, possession or custody of the document, or the right to secure the document or copy thereof from any person or public or private entity having physical possession thereof.

3. In responding to these requests, You are required to make a diligent search of all documents and information in Your possession or available to You or Your representatives or agents.

4. Any request for documents is meant to include all documents in Your possession, custody or control, whether the documents were created or compiled by You or by any other person(s) for any reason whatsoever, and including all Documents that You have a legal right to obtain copies of.

5. The words "and" and "or" shall be construed either conjunctively or disjunctively to bring within the scope of each request information which might otherwise be construed to be outside its scope.

6. All references to the singular include the plural, and all references to the plural include the singular. Similarly, the use of the present tense of a verb shall be considered to include within its meaning the future and past tense, and vice versa.

7. The terms "all," "any," "every," and "each" shall each be construed as encompassing any and all.

8. The use of any tense of any verb shall also include within its meaning all other tenses of the verb where the clear meaning of a request is not distorted by the change of tense.

9. Each request should be construed to include the time period from January 1, 2002 through the present (unless stated differently by a specific document request).

10. If in responding to a request You claim any ambiguity in interpreting the request or a definition or instruction applicable thereto, such claim shall not be utilized by You as a basis for refusing to produce documents responsive thereto. Instead, You shall set forth as part of Your response to such request the language deemed to be ambiguous and the interpretation chosen to be used in responding to the Request.

11. If You withhold any document or portion of a document from production on the basis of a claim of attorney-client or any other privilege, or on the basis of the attorney work-product doctrine, identify each such document that is withheld or redacted by providing in a Privilege Log the following information: the name of each writer, editor, or other creator of the document; the document's title (if any); the name of each sender or recipient of the document (or any copies thereof); the name and address of each person who has custody of the document (or any copy thereof); the date of each document and each copy; a description of the content or redacted portion of each document; the privilege(s) or protection(s) claimed and the basis of Your claim of privilege or protection.

12. If You withhold any document from production on the basis that the request is objectionable, state the objection with regard to the particular portion(s) of the request which is/are deemed objectionable. Unless the objection is directed to the entire request and each and every document requested therein, provide all documents responsive to all portions of the request not deemed objectionable.

13. In producing a document, produce a copy or reproduction of the original, together with all non-identical copies and drafts. Documents that are attached to one another should not be separated.

14. The documents produced in response to the document requests shall be produced as they are kept in the ordinary course of business and shall be organized so that Defendant can ascertain the files in which they were located, their relative order in such files, and how such files were maintained.

15. All electronically stored documents and information should be produced in accordance with the attached Specifications for Production of ESI and Digitized ("Scanned") Images unless an alternative arrangement is reached in writing with the receiving party.

16. These requests are continuing in nature. If, after responding to these requests, up until and including the time of trial, You or any person on your behalf obtain(s) or become(s) aware of additional information that would be responsive to these requests, You are required to serve a supplemental production containing all such subsequently discovered or acquired information as soon as reasonably possible after receipt or discovery of the information.

DOCUMENT REQUESTS

DOCUMENT REQUEST NO. 1:

Documents sufficient to describe the nature and extent of any work performed by RTI on behalf of CMS or HHS related to MA Risk Adjustment-related services or the development of the CMS-HCC Risk Adjustment Model, including but not limited to a copy of each signed contract pertaining to said work, a description of the

scope of services to be provided under the contract(s), and any statements of work concerning or arising from such contracts.

DOCUMENT REQUEST NO. 2:

Documents sufficient to show the names of individuals who worked on Your contract(s) with CMS or HHS related to MA Risk Adjustment services and/or the development of the CMS-HCC Risk Adjustment Model and said individuals' roles and responsibilities related to their work on the same.

DOCUMENT REQUEST NO. 3:

All Documents and Communications between RTI and CMS, HHS, and/or HHS-OIG related to UnitedHealth and/or UnitedHealth's Medicare Advantage contracts with CMS.

DOCUMENT REQUEST NO. 4:

All Documents or Communications authored, modified, sent, received, or relied upon by RTI related to UnitedHealth Risk Adjustment Programs or UnitedHealth Risk Adjustment data submissions to CMS.

DOCUMENT REQUEST NO. 5:

All Documents and Communications relating to any training, guidance, or technical assistance RTI provided to CMS and/or CMS provided to RTI pertaining to MA Risk Adjustment, including but not limited to training or guidance regarding:

- Medicare Advantage proposed or final regulations and requirements;
- The accuracy and truthfulness of Diagnosis Codes reported by MA Plans;
- MAOs' submission of Risk Adjustment data to CMS;
- CMS's Risk Adjustment payments to MAOs;
- Coding and reporting under the ICD guidelines;
- MAOs' compliance obligations with respect to Risk Adjustment, RADV Audits, and/or MAOs' retention or return of potential or actual overpayments as a result of MA Plan review of Risk Adjustment Data;

- Any proposed or final laws, regulations, and/or obligations imposed on MAOs to conduct Two-Way Looks;
- Under-Coding of chronic conditions;
- Retrospective chart review practices; and/or
- The CMS-HCC Risk Adjustment Model.

DOCUMENT REQUEST NO. 6:

Any Documents or Communications related to training, guidance, business requirements, or documentation concerning MA Risk Adjustment upon which RTI relied to perform its work under its MA Risk Adjustment-related contract(s) with CMS or HHS.

DOCUMENT REQUEST NO. 7:

All Documents or Communications developed, authored, modified, sent, received, or relied upon by RTI related to the development and operation of the CMS-HCC Risk Adjustment Model, including but not limited to Documents identifying and explaining the specific data used to calibrate the CMS-HCC Risk Adjustment Model.

DOCUMENT REQUEST NO. 8:

All Documents, Communications, data and programming logic sufficient to show how the data were selected and which records were specifically selected to create the 5% Medicare Standard Analytic files (or 5% sample of the relevant Fee-For-Service Medicare datasets) used to develop, calibrate, and recalibrate the CMS-HCC Risk Adjustment Model, including but not limited to programming logic, business requirements Documents, technical requirements Documents, database schema, listing of assumptions, listing of inputs, log files created during execution, work plans and listing of work steps related to whether the sample was random or customized.

DOCUMENT REQUEST NO. 9:

All Documents, Communications, data and programming logic sufficient to show what, if any, exclusions and/or filtering logic was applied to the 5% Medicare Standard Analytic files (or 5% sample of the relevant Fee-For-Service Medicare datasets) or any other data files to create the dataset used to develop, calibrate, and recalibrate the CMS-HCC Risk Adjustment Model, including but not limited to programming logic, business requirements Documents, technical requirements Documents, database schema, listing of assumptions, listing of inputs, log files created during execution, work plans and listing of work steps.

DOCUMENT REQUEST NO. 10:

The datasets used to develop, calibrate, and recalibrate the CMS-HCC Risk Adjustment Model.

DOCUMENT REQUEST NO. 11:

All Documents or Communications developed, authored, modified, sent, received, or relied upon by RTI related to any contemplated or actual adjustment(s) to or recalibration of the CMS-HCC Risk Adjustment Model to account for unsupported Diagnosis Codes in Fee-For-Service Medicare data, including but not limited to any adjustments to or recalibrations of the CMS-HCC Risk Adjustment Model coefficients.

DOCUMENT REQUEST NO. 12:

All Documents or Communications developed, authored, modified, sent, received, or relied upon by RTI related to the RADV Medicare Fee-For-Service ("FFS") error rate adjuster discussed in CMS's *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits* (Feb. 24, 2012), including but not limited to Documents describing any effort by the Government to calculate a Medicare FFS error rate; Documents describing any analysis by the Government related to measuring the accuracy of diagnoses submitted on Medicare FFS claims; or

Documents regarding any effort by the Government to analyze, compute, or measure the impact of unsupported Diagnosis Codes in FFS Medicare claims data on the amount, magnitude, or value of the Dollar Coefficients or Relative Factors in the CMS-HCC Risk Adjustment Model or the Risk Scores generated by the CMS-HCC Risk Adjustment Model.

DOCUMENT REQUEST NO. 13:

All Documents or Communications developed, authored, modified, sent, considered, analyzed, received, or relied upon by CMS related to CMS's proposed rule, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, 83 Fed. Reg. 54982 (Nov. 1, 2018), or CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* and accompanying Technical Appendix, including but not limited to, Documents or Communications regarding any effort by the Government to analyze, compute, or measure the impact of unsupported Diagnosis Codes in FFS Medicare claims data on the amount, magnitude, or value of the Dollar Coefficients or Relative Factors in the CMS-HCC Risk Adjustment Model or the Risk Scores generated by the CMS-HCC Risk Adjustment Model.

DOCUMENT REQUEST NO. 14:

All data created, modified, sent, considered, analyzed, received, or relied upon by RTI related to CMS's proposed rule, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, 83 Fed. Reg. 54982 (Nov. 1, 2018), or CMS's October 26, 2018 Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment*

Data Validation Audits and accompanying Technical Appendix, including but not limited to, the "the 2004-2005 [FFS] file used for model calibration" referred to on page 5 of the Technical Appendix, the "2011 overpayment run" and the "MA sample" selected from the "2011 overpayment run" referred to on page 5 of the Technical Appendix, and the Comprehensive Error Rate Testing audit data and "sample of FFS claims and associated medical records . . . collected from the (CERT) audit" referred to on pages 5–6 of the Technical Appendix.

DOCUMENT REQUEST NO. 15:

All Documents, Communications, or data and programming logic sufficient to show what, if any, exclusions and/or filtering logic was applied to the data used in CMS's study described in the October 26, 2018 Technical Appendix accompanying the Executive Summary titled *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits*, including but not limited to programming logic, business requirements Documents, technical requirements Documents, database schema, listing of assumptions, listing of inputs, log files created during execution, work plans and listing of work steps.

DOCUMENT REQUEST NO. 16:

All Documents related to internal discussions, research, analyses, and/or calculations regarding the preparation and publication of Gregory Pope et al., *Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model*, 25 Health Care Financing Rev. 4 (Summer 2004), prepared in association with CMS Contract Numbers 500-95-048 and 500-00-0030, including Communications with CMS regarding the same.

DOCUMENT REQUEST NO. 17:

All Documents related to internal discussions, research, analyses, and/or calculations regarding the preparation and publication of Gregory Pope et al., *Evaluation of the CMS-HCC Risk Adjustment Model Final Report* (Research Triangle Park: RTI International, March 2011), prepared in association with CMS

Contract No. HHSM-500-2005-00029I TO 0006, including Communications with CMS regarding the same.

DOCUMENT REQUEST NO. 18:

All Documents or Communications authored, modified, sent, received, or relied upon by RTI regarding MA Organizations', MA Plans', and/or Providers' inquiries regarding MA Risk Adjustment submitted through any CMS Risk Adjustment web portal or transmitted via email to any MA Risk Adjustment helpdesk or mailbox, such as the analyst@riskadjustment.com account.

DOCUMENT REQUEST NO. 19:

All Communications between RTI and A. Reddix & Associates, Inc. ("ARDX") related to MA Risk Adjustment made during the course of RTI's MA Risk Adjustment-related contract(s) with CMS or HHS.

Dated: February 1, 2019

Respectfully submitted,

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

By _____
David J. Schindler
Attorneys for UnitedHealth Defendants

Collection of Electronically Stored Information (ESI)

1. Specification Modifications

Any modifications or deviations from the Production Specifications may be done only with the express written agreement of the parties. Any responsive data or documents that exist in locations or native forms not discussed in these Production Specifications remain responsive and, therefore, arrangements should be made with the receiving party to facilitate their production.

2. Production Format of ESI and Imaged Hard Copy

Responsive ESI and imaged hard copy shall be produced in the format outlined below. All ESI, except as outlined below in sections 5 – 20, shall be rendered to TIFF image format, and accompanied by a Concordance® Image Cross Reference file. All applicable metadata (see section 3 below) shall be extracted and provided in Concordance® load file format.

a. Image File Format:

All images, paper documents scanned to images, or rendered ESI, shall be produced as 300 dpi single-page TIFF files, CCITT Group IV (2D Compression). Images should be uniquely and sequentially Bates numbered and unless otherwise specified, Bates numbers should be an endorsement on each image.

- All TIFF file names shall include the unique Bates number burned into the image.
- Each Bates number shall be a standard length, include leading zeros in the number, and be unique for each produced page.
- All TIFF image files shall be stored with the ".tif" extension.
- Images shall be OCR'd using standard COTS products.
    - An exception report shall be provided when limitations of paper digitization software/hardware or attribute conversion do not allow for OCR text conversion of certain images. The report shall include the DOCID or Bates number(s) corresponding to each such image.
- All pages of a document or all pages of a collection of documents that comprise a folder or other logical grouping, including a box, shall be delivered on a single piece of media.
- No image folder shall contain more than 2000 images.

b. Concordance® Image Cross Reference file: Images should be accompanied by a Concordance® Image Cross Reference file that associates each Bates number with its corresponding single-page TIFF image file. The Cross Reference file should also contain the image file path for each Bates numbered page.

- Image Cross Reference Sample Format:

ABC00000001,OLS,D:\DatabaseName\Images\001\ ABC00000001.TIF,Y,,,
ABC00000002,OLS,D:\DatabaseName\Images\001\ ABC00000002.TIF,,,,
ABC00000003,OLS,D:\DatabaseName\Images\001\ ABC00000003.TIF,,,,
ABC00000004,OLS,D:\DatabaseName\Images\001\ ABC00000004.TIF,Y,,,

c. Concordance® Load File: Images should also be accompanied by a "text load file" containing delimited text that will populate fields in a searchable, flat database environment. The file should contain the required fields listed below in section 3.

- Text delimited load files are defined using the standard Concordance delimiters. For example:

Field Separator	¶ *or Code 020*
Text Qualifier	þ *or Code 254*

- The text file should also contain hyperlinks to applicable native files, such as Microsoft Excel or PowerPoint files.
- There should be one line for every record in a collection.
- The load file must contain a field map/key listing the metadata/database fields in the order they appear within the data file. For example, if the data file consists of a First Page of a Record (starting Bates), Last Page of a Record (ending Bates), DOCID, DOCDate, File Name, and a Title, then the structure may appear as follows:

þBEGDOCþ¶þENDDOCþ¶þDOCIDþ¶þDOCDATEþ¶þFILENAMEþ¶þTITLEþ

d. The extracted/OCR text for each document should be provided as a separate single text file. The file name should match the BEGDOC# or DOCID for that specific record and be accompanied by the .txt extension.

e. Directory and folder structure: The directory structure for productions should be:

*CaseName***LoadFiles**
*CaseName***Images** < For supporting images (can include subfolders as needed)
*CaseName***Natives** <Native Files location (can include subfolders as needed)
*CaseName***Text** <Extracted Text files location (can include subfolders as needed)

3. Required Metadata/Database Fields

- A "✓" denotes that the indicated field should be present in the load file produced.
- "Other ESI" includes data discussed in sections 5 – 20 below, but does not include email, email repositories (section 11), "stand alone" items (section 11), and imaged hard copy material (section 9). Email, email repositories, and "stand alone" materials (section 11) should comply with "Email" column below. Imaged hard copy materials should comply with the "Hard Copy" column.

Specifications for Production of ESI and Digitized ("Scanned") Images
United States *ex rel.* Poehling v. UnitedHealth Group

Field name	Field Description	Field Type	Field Value	Hard Copy	E-mail	Other ESI
COLLECTION SOURCE	Name of the Company/Organization data was collected from	Text	160	✓	✓	✓
SOURCE ID (BOX #)	Submission/volume/box number	Text	10	✓	✓	✓
CUSTODIAN	Custodian/Source - format: Last, First or ABC Dept.	Text	160	✓	✓	✓
ALL CUSTODIANS	All Custodians that had a version of the MD5 Hash Duplicate - format: Last, First; separated by semi colons			✓		✓
AUTHOR	Creator of the document	Text	500			✓
BEGDOC#	Start Bates (including prefix) - No spaces	Text	60	✓	✓	✓
ENDDOC#	End Bates (including prefix) - No spaces	Text	60	✓	✓	✓
DOCID	Unique document Bates # or populate with the same value as Start Bates (DOCID = BEGDOC#)	Text	60	✓	✓	✓
PGCOUNT	Page Count	Number	10	✓	✓	✓
GROUPID	Contains the Group Identifier for the family, in order to group files with their attachments	Text	60		✓	✓
PARENTID	Contains the Document Identifier of an attachment's parent	Text	60		✓	✓
ATTACHIDS	Child document list; Child DOCID or Child Start Bates	Text – semicolon delimited	Unlimited	✓	✓	✓
ATTACHLIST	List of Attachment filenames	Text – semicolon delimited	Unlimited		✓	✓
BEGATTACH	Start Bates number of first attachment	Text	60	✓	✓	✓
ENDATTACH	End Bates number of last attachment	Text	60	✓	✓	✓

Specifications for Production of ESI and Digitized ("Scanned") Images
United States *ex rel.* Poehling v. UnitedHealth Group

Field name	Field Description	Field Type	Field Value	Hard Copy	E-mail	Other ESI
PROPERTIES	Privilege notations, Redacted, Document Withheld Based On Privilege	Text – semicolon delimited	Unlimited	✓	✓	✓
RECORD TYPE	Use the following choices: Image, Loose E-mail, E-mail, E-Doc, Attachment, Hard Copy or Other. If using Other, please specify what type after Other	Text	60	✓	✓	✓
FROM	Author - format: Last name, First name.	Text	160		✓	✓
TO	Recipient - format: Last name, First name.	Text – semicolon delimited	Unlimited		✓	✓
CC	Carbon Copy Recipients - format: Last name, First name.	Text – semicolon delimited	Unlimited		✓	✓
BCC	Blind Carbon Copy Recipients - format: Last name, First name.	Text – semicolon delimited	Unlimited		✓	✓
SUBJECT	Subject line/Document Title	Text	Unlimited		✓	✓
CONVINDEX	E-mail system ID used to track replies, forwards, etc.	Text	Unlimited		✓	
DOCDATE	Last Modified Date for files and Sent date for e-mail, this field inherits the date for attachments from their parent.	Date	MM/DD/YYYY		✓	✓
DATE TIME SENT	Date Sent (USE TIME ZONE OF COLLECTION LOCALITY)	Date and Time	MM/DD/YYYY HH:MM:SS		✓	✓
DATE TIME CRTD	Date Created (USE TIME ZONE OF COLLECTION LOCALITY)	Date and Time	MM/DD/YYYY HH:MM:SS		✓	✓
DATE TIME SVD	Date Saved (USE TIME ZONE OF COLLECTION LOCALITY)	Date and Time	MM/DD/YYYY HH:MM:SS		✓	✓

Specifications for Production of ESI and Digitized ("Scanned") Images
United States *ex rel.* Poehling v. UnitedHealth Group

Field name	Field Description	Field Type	Field Value	Hard Copy	E-mail	Other ESI
DATE TIME MOD	Date Last Modified (USE TIME ZONE OF COLLECTION LOCALITY)	Date and Time	MM/DD/YYYY HH:MM:SS		✓	✓
DATE TIME RCVD	Date Received (USE TIME ZONE OF COLLECTION LOCALITY)	Date and Time	MM/DD/YYYY HH:MM:SS		✓	
DATE TIME ACCD	Date Accessed (USE TIME ZONE OF COLLECTION LOCALITY)	Date and Time	MM/DD/YYYY HH:MM:SS		✓	✓
FILE SIZE	Native File Size in bytes	Number	10			✓
FILE NAME	File name - name of file as it appeared in its original location	Text	Unlimited			✓
APPLICATION	Application used to create native file (e.g. Excel, Outlook, Word)	Text	160		✓	✓
FILE EXTENSION	Extension for the file (e.g. .doc, .pdf, .wpd)	Text	10		✓	✓
FILEPATH	Data's original source full folder path	Text	Unlimited		✓	✓
FOLDER ID	Complete E-mail folder path (e.g. Inbox\Active) or Hard Copy container information (e.g. folder or binder name)	Text	Unlimited	✓	✓	✓
MD5 HASH	MD5 Hash value (used for deduplication or other processing) (e-mail hash values must be run with the e-mail and all of its attachments)	Text	Unlimited		✓	✓
MESSAGEHEADER	E-mail header. Can contain IP address	Text	Unlimited		✓	
ATTACHMCOUNT	Number of attachments (any level child document) associated with a ParentID	Text	10		✓	

Field name	Field Description	Field Type	Field Value	Hard Copy	E-mail	Other ESI
FILE TYPE	Identifies the application that created the file Type of file, not to be confused with file extension	Text	160		✓	✓
COMMENTS	Identifies whether the document has comments associated with it	Text	10		✓	✓
MESSAGE TYPE	Exchange Message class or equivalent	Text	60		✓	
EXTENDED PROPERTIES	For PDFs Only	Text	600		✓	✓
CONFIDENTIAL DESIGNATION	Identifies whether the document is Confidential or Attorneys' Eyes Only	Text	60	✓	✓	✓
TEXT FILEPATH	Relative file path of the text file associated with either the extracted text or the OCR	Text	Unlimited	✓	✓	✓
NATIVE LINK	Relative file path location to the native file	Text	Unlimited		✓	✓

4. Search, De-Duplication, Near-Duplicate Identification, E-mail Conversation Threading and Other Culling Procedures

De-duplication of exact copies across all custodian data (i.e., globally) is required in accordance with the following parameters: all custodians must be provided in the load file "ALL CUSTODIANS" field for duplicate documents that are either (1) hard copy images (as detailed in Section 9) or (2) ESI documents that are not Emails or "Stand alone" documents (as detailed in Section 11). Additionally, parties will work collaboratively to address requests for file path and/or custodian metadata on other documents.

The producing party shall not use any other procedure to cull, filter, group, separate or de-duplicate, or near-deduplicate, etc. (i.e., reduce the volume of) responsive material before discussing with and obtaining the written approval of the receiving party. All objective coding (e.g., near duplicate ID or e-mail thread ID) shall be discussed and produced to the receiving party as additional metadata fields. The producing party will not employ analytic software or technology to search, identify, or review potentially responsive material, including but not limited to technology assisted review (TAR) or predictive coding, without first discussing with the receiving party.

5. Hidden Text

All hidden text (e.g., track changes, hidden columns, mark-ups, notes) shall be expanded and rendered in the image file. For files that cannot be expanded the native files shall be produced with the image file.

6. Embedded Files

All non-graphic embedded objects (Word documents, Excel spreadsheets, .wav files, etc.) that are found within a file shall be extracted and produced. For purposes of production, the embedded files shall be treated as attachments to the original file, with the parent/child relationship preserved.

7. Image-Only Files

All image-only files (non-searchable .pdfs, multi-page .tiffs, Snipping Tool and other screenshots, etc., as well as all other images that contain text) shall be produced with associated OCR text and metadata/database fields identified in section 3 for "Other ESI."

8. Encrypted Files

The producing party will use reasonable efforts to decrypt any data (whether individual files or digital containers) that is protected by a password, encryption key, digital rights management, or other encryption scheme, prior to processing for production.

a. The unencrypted text shall be extracted and provided per section 2.c. The unencrypted files shall be used to render images and provided per sections 2.a and 2.b. The unencrypted native file shall be produced pursuant to sections 10-20.
b. If such protected data is encountered but unable to be processed, each file or container shall be reported as an exception in the accompanying Exception Report (pursuant to section 26) and shall include all available metadata associated with the data, including custodian information.

9. Production of Imaged Hard Copy Records

All imaged hard copy material shall reflect accurate document unitization including all attachments and container information (to be reflected in the PARENTID, ATTACHID, BEGATTACH, ENDATTACH and FOLDERID).

a. Unitization in this context refers to identifying and marking the boundaries of documents within the collection, where a document is defined as the smallest physical fastened unit within a bundle. (e.g., staples, paperclips, rubber bands, folders, or tabs in a binder).
b. The first document in the collection represents the parent document and all other documents will represent the children.
c. All documents shall be produced in black and white TIFF format unless the image requires color. An image requires color when color in the document adds emphasis to information in the document or is itself information that would not be readily apparent on the face of a black and white image. Images identified as requiring color shall be produced as color 300 dpi single-page JPEG files.
d. All objective coding (e.g., document date or document author) should be discussed and produced to the receiving party as additional metadata/database fields.

10. Production of Spreadsheets and Presentation Files

All spreadsheet and presentation files (e.g. Excel, PowerPoint) shall be produced in the unprocessed "as kept in the ordinary course of business" state (i.e., in native format), with an associated placeholder image and endorsed with a unique Bates number. *See* section 19 below. The file produced should maintain the integrity of all source, custodian, application, embedded and related file system metadata. No alteration shall be made to file names or extensions for responsive native electronic files in the File Name field.

11. Production of Items Originally Generated in E-mail Repositories but Found and Collected Outside of E-mail Repositories, i.e., "Stand-alone" Items

Any parent e-mail or other parent items (e.g., calendar, contacts, tasks, notes, etc.) found and collected outside of e-mail repositories (e.g., items having extensions .msg, .htm, .mht, etc.), shall be produced with the "Loose E-mail" metadata fields outlined in section 3, including but not limited to any attachments, maintaining the family (parent/child) relationship.

12. Production of Instant Messenger (IM), Voicemail Data, Audio Data, Video Data, etc.

The producing party shall identify, collect, and produce any and all data which is responsive to the requests which may be stored in audio or video recordings, cell phone/PDA/Blackberry/smart phone data, tablet data, voicemail messaging data, instant messaging, text messaging, conference call data, video/audio conferencing (e.g., GoTo Meeting, WebEx), and related/similar technologies. However, such data, logs, metadata or other files related thereto, as well as other less common but similar data types, shall be produced after consultation with and written consent of the receiving party about the format for the production of such data.

13. Production of Social Media

Prior to any production of responsive data from social media (e.g., Twitter, Facebook, Google+, LinkedIn, etc.) the producing party shall first discuss with the receiving party the potential export formats before collecting the information.

14. Production of Structured Data

If responsive data exists in a structured database (e.g., Oracle, SAP, SQL, MySQL, QuickBooks, etc.), the producing party and receiving party shall discuss what additional information, if any, need be provided with that production.

15. Production of Structured Data from Proprietary Applications

Prior to any production of structured data from proprietary applications (e.g., proprietary timekeeping, accounting, sales rep call notes, CRMs, SharePoint etc.) the producing party and receiving party discuss what additional information, if any, need be provided with that production.

16. Production of Photographs with Native File or Digitized ESI

Photographs shall be produced as single-page JPEG files with a resolution equivalent to the original image as they were captured/created. All JPEG files shall have extracted metadata/database fields provided in a Concordance® load file format as outlined in section 3 for "Other ESI."

17. Production of Images from which Text Cannot be OCR Converted

An exception report shall be provided when limitations of paper digitization software/hardware or attribute conversion do not allow for OCR text conversion of certain images. The report shall include the DOCID or Bates number(s) corresponding to each such image.

18. Production of ESI from Non-PC or Non-Windows-based Systems

If responsive ESI is in non-PC or non-Windows-based Systems (e.g., Apple, IBM mainframes, and UNIX machines, Android device, etc.), the ESI shall be produced after discussion with and written consent of the receiving party about the format for the production of such data.

19. Production of Native Files (When Applicable Pursuant to These Specifications)

Production of native files, as called for in these specifications, shall have extracted metadata/database fields provided in a Concordance® load file format as defined in the field specifications for "Other ESI" as outlined in section 3.

ESI shall be produced in a manner which is functionally usable by the receiving party. The following are examples:

a. AutoCAD data, e.g., DWG and DXF files, shall be processed/converted and produced as single-page JPG image files and accompanied by a Concordance® Image formatted load file as described above. The native files shall be placed in a separate folder on the production media and linked by a hyperlink within the text load file.

b. GIS data shall be produced in its native format and be accompanied by a viewer such that the mapping or other data can be reviewed in a manner that does not detract from its ability to be reasonably understood.

c. Audio and video recordings shall be produced in native format and be accompanied by a viewer if such recordings do not play in a generic application (e.g., Windows Media Player).

20. Bates Number Convention

All images should be assigned Bates numbers before production to the receiving party. The numbers should be endorsed on the actual images. Native files should be assigned a single Bates number for the entire file. The Bates number shall not exceed 30 characters in length and shall include leading zeros in the numeric portion. The Bates number shall be a unique number given to each page (when assigned to an image) or to each document (when assigned to a native file). The numbering convention shall remain consistent throughout the entire production. There shall be no spaces between the prefix and numeric value. If suffixes are required, please use "dot notation." Below is a sample of dot notation:

PREFIX0000001	PREFIX0000003
PREFIX0000001.001	PREFIX0000003.001
PREFIX0000001.002	PREFIX0000003.002

21. Media Formats for Storage and Delivery of Production Data

Electronic documents and data shall be delivered on any of the following media:

a. CD-ROMs and/or DVD-R (+/-) formatted to ISO/IEC 13346 and Universal Disk Format 1.02 specifications; Blu-ray.

b. External hard drives (USB 3.0 or higher, Firewire or eSATA, formatted to NTFS format specifications) or flash drives.

c. Storage media used to deliver ESI shall be appropriate to the size of the data in the production.

d. Media should be labeled with the case name, production date, Bates range, and producing party.

22. Virus Protection and Security for Delivery of Production Data

Production data shall be free of computer viruses. Any files found to include a virus shall be quarantined by the producing party and noted in a log to be provided to the receiving party. Password protected or encrypted files or media shall be provided with corresponding passwords and specific decryption instructions. No encryption software shall be used without the written consent of the receiving party.

23. Compliance and Adherence to Generally Accepted Technical Standards

Production shall be in conformance with standards and practices established by the National Institute of Standards and Technology ("NIST" at www.nist.gov), U.S. National Archives & Records Administration ("NARA" at www.archives.gov), American Records Management Association ("ARMA International" at www.arma.org), American National Standards Institute ("ANSI" at www.ansi.org), International Organization for Standardization ("ISO" at www.iso.org), and/or other U.S. Government or professional organizations.

24. Read Me Text File

All deliverables shall include a "read me" text file at the root directory containing: total number of records, total number of images/pages or files, mapping of fields to plainly identify field names, types, lengths, and formats. The file shall also indicate the field name to which images will be linked for viewing, date and time format, and confirmation that the number of files in load files matches the number of files produced.

25. Transmittal Letter to Accompany Deliverables

All deliverables should be accompanied by a transmittal letter including the production date, case name and number, producing party name, and Bates number range produced.

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