ORAL ARGUMENT SCHEDULED FOR OCTOBER 10, 2008
No. 07-5343

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

CONSUMERS' CHECKBOOK, CENTER
FOR THE STUDY OF SERVICES,

Plaintiff-Appellee,

v.

UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES,

Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

AMICI CURIAE BRIEF OF AARP, CENTER FOR MEDICARE ADVOCACY, INC., NATIONAL BUSINESS GROUP ON HEALTH, and PACIFIC BUSINESS GROUP ON HEALTH IN SUPPORT OF PLAINTIFF-APPELLEE

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES and RULE 26.1 DISCLOSURE

Pursuant to Circuit Rule 28(a)(1), undersigned counsel certifies as follows:

A. <u>Parties and *Amici*:</u>

Consumers' Checkbook is plaintiff-appellee in No. 07-5343.

Department of Health and Human Services, Michael O. Leavitt, in his official capacity as Secretary of the Department of Health and Human Services, and Leslie V. Norwalk, in her official capacity as Acting Administrator of the Centers for Medicare and Medicaid Services, are defendants-appellants in No. 07-5343.

American Medical Association is a Movant-Intervenor in No. 07-5343.

AARP, Center for Medicare Advocacy, Inc., National Business Group on Health, and Pacific Business Group on Health are filing a brief *amici curiae* brief supporting affirmance of the decision of the U.S. District Court for the District of Columbia and Plaintiff-Appellee.

Rule 26.1 Disclosure

Pursuant to D.C. Circuit Rule 26.1, *amici curiae* AARP, Center for Medicare Advocacy, Inc., National Business Group on Health, and Pacific Business Group on Health state the following:

AARP is a 501(c)4 nonprofit corporation with no parent companies, and which issues no stock. It has no parent companies or publicly held company that has a 10% or greater ownership interest (such as stock or partnership shares) in the entity. Through a wholly owned subsidiary, AARP Services, Inc., AARP makes available products and services from third party providers to its members. AARP's general purpose is as a membership association with almost forty million

members aged 50 and older dedicated to the needs and interests of mid-life and older persons, including but not limited to access to affordable, high quality health care and economic security.

Center For Medicare Advocacy, Inc. (CMA) is a nonprofit corporation with no parent companies, and which issues no stock. It has no parent companies or publicly held company that has a 10% or greater ownership interest (such as stock or partnership shares) in the entity. CMA's general purpose is to provide education, analytical research, advocacy, and legal assistance to assist people nationwide, primarily the elderly and people with disabilities, to obtain necessary health care.

National Business Group on Health (NBGH) is a nonprofit corporation with no parent companies, and which issues no stock. It has no parent companies or publicly held company that has a 10% or greater ownership interest (such as stock or partnership shares) in the entity. NBGH's general purpose is as a membership organization with large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues.

Pacific Business Group on Health (PBGH) is a nonprofit corporation with no parent companies, and which issues no stock. It has no parent companies or publicly held company that has a 10% or greater ownership interest (such as stock or partnership shares) in the entity. PBGH's general purpose is as a coalition of businesses interested in promoting improvements in health care.

B. <u>Ruling Under Review:</u>

The ruling under review is the United States District Court's August 22, 2007, Order (Sullivan, J.) granting Plaintiff's Motion for Summary Judgment, denying Defendants' Motion for Summary Judgment, and directing Defendants' to release requested records. The

Memorandum Opinion accompanying the Order is reported at *Consumers' Checkbook, Center for Study of Services v. Department of Health & Human Services*, 502 F.Supp.2d 79 (D.D.C. 2007).

C. <u>Related Cases</u>:

The case has not been before this Court or any other Court. We are not aware of any related cases currently pending in this Court or in any other Court.

Dated: June 17, 2008

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GLOSSARY

CMS	Centers for Medicare and Medicaid Services
HHS	U.S. Department of Health and Human Services, and Michael O. Leavitt,in his official capacity as Secretary of the Department of Health and Human Services, and Leslie V. Norwalk, in her official capacity as Acting Administrator of the Centers for Medicare and Medicaid Services

INTEREST OF *AMICI CURIAE*

AARP is a nonprofit, nonpartisan organization with almost forty million members aged 50 and older dedicated to the needs and interests of mid-life and older persons. AARP supports access to affordable, high quality health care and economic security for everyone. To that end, AARP advocates at the state and national level to ensure that individuals have access to quality health care through publicly administered health insurance programs, including Medicare, which serves more than 43 million aged and disabled beneficiaries. As an important means of assuring high quality care for Medicare beneficiaries, AARP encourages measurement, assessment, and public reporting of the performance of participating Medicare providers, including information on individual physicians, hospitals, and health plans. This information can help consumers make more informed health care decisions and help Medicare officials evaluate the quality and efficiency of care provided to program beneficiaries. Because physicians typically treat both Medicare and non-Medicare patients, the most robust information (and therefore the most useful) would come from combining Medicare data on physicians with data collected by private payers.

The Center for Medicare Advocacy, Inc. is a national, private, non-profit organization, founded in 1986, that provides education, analytical research, advocacy, and legal assistance to assist people nationwide, primarily the elderly and people with disabilities, to obtain necessary health care. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training regarding Medicare and health care rights throughout the country, advocates on behalf of beneficiaries in administrative and legislative forums, and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage. To carry out its goals, and to effectuate generally the improvement in the nation's health care system, the Center strongly

supports making information on health systems derived from the Medicare program's database publicly available.

The National Business Group on Health is the national voice of large employers dedicated to finding innovative and forward-thinking solutions to the nation's most important health care issues. The National Business Group on Health is a non-profit organization of about 300 member companies, primarily large employers including almost two-thirds of the Fortune 100, who provide health benefits to about 55 million employees, retirees, and their families. Many member companies provide retiree benefits either through or in coordination with Medicare coverage. As part of its advocacy effort to improve the effectiveness and efficiency of health care, the National Business Group on Health supports making health systems information, including data on individual physicians, institutions, and health plans, publicly available. This information is vital to consumers and purchasers when making informed health care decisions about providers and plans.

The Pacific Business Group on Health (PBGH) is one of the nation's top business coalitions focused on health care. PBGH is a respected voice in the state and national dialogue on how to improve the quality and effectiveness of health care while moderating costs. Partnering with California's and the nation's leading health plans, provider organizations, consumer groups, and other stakeholders, PBGH works on many fronts to promote improvements in health care by measuring provider performance, making reports available to consumers, and encouraging payments that reward better quality. PBGH has a long history of working to improve the Medicare program. PBGH cares about assuring its effectiveness because of the millions of Americans it serves, the billions of dollars spent, and its impact on the overall health care system.

SUMMARY OF ARGUMENT

The U.S. health care system does not provide consistent, high quality medical care to all people. As the most frequent users of the health care system, older persons are especially vulnerable to the effects of poor care. Transparency of health care quality and cost information is a necessary strategy to achieve high quality care because it provides feedback to health care providers to help identify practice areas that need improvement, and allows patients, referring physicians, and health care purchasers to select physicians who perform high quality services.

The current state of publicly reported health care quality and cost information is inadequate with respect to physician-level data. This is particularly true in the Medicare program, which has lagged behind private efforts to make physician-specific health care information more transparent.

Transparency of health care quality and cost information is also essential to improving oversight of the federal government's operations and activities, particularly its use of Medicare funds. As the agency responsible for administering health coverage for more than 43 million Medicare beneficiaries, HHS has the obligation to assure taxpayers and the public that Medicare spends its funds appropriately and efficiently.

Health care transparency can also reduce health care spending. By making information on quality and cost information available to the public and shining a light on the performance of providers, they are likely to respond with improved use of resources and better care. Furthermore, if consumers know the quality and cost of health care services, they are more likely to seek out providers who offer the best value and treatments that most reflect their personal preferences.

ARGUMENT

INTRODUCTION

The current state of publicly reported health care quality and cost information is inadequate with respect to physician-level data. This is particularly true in the Medicare program, which has lagged behind private efforts to make physician-specific health care information more transparent.

Medicare is the nation's largest health insurance program with more than 43 million beneficiaries.[1] *See* CMS, *Medicare Coverage, available at* http://www.cms.hhs.gov /CoverageGenInfo/ (last visited June 16, 2008). The program processes over one billion claims per year. *See* HHS, *HHS: What We Do, available at* http://www.hhs.gov/about/whatwedo.html/ (last visited June 16, 2008). The opportunity to analyze such a large volume of claims would provide invaluable insights into the U.S. healthcare system, especially the quality and efficiency of health care providers in Medicare.

Disclosure of physician-level Medicare claims data is consistent with the current trend toward making health care quality and cost information more transparent and is an important component of quality improvement initiatives.

I. TRANSPARENCY OF HEALTH CARE QUALITY AND COST INFORMATION IMPROVES HEALTH CARE QUALITY.

A. Consistent High Quality Health Care Is Lacking In The U.S.

The U.S. health care system does not provide consistent, high quality medical care to all people. *See* Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* 24 (National Academies Press

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[1] Medicare is a Federal health insurance program that provides comprehensive health insurance to individuals 65 and older, and to those under 65 with certain disabilities. *See* 42 U.S.C. §1395c-1395d, 1395j-1395k (2008). The program is administered by the Centers for Medicare & Medicaid Services ("CMS"), which is a component of the U.S. Department of Health and Human Services ("HHS").

2001)("Institute of Medicine, *Crossing the Quality Chasm*"). It is estimated that U.S. adults receive about half of recommended health care services. *See* Elizabeth A. McGlynn et al., *The Quality of Care Delivered to Adults in the United States*, 348 New Eng. J. Med., 2635, 2635-45 (2003). In addition, tens of thousands of Americans die each year as a result of preventable mistakes in their care. *See To Err is Human: Building a Safer Health System* (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson, eds., 1999).

As the most frequent users of the health care system, older persons are especially vulnerable to the effects of poor care. The quality of care older persons receive varies widely from one condition and type of care to another. *See* RAND Health, *The Quality of Health Care Received by Older Adults* (2004), *available at* http://www.rand.org/pubs/research_briefs/2005/RB9051.pdf ("RAND Health, *The Quality of Health Care Received by Older Adults*"); *see also* News Release, The Commonwealth Fund, *At 40 Years, Medicare a Leader in Ensuring Access to Health Care,* (May 6, 2005), *available at* http://www.commonwealthfund.org/newsroom/newsroom_show.htm?doc_id=275625 (noting that "Medicare is a national program that should guarantee high standards of care throughout the country but right now the quality of American health care is too variable and uneven"). Moreover, care for certain conditions most prevalent in old age, such as incontinence and falls, is even poorer than care for general medical conditions. *See* RAND Health, *The Quality of Health Care Received by Older Adults.*

Quality problems can be characterized as problems of underuse, misuse, and overuse of health care services. For example, many Medicare beneficiaries do not receive treatments whose value is known to be beneficial, such as recommended screenings for colorectal, breast, or cervical cancer, treatment for depression, and control of high blood pressure and high cholesterol. In addition, many beneficiaries suffer complications or acquire infections during

hospital stays that should have been prevented such as ventilator-associated pneumonia, which is associated with high mortality, increased length of a hospital stay and high cost, surgical site infections, or catheter-associated urinary tract infections. *See* Centers for Disease Control and Prevention, *Estimates of Healthcare-Related Infections* 47, 76, *available at* http://www .cdc.gov/ncidod/dhqp/hai.html (last visited June 16, 2008). For example, in American hospitals, health care associated infections account for 1.7 million infections and 99,000 associated deaths each year. *Id.*

B. Transparency of Health Care Quality and Cost Information Encourages Providers and Health Plans To Deliver Higher Quality Care.

Transparency of health care quality and cost information is a necessary strategy to achieve high quality care. *See* Institute of Medicine, *Crossing the Quality Chasm.* Public reporting of quality information improves quality primarily in two ways. First, public reporting provides feedback to health care providers that helps identify areas of their practice needing improvement. *See* John M. Colmers, The Commonwealth Fund, *Public Reporting and Transparency* 5 (2007), *available at* http://www.commonwealthfund.org/usr_doc/Colmers _pubreportingtransparency_988.pdf?section=4039 ("Colmers, *Public Reporting and Transparency*"). There is evidence that entities whose data is publicly reported have higher quality. *See generally* National Committee for Quality Assurance, *The State of Health Care Quality 2007*(2007), *available at* http://www.ncqa.org/Portals/0/Publications/Resource% 20Library/SOHC/SOHC_07.pdf. Second, public reporting of quality information allows patients, referring physicians, and health care purchasers to select physicians who perform high quality services, thereby incenting better performance with a higher volume of patients. Physicians should be expected to use information on performance to make referrals to the most effective and efficient providers. *See* Colmers, *Public Reporting and Transparency* at 5.

Making quality information public will increase health care providers' motivation to improve. *See* Judith H. Hibbard, Jean Stockard, & Martin Tusler, *Does Publicizing Hospital Performance Stimulate Improvement Efforts?*, 22(2) Health Affairs 84, 84 (2003), *available at* http://content.healthaffairs.org/cgi/reprint/22/2/84 ("Hibbard, *Does Publicizing Hospital Performance Stimulate Improvement Efforts"*); *see also* Katherine K. Shea, Anthony Shih, & Karen Davis, The Commonwealth Fund, *Health Care Opinion Leaders' Views on the Transparency of Health Care Quality and Price Information in the United States* 2, 5 (2007) (noting that greater transparency can stimulate providers' performance)("Shea et al., *Health Care Opinion Leaders' Views*"). Public reporting of performance information also stimulates quality improvement among hospitals with reported areas of low performance. *See* Hibbard, *Does Publicizing Hospital Performance Stimulate Improvement Efforts?* Furthermore, making this information public stimulates long-term improvements that go beyond the smaller-scale impact of internal quality reports. *See* Judith H. Hibbard, Jean Stockard, & Martin Tusler, *Hospital Performance Reports: Impact on Quality, Market Share, and Reputation*, 24(4) Health Affairs 1150, 1158 (2005), *available at* http://content.healthaffairs.org/cgi/reprint/24/4/1150.

In response to the increasing demand for disclosure and accountability, numerous private and public entities have been collecting and releasing comparative data on hospitals, health plans, and individual physicians. This information is typically compiled and presented as a "health care report card."[2] RAND Health, *Report Cards for Health Care,*

[2] The National Committee for Quality Assurance, National Quality Forum, Pacific Business Group on Health, Leapfrog Group, and HealthGrades publicly report provider performance information. *See* National Committee for Quality Assurance, *Report Cards* (2008), http://www.ncqa.org/tabid/60/Default.aspx; National Quality Forum (2008), http://www.qualityforum.org/; Pacific Business Group on Health, *California HMO Report Card: Promoting Standardized Health Plan Quality Information* (2000), http://www.pbgh.org/programs/hmo_report_card.asp; The Leapfrog Group, *Leapfrog Hospital Quality*

http://www.rand.org/pubs/research_briefs/RB4544/index1.html ("RAND Health, *Report Cards for Health Care*"). The purpose of the health care report card is to provide comparative information on provider performance. *See* Martin N. Marshall et al, *Public Reporting on Quality in the United States and The United Kingdom*, 22(3) Health Affairs 134, 136 (2003). The data elements in such report cards vary by the unit of analysis (e.g., physician or hospital) and type of information presented, such as accreditation status of an individual or entity; reports from patients on their experiences with care (e.g., in a hospital or health plan); and results of performance as measured by clinical process and outcome indicators. *See* RAND Health, *Report Cards for Health Care.* Public reporting of individual physicians or physician groups' performance is not yet as common as hospital or health plan reports. *See* Colmers, *Public Reporting and Transparency at* 6. Therefore, disclosure of the requested Medicare claims data will significantly advance and enhance the scope of report cards describing services provided to Medicare beneficiaries at the level of analysis that is most salient to patients—the physician level.

C. Transparency Allows Consumers To Make More Informed Decisions About Their Health Care.

Transparency of health care quality and cost information helps consumers to make informed decisions when selecting a physician, health plan, or hospital, or when choosing among alternative treatments. Ninety-five percent of Americans believe that having information about the quality of health care provided by physicians or hospitals is important, while ninety-one percent think that having cost information about care prior to receiving care is important. *See* Shea et al., *Health Care Opinion Leaders' Views.* Yet, patients report they rarely have quality

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and Safety Survey Results (2007), http://www.leapfroggroup.org/cp; HealthGrades (2008), http://www.healthgrades.com/.

and cost information available to them. *See* Sara R. Collins & Karen Davis, *Transparency in Health Care: The Time Has Come*, The Commonwealth Fund 7 (2006), *available at* http://www.commonwealthfund.org/usr_doc/TransparencyTestimony_Collins_3-15-06.pdf?section=4039; *see also* The Henry J. Kaiser Family Foundation, Agency for Healthcare Research and Quality & Harvard School of Public Health, *National Survey on Consumers' Experiences With Patient Safety and Quality Information* 5 (2004), *available at* http://www.kff.org/kaiserpolls/7209.cfm (noting that respondents would find information about a physicians' experience with a particular procedure useful when comparing doctors).

Consumers of health care services need information to help them at various points of interaction with the health system, from the time they choose a health care plan, to the time they choose a provider for a specific service. *See* Colmers, *Public Reporting and Transparency* at 4; *see also* AARP Public Policy Institute, *Decision-Making in Consumer-Directed Health Plans* i, iv-vi, 2-13 (2003), *available at* http://assets.aarp.org/rgcenter/health/2003_05_cdp.pdf. One of the most powerful forces driving improvement in health care is the informed consumer. *See* National Committee on Quality Assurance, *The Basics: Public Reporting*, *available at* http://www.ncqa.org/tabid/442/Default.aspx (last visited June 16, 2008). Consumers who make informed choices, and who are engaged in their own health care, experience better health outcomes. *Id.*

D. Transparency Leads To Improved Oversight.

Transparency of health care quality and cost information is essential to improving oversight of the federal government's operations and activities, particularly its use of Medicare funds. As the agency responsible for administering health coverage for more than 43 million Medicare beneficiaries, HHS and CMS, which directly oversees the Medicare program, have the

obligation to assure taxpayers and the general public that Medicare funds are spent appropriately, efficiently, and in furtherance of the goal "to continually reduce the burden of illness, injury, and disability, and to improve the health of the people of the United States." *See* Institute of Medicine, *Crossing the Quality Chasm* at 39, 166 (quoting President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Final Report* (1998), *available at* http://www.hcqualitycommission.gov/final/execsum.html).

To this end, transparency of the requested Medicare claims data will show the volume of certain medical and surgical procedures that Medicare physicians perform. This information is important because the volume of particular procedures performed by a particular provider is an important indicator of better health outcomes. *See* John D. Birkmeyer et al., *Surgeon Volume and Operative Mortality in the United States*, 349 New Eng. J. Med. 2117, 2117-2127 (2003); Ethan A. Halm, Clara Lee & Mark R. Chassin, *Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature*, 137 Ann. Internal Med., 511, 511-520 (2002); H.S. Luft, J.P. Bunker & A.C. Enthoven. *Should Operations be Regionalized? The Empirical Relation between Surgical Volume and Mortality,* 301 New Eng. J. Med. 1364, 1364-1369 (1979). In addition, the requested data can be compared with publicly available board certification records, disciplinary records, or independent quality assessments, to ascertain whether physicians with insufficient certifications, disciplinary histories, or poor scores on evaluations perform a large number of surgical or medical procedures. *See* Br. of Plaintiff-Appellee at 23. Unless the individual physician practices are publicly identified, consumers cannot make truly informed decisions with respect to choosing the best doctors to meet their personal needs and preferences.

Greater transparency of Medicare physician information is particularly important at a time when Medicare is striving to respond to known quality deficiencies by publishing more information on participating providers. *See* HHS, *Pilot Programs*, http://www.hhs.gov/valuedriven/pilot/index.html. The oversight system must address quality problems in a wide array of health care settings, such as physician offices, hospitals, skilled nursing facilities, and home health, when the system is severely under funded. *See* Bruce C. Vladeck & Barbara S. Cooper, *Making Medicare Work Better*, Institute for Medicare Practice 14 (2001), *available at* http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13600. Although Medicare has made some progress in expanding the availability of information about quality, physician-specific information demonstrating their practice patterns is sorely needed but still lacking.

II. TRANSPARENCY OF HEALTH CARE QUALITY AND COST INFORMATION REDUCES HEALTH CARE SPENDING.

A. U.S. Health Care Spending is the Highest in the World.

Per capita health care spending in the U.S. is the highest in the world, and only continues to increase. In 2006, health care spending in the U.S. increased 6.7 percent to $2.1 trillion, or $7,026 per person. *See* National Health Statistics Group, CMS *National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960-2006, available at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf (last checked June 16, 2008) ("CMS, *National Health Expenditures Aggregate*"). Health care spending is projected to reach $4.2 trillion by 2017. Office of the Actuary, CMS, *National Health Expenditure Projections 2007-2017, available at* http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf (last

checked June 16, 2008). In 2006, health care represented 16 percent of the gross domestic product, and this figure is expected to reach 20 percent within a decade. *Id.*

B. Medicare Spending is a Large Component of the Federal Budget and National Health Care Spending.

The Medicare program is a large component of the federal budget and national health care spending. *See* The Henry J. Kaiser Family Foundation, *Medicare Spending and Financing* (2007), *available at* http://www.kff.org/medicare/upload/7305-02.pdf. In 2006, Medicare spending accounted for 12% of the federal budget. *Id.* And, spending on Medicare benefits was 20% of the nation's total health care spending. *Id.* Annual growth in Medicare spending is largely influenced by the same factors that affect health spending in general: increasing prices of health care services, increasing volume and utilization of services, and expensive new technologies. *Id.* In 2006, the program spent $401.3 billion — an 18.7 percent increase from the previous year. *See* CMS, *National Health Expenditures Aggregate* at Table 3. This increase in spending represents the fastest rate of growth in Medicare since 1981. *Id*; *see also* Aaron Catlin et al., *National Health Spending in 2006: A Year of Change for Prescription Drugs*, 27(1) Health Affairs 14, 23 (2008), *available at* http://content.healthaffairs.org/cgi/reprint/27/1/14. Of the $401.3 billion spent on Medicare in 2006, $92 billion was spent on physician and clinical services alone. *See* CMS, *National Health Expenditures Aggregate* at Table 11.

C. Transparency of Health Care Quality and Cost Information Reduces Health Care Spending.

As U.S. health care costs continue to rise, there is an urgency to find ways to contain costs by curtailing the rate of growth in spending. Health care transparency is one means of fostering improvement in care delivery. By making information on quality and cost information

available to the public and shining a light on providers' performance, providers are likely to respond with improved use of resources and better care.

Furthermore, if consumers know the cost and quality of health care services, they are more likely to seek out providers who offer the best value and treatments that most reflect their personal preferences. *See generally* Congressional Budget Office, *Increasing Transparency in the Pricing of Health Care Services and Pharmaceuticals* (2008), *available at* http://www.cbo.gov/ftpdocs/92xx/doc9284/06-05-PriceTransparency.pdf. In other words, better information on costs coupled with information on quality will lead consumers to use health care more efficiently. *Id.* Transparent, public information not only encourages consumers to consider quality and cost-effectiveness in their health care decisions, but also guides effort to improve outcomes and slow the rise of health care costs. *See* Consumer-Purchaser Disclosure Project, *Ensuring High Quality, Affordable Health Care* (2007), *available at* http://healthcaredisclosure.org/docs/files/DisclosureFactSheetsAllCombined10-10-07.pdf.

III. HHS' REFUSAL TO RELEASE MEDICARE CLAIMS DATA FLOUTS AN EXECUTIVE ORDER AND HHS' VALUE-DRIVEN HEALTH CARE INITIATIVE.

CMS' refusal to release the data requested in this case is contrary to Executive Order 13410, issued on August 22, 2006, directing federal agencies, including HHS, to provide health care quality and cost information to consumers.[3] The purpose of the Order is "to ensure that health care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through…transparency regarding health care quality and price." *See* Exec, Order 13,410, 3 C.F.R. at 240 (2007). "It is further the purpose of this order to make relevant information available to these beneficiaries, enrollees, and providers in a readily useable

[3] Exec. Order 13,410, 3 C.F.R. 240-42 (2007).

manner and in collaboration with similar initiatives in the private and non-Federal public sector." *Id.*

In addition, CMS' refusal to release the data at issue here is contrary to HHS' Value Driven Health Care Initiative. Notwithstanding its position in this case, HHS states that it has made transparency of health care quality and cost information a top priority. According to HHS, "transparency is a broad-scale initiative enabling consumers to compare the quality and price of health care services, so they can make informed choices among doctors and hospitals." *See* HHS, *Value-Driven Health Care*, http://www.hhs.gov/valuedriven/ (last visited June 16, 2008)("HHS, *Value-Driven Health Care*"). In furtherance of this goal, HHS launched the Value-Driven Health Care Initiative, and created an entire website dedicated to making health care quality and cost information more transparent. *Id.* The goal of HHS' initiative is to provide consumers with easy-to-use information about the quality and cost of their health care to enable them to make informed choices among physicians and hospitals. CMS has made comparative quality and cost information about health plans, nursing homes, and hospitals publicly available. *See* HHS, *Medicare*, http://www.medicare.gov (last visited June 16, 2008); *see also* CMS, *Hospital Compare*, http://www.cms.hhs.gov/hospitalqualityinits/25_hospitalcompare.asp (last visited June 16, 2008). However, the public cannot access quality and cost information with respect to individual physicians.

Of the initiative, HHS Secretary, Michael O. Leavitt, has said "Every American should have access to a full range of information about the quality and cost of their health care options." *See* Michael O. Leavitt, HHS, *Better Care, Lower Costs. You deserve to know...Health Care Transparency, available at* http://www.senate.mo.gov/06info/comm/interim/need/ Probst booklet.pdf (last visited June 16, 2008). On its website, HHS has touted the need for various

health care stakeholders, both public and private, to collaborate in making health care quality and cost information more transparent. *See* HHS, *Value-Driven Health Care.* HHS has also frequently acknowledged the importance and value of Medicare claims data for measuring physician quality. *Id.*

On the Value-Driven website, HHS highlights six pilot programs that are serving as demonstration sites to pioneer the pooling of private data with Medicare claims data. The goal is to produce "more accurate, comprehensive measures of quality of services at the provider level." *See* HHS, *Pilot Programs*, http://www.hhs.gov/valuedriven/pilot/index.html (last visited June 16, 2008). The results, in part, are to provide Medicare beneficiaries with performance information that would allow them to make more informed choices in obtaining Medicare covered services. *Id.* A careful review of the different initiatives on their respective websites[4] shows that quality and cost information is available for various providers, including health plans, hospitals, and physician groups. However, the initiatives do not provide information about individual physicians. Therefore, if a Medicare beneficiary were seeking a physician to perform a high-risk Coronary Artery Bypass Graft ("CABG") or knee surgery, he or she would not be able to obtain Medicare-specific information about various individual physicians' experience in performing these procedures (although such data is available for CABG, in certain states).[5]

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[4] *See* California Cooperative Healthcare Reporting Initiative, San Francisco, CA at http://www.cchri.org/; Indiana Health Information Exchange, Indianapolis, IN at http://www.ihie.com/; Massachusetts Health Quality Partners, Boston, MA at http://www.mhqp.org/default.asp?nav=010000; Minnesota Community Measurement, Minneapolis, MN at http://www.mnhealthcare.org/~main.cfm; Arizona State University - Center for Health Information & Research, Tempe, Arizona at http://chir.asu.edu/; Wisconsin Collaborative for Healthcare Quality, Madison, WI at http://www.wchq.org/.

[5] New York State reports severity-adjusted mortality rates for CABG surgery by hospital and surgeon; PA reports risk-adjusted CABG mortality rates for surgeons, hospitals, and certain health insurance plans; MA and MN report quality measures for CABG at the medical group level. *See* Colmers, *Public Reporting and Transparency* at 6; CA reports CABG mortality rates for hospitals. *See* Pacific Business

Without physician-specific information, beneficiaries are unable to assess how experienced a particular physician is in performing medical and surgical procedures.

In its brief, HHS states that "While plaintiff seeks to post the number of times a particular provider has performed a particular service under Medicare, the quality measures initiated by HHS generate more valid, specific and comprehensive information on the quality of care delivered." *See* Brief of Defendant-Appellant at 39. However, HHS fails to explain how consumers can determine performance at the individual doctor level from the quality measures it references or whether its efforts would inform consumers seeking out physicians to perform certain high-risk procedures about the experience of particular physicians. The brief goes on to state "HHS is pursuing initiatives which would provide comprehensive information comparing the quality and price of health care services so that consumers can make informed choices among doctors, hospitals, and other health care providers." *Id* at 39-40. Again, HHS fails to explain how this "comprehensive information" will provide the type of information Consumers' Checkbook wants to make publicly available—information that consumers can use to assess individual physicians' experience with various high-risk procedures.

Checkbook's efforts here are entirely consistent with HHS' Initiative, and would produce information invaluable to improving health care quality and efficiency. To achieve its stated objectives, CMS must release the requested data.

CONCLUSION

For the forgoing reasons, *Amici* AARP, Center for Medicare Advocacy, Inc., National Business Group on Health, and the Pacific Business Group on Health urge the Court to affirm

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Group on Health, *California Hospital CABG Mortality Reporting Program, available at* http://www.pbhg.org/programs/cabg/default.asp (last visited June 12, 2008).

the U.S. District Court's Order for HHS/CMS to provide the information requested by Plaintiff-Appellee Consumers' Checkbook.

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)(7)(C)

I hereby certify that the foregoing *Amici Curiae* Brief in support of Plaintiff-Appellee Consumers' Checkbook, Center for the Study of Services complies with the type-volume limitations of Fed. R. App. Pro. 32(a)(7)(C). The brief contains 4476 words according to the word processing software used to produce it.

Dated: June 17, 2008

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CERTIFICATE OF SERVICE

I hereby certify that, on this 17th day of June, 2008, I served two copies of the *Amici Curiae* Brief in support of Plaintiff-Appellee Consumers' Checkbook, Center for the Study of Services, via Federal Express and electronic mail upon counsel at the addresses below:

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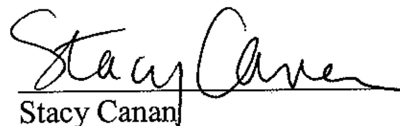

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