IN THE SUPREME COURT OF PENNSYLVANIA

No. 45 EAP 2014

JAMES EISEMAN, JR. and THE PUBLIC INTEREST LAW CENTER OF PHILADELPHIA,

Appellants,

v.

DENTAL BENEFIT PROVIDERS, INC., UNITEDHEALTHCARE OF PENNSYLVANIA, INC. d/b/a UNITEDHEALTHCARE COMMUNITY PLAN, and HEALTHAMERICA PENNSYLVANIA, INC., d/b/a COVENTRYCARES,

Appellees.

BRIEF OF *AMICUS CURIAE* PROFESSOR DANIEL POLSKY, PH.D. IN SUPPORT OF APPELLANTS

On Appeal from the Order of the Commonwealth Court in Case No. 1935 C.D. 2012, Affirming in Part and Reversing in Part the Final Determination of the Office of Open Records in No. AP 2011-1098 (*Eiseman I*)

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Statement of Interest of *Amicus Curiae*

Amicus is the Executive Director of the University of Pennsylvania's Leonard Davis Institute of Health Economics and a professor of Medicine in the Perelman School of Medicine and the Robert D. Eilers Professor of Health Care Management in the Wharton School at the University of Pennsylvania.[1] His sole interest in this case is to improve the functioning of the health care system and the availability of the negotiated rate data that would become available under Pennsylvania's Right-to-Know Law if this Court reverses the Commonwealth Court's Order is critical in that regard.

Daniel Polsky, Ph.D., has been on the faculty at University of Pennsylvania since 1996. He currently serves on the Congressional Budget Office's Panel of Health Advisers and the Institute of Medicine's Board on Population Health. He was the Senior Economist on health issues at the President's Council of Economic Advisers in 2007-08. He received a Ph.D. in Economics from the University of Pennsylvania in May 1996 and a Master of Public Policy from the University of Michigan in 1989. He was co-author on AcademyHealth's Article of the Year in 2014 and he received the Samuel Martin Health Evaluation Sciences Research Award in 2005. His research areas include access to health care, workforce, and economic evaluation of medical and behavioral health interventions.

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[1] Dr. Polsky's curriculum vitae is attached as Exhibit A.

Introduction

The Commonwealth of Pennsylvania faces an urgent need to improve the quality of the health care system. Information is a necessary asset to meet this goal,[2] and data demonstrating the amount of Medicaid funds that actually reach providers to care for patients is especially vital. Greater transparency in the Medicaid program will drive improvement in the delivery of high-quality care by providing a window into the efficacy of the Medicaid program and the quality of care delivered to Medicaid beneficiaries. Wider availability of the rates negotiated and paid by Manage Care Organizations ("MCOs") and subcontractors to providers (collectively, "negotiated rate data") has the potential to dramatically advance the quality and the efficiency of health care by providing researchers and policy makers with a more complete view of Medicaid. Critically, it will help identify important gaps of treatment by physician specialty.

The state of publicly reported Medicaid data with respect to negotiated rates is inadequate to fully assess and improve the Medicaid program, and lags behind federal and private efforts to make health care information more transparent. The current trend is toward making health care quality and cost information more transparent because that information is an important component of quality

[2] *See, e.g.*, Office of Management and Budget (OMB), Memorandum 13-13, *Open Data Policy, Managing Data as an Asset*, May 9, 2013 (available at http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-13.pdf).

improvement initiatives.[3] There is wide acceptance among health care economists that releasing this type of data is necessary to support the data-driven decision making required to improve the health care system. The federal government has also recognized that access to data from state Medicaid programs will provide a fuller picture of care and help improve the health care system.[4] Nevertheless, the influence that provider rates have on the quality and scope of services provided through Medicaid remains largely unexamined.

Transparency of negotiated rate data is also essential for collaboration between researchers and policy makers to improve the delivery of health care to Medicaid recipients in the Commonwealth. Medicaid is a large and important program. Researchers, policy makers, and the Commonwealth have a shared interest in Medicaid providing the highest quality health care in an efficient

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[3] *See, e.g.*, Health and Human Services, *Open Government Plan* (available at http://www.hhs.gov/open/plan/opengovernmentplan/index.html); Centers for Medicare and Medicaid Services, *Medicare Provider Utilization and Payment Data: Physician and Other Supplier*, (available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html).

[4] *See* Niall Brennan, Patrick H. Conway, Marilyn Tavenner, *The Medicare Physician-Data Release – Context and Rationale*, N Engl J Med 2014; 371:99-101, July 10, 2010 ("We agree that the value of these data would be enhanced with the inclusion of claims data from other sources, and we would welcome a dialogue about how … state Medicaid programs … could contribute their own provider-level utilization information in order to build a fuller picture of care.") (available at http://www.nejm.org/doi/full/10.1056/NEJMp1405026?viewType=Print&viewClass=Print#ref2).

manner. The denial of access to negotiated rate data prevents researchers from bringing their expertise to the table and fully examining all options to ensure Medicaid operates in the public interest.

Argument

I. Access to Negotiated Rate Data Is Critical to Evaluating Pennsylvania's Health Care System

A proper understanding of negotiated rates paid to health care providers is critical to evaluating the costs and benefits of Pennsylvania's Medicaid program. The levels of Medicaid rates are an important factor in determining health care providers' willingness to treat Medicaid patients and the scope of engagement with the Medicaid population within a medical practice.[5] Medicaid rates that are

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[5] *See, e.g.*, Adam Wilk and David Jones, *To Extend or Not Extend the Primary Care "Fee Bump" in Medicaid*, J. of Health Politics, Policy and Law, 39, No. 6: 1263-1275 (2014); Stephen Zuckerman, and Dana Goin, *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured (2012) (available at www.kff.org/medicaid/8398.cfm); Steve Berman, Judith Dolins, Suk-fong Tang, and Beth Yudkowsky, *Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients*, Pediatrics 110, No. 2: 239-48 (2002); Andrew Coburn, Stephen Long, and Susan Marquis, *Effects of Changing Medicaid Fees on Physician Participation and Enrollee Access*, Inquiry 36, No. 3:265-79 (1999); Janet Perloff, Phillip Kletke, James Fossett, and Steven Banks, *Medicaid Participation among Urban Primary Care Physicians*, Medical Care 35, No. 2: 142-5 (1997); Mahmud Hasan, Janet Bronstein and Victoria Johnson, *Office Practice Volume Differential among Medicaid Participants*, Journal of Economics and Finance, 20:67-75 (1997); Janet Perloff, Phillip Kletke, and James Fossett, *Which Physicians Limit Their Medicaid Participation, and Why*, Health Services Research 30, No. 1: 7-26 (1995).

significantly lower than rates paid to treat privately insured patients discourage health care providers from treating Medicaid recipients, which restricts Medicaid patients' access to health care. Conversely, Medicaid rates that are on par with rates paid to treat privately insureds patient increase the willingness of health care providers to treat Medicaid patients and would expand Medicaid recipients' access to health care.

Indeed, the Pennsylvania Department of Public Welfare ("DPW") itself has recognized that low fees are hindering Medicaid beneficiaries' access to health care.[6] The lack of access to the negotiated rate data prevents a full exploration of the relationship between fees and access. Most importantly, the specificity of this information could help identify important gaps by specialty of the physician. This is critical to better understanding and addressing disparities in health care cost, quality, and outcomes.

The availability of negotiated rates can also improve research addressing the quality of care for Medicaid beneficiaries. For one, access is tied to quality and the assessment of access issues as described above can help identify potential areas

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[6] *See Healthy PA 1115 Waiver Application*, 11, Feb. 19, 2014, ("Pennsylvania Medicaid provides payment rates for some services that are lower than Medicare or private market payers, causing some providers to forego participation in the program.") (*available at* http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_071204.pdf).

where Medicaid quality is insufficient. Also, MCOs often utilize the capitation payment system where a physician group is paid a fixed amount for each enrolled patient for a fixed period of time, regardless of whether that patient seeks care. The evidence on capitated payment rates suggest that quality of care under this system is related to the payment rates.[7] Research could reveal payment levels that would maximize the quality of care provided in the capitated payment system. Finally, future experimentation with alternative payment models could be evaluated for cost and quality if the information was available for analysis.[8]

A. Public Access to the Negotiated Rate Data Will Improve Policy Making and Create Important New Research Opportunities

Sufficient information is a requirement for sound policy making. Recent research has found that the lack of access to negotiated rate data prevents fully informed policy decisions regarding state Medicaid spending.[9] Where Medicaid benefits are administered largely or entirely through MCOs, researchers and policy makers would benefit from access to negotiated rate data because the fees passed

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[7] *See, e.g.*, Goodson, et. al, The Future of Capitation: The Physician Role in Managing Change in Practice, J Gen Intern Med., Apr. 2001; 16(4): 250–256 (2001).

[8] Eric Hammelman, et al., *Reforming Physician Payments: Lessons for California*, California Healthcare Foundation (2009) (available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20ReformingPhysicianPaymentsLessonsFromCA.pdf).

[9] *Wilk*, footnote 6, supra.

through managed care organization may not actually reach primary care physicians.[10] Thus, the Commonwealth may increase fees in an attempt to improve health care quality, but see those efforts thwarted by MCOs and subcontractors that do not pass the fee increase to providers.

Data that sets forth the negotiated rates paid will provide the empirical basis for analyses of Medicaid's performance. A lack of access to data has rendered several other important areas of research unexplored. For example, it is not known whether those providers that get higher rates for their services are higher quality providers or are providers that are more limited in supply. Variation in rates has strong economic foundations in economic theory and research. It is important to explore whether variations observed in the Commonwealth's Medicaid program fits this rationale. If the variation does not fit existing economic models, research may develop better economic models or, more likely, research could identify a more rationalized reimbursement system (*i.e.*, a system that rewards providers based on the quality and efficiency of health care service provided).

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[10] *Id.*

B. Access to Negotiated Rate Data Will Encourage Government Collaboration and Accountability.

Government should be collaborative and engage citizens in its work.[11] Collaboration improves the effectiveness of government by encouraging partnerships between the government, the public, and private institutions.[12] Releasing negotiated rate data will help researchers and policy makers better understand Medicaid operations and how well it performs. This understanding will allow these stakeholders to contribute ideas and expertise so that the Commonwealth can make decisions necessary to improve the functioning of the health care system.

The Commonwealth should also be held accountable for its operation of Medicaid. Transparency is essential to government oversight and accountability because it provides information for citizens about what their Government is doing.[13] But transparency in and of itself is not the end goal; it is a necessary step

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[11] *See* Memorandum to the Heads of Executive Departments and Agencies: *Transparency and Open Government* (available at http://www.whitehouse.gov/the_press_office/Transparency_and_Open_Government/).

[12] *See* Office of Management and Budget (OMB), Memorandum 10-06, *Open Government Directive*, Dec. 8, 2009 (available at http://www.whitehouse.gov/sites/default/files/omb/assets/memoranda_2010/m10-06.pdf).

[13] *See* Memorandum to the Heads of Executive Departments and Agencies: *Transparency and Open Government* (available at

toward the interrelated objective of improving healthcare quality. Examination of this data will help hold DPW and elected officials to account for how that money is spent and how the program is performing.

C. Examining the Influence of Amounts Paid to Providers Will Improve the Medicaid Program

The Medicaid program was created to provide necessary medical care to low-income Americans, particularly children. The public interest in knowing the financial incentives provided to physicians through Medicaid rates outweighs any concerns health care providers may have about the release of negotiated rate data. Making the negotiated rates publically known should help deter MCOs, subcontractors, and providers from providing or withholding services in order to benefit financially, and could deter providers from becoming involved in improper practices.

Medicaid reimbursements should reward physicians for providing quality care in an efficient manner. Making the fees paid publically available will help ensure that rates are being paid based on quality and efficiency of care rather than other facts such as a provider's negotiating power. Analyzing negotiated rate data, and thereafter establishing a rational basis for setting provider rates will serve to

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http://www.whitehouse.gov/the_press_office/Transparency_and_Open_Government/).

improve how Medicaid operates and further its purpose of ensuring low-income Pennsylvanians receive quality health care.

D. The Federal Government Provides Access to Analogous Medicaid Data

In April 2014, the federal government released data on services and procedures provided to Medicare beneficiaries by physicians and other health care professionals.[14] The data also shows payment and submitted charges for those services and procedures by provider. The data release was "unprecedented in its size and scope: it included nearly 10 million records accounting for more than $77 billion in Medicare payments. The data have been downloaded or accessed more than 300,000 times from the CMS website since their release."[15] Health and Human Services Secretary Kathleen Sebelius recognized that "[t]he release of these data sets furthers the administration's efforts to increase transparency and support data-driven decision making which is essential for health care transformation[.]"[16] The release of federal Medicare data has the promise to lead

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[14] Niall Brennan, Patrick H. Conway, Marilyn Tavenner, *The Medicare Physician-Data Release – Context and Rationale*, N Engl J Med 2014; 371:99-101, July 10, 2010 (available at http://www.nejm.org/doi/full/10.1056/NEJMp1405026?viewType=Print&viewClass=Print#ref2).

[15] *Id.*

[16] Health and Human Services, HHS Releases New Data and Tools to Increase Transparency on Hospital Utilization and Other Trends, June 2, 2014 (available at http://www.hhs.gov/news/press/2014pres/06/20140602a.html).

to a new wave of research and analysis.[17] Release of the Pennsylvania Medicaid provider rate data will provide similar research opportunities.

Conclusion

For the forgoing reasons, *Amicus* respectfully requests that this Court reverse the Commonwealth Court's Order and direct that the information requested by Plaintiff-Appellant be provided.

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[17] Media outlets have already begun examining this data. *See, e.g.,* Julie Creswell, Sheri Fink and Sarah Cohen, *Hospital Charges Surge for Common Ailments, Data Shows*, N.Y Times, June 3, 2014, at B1; Reed Abelson and Sarah Cohen, *Sliver of Doctors Get Big Share of Payouts*, N.Y. Times, April 9, 2014, at A1. The Wall Street Journal provides a searchable online database by provider, name, specialty, and location. http://projects.wsj.com/medicarebilling/.

CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the 14,000 word limit established by Pa. R.A.P. 2135.

CERTIFICATE OF SERVICE

I, Nicholas Urban, hereby certify that on this day a copy of my *Amicus Curiae* Professor Daniel Polsky, Ph.D. was sent via first class mail to:

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