APPENDIX

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,

Plaintiffs,

v.

99mmH-mcr
Case No. 78-178-Civ-J-S

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,

Defendants,

DOW JONES & COMPANY, INC.

Intervening Defendant.
_____/

DOW JONES & COMPANY, INC.'S MOTION TO INTERVENE

Dow Jones & Company, Inc. ("Dow Jones"), publisher of *The Wall Street Journal* (the "*Journal*"), respectfully moves to intervene, pursuant to Rule 24 of the Federal Rules of Civil Procedure, to vacate a permanent injunction issued by this Court in *Florida Medical Association v. HEW*, 479 F. Supp. 1291 (M.D. Fla. 1979). This Motion is based on the following Memorandum and the Declarations of Michael Allen ("Allen Decl."), Maurice Tamman ("Tamman Decl.") and Mark Schoofs ("Schoofs Decl.").[1]

MEMORANDUM OF POINTS AND AUTHORITIES

Over three decades ago, this Court entered an injunction that still serves as a nation-wide gag order, severely limiting access to essential information about one of the most important and expensive government programs – Medicare. *Florida Med. Ass'n*, 479 F. Supp.

[1] Dow Jones's proposed Answer with Crossclaims and Counterclaim is attached as Exhibit A. The Allen, Tamman, and Schoofs Declarations are attached as Exhibits B, C, and D.

at 1311 (the "1979 Injunction"). In 1979, the plaintiffs in this action, including the American Medical Association ("AMA"), successfully petitioned this Court to prohibit the government from disclosing the amount of taxpayer dollars individual doctors receive from Medicare reimbursements. Leaving aside whether it was ever legally justifiable, the 1979 Injunction is now glaringly outdated, based on a legal and factual landscape that bears virtually no resemblance to the present day. Nonetheless, since 1979, the government (now in the form of the Centers for Medicare & Medicaid Services ("CMS")) has closely guarded and withheld from public view multiple databases that are widely considered the best source of information about the disposition of Medicare funds that comprise one-eighth of the total federal budget. One of the databases, the Carrier Standard Analytic File (the "Carrier File"), is an enormous database of all fee-for-service Medicare Part B claims in the United States. The Carrier File, unique because it contains information about the direct billings of and reimbursements to individual providers, is a key tool for identifying Medicare abuse.[2]

When the *Journal* embarked on a landmark project last year to investigate Medicare fraud and the American healthcare system, the newspaper teamed up with a non-profit group and attempted to obtain key Medicare data. After a Freedom of Information Act ("FOIA") request that CMS denied, an ensuing FOIA lawsuit, a protracted settlement, and payment by Dow Jones of several thousands of dollars, the *Journal* finally obtained access to a limited set of Medicare data subject to materially restrictive terms. That data, along with over six months of intensive investigative reporting and several additional requests for information, resulted in last year's groundbreaking *Journal* series, *Secrets of the System* (the "Series").

[2] CMS is an agency of the Department of Health and Human Services ("HHS"), the renamed Department of Health, Education and Welfare ("HEW").

The Series exposed suspicious billing activity by some doctors and reimbursement patterns carrying strong indicia of fraud. It also raised questions as to whether the government is effectively mining the data at its disposal to prevent improper Medicare billing, and whether regulatory loopholes and other economic incentives encourage some doctors to disregard their patient's best interests and instead pursue unnecessary or high-cost procedures.

The Series introduced *Journal* readers to a family-practice doctor who pocketed more than $2 million from Medicare in 2008 by charging for an improbable number of obscure medical tests, and an internal medicine doctor who received more than $8.1 million from Medicare over three years while treating a suspiciously high percentage of patients with an extremely rare nerve and muscle condition. The *Journal* also explained that some of the nation's leading urologists are funneling prostate cancer patients toward a treatment that earns the doctors the highest reimbursement, while some spine surgeons are receiving large sums of money from medical device makers as the hospitals where they work receive significant amounts of Medicare money for controversial surgeries using those same devices.

But almost as telling as what the Series revealed was what was missing. *First*, based on the 1979 Injunction, CMS agreed to disclose only a random 5% sample of the Carrier File. Because the sample contained 5% of patients, not providers, the *Journal* could not determine what percentage of any given provider's patients was contained in the sample. The *Journal* thus was left with a statistically incomplete portrait that only identified extreme outliers. Even with this limited subset of information, the *Journal* still managed to identify doctors in the Series who have highly suspicious billing patterns, as well as several other doctors engaging in extremely questionable practices who were not included in the Series because of

limitations imposed by or arising out of the 1979 Injunction. If allowed unrestricted use of the Medicare data, including the Carrier File, there is little doubt that the *Journal* could identify and report on far more instances of abuse, including subtle but significant patterns of impropriety that are impossible to identify with such a limited subset of Medicare data.

Second, because of the 1979 Injunction, CMS provided the *Journal* with Medicare billing data on the condition that the *Journal* not reveal the identities of individual doctors. In the course of its newsgathering, therefore, the *Journal* could not disclose to state medical boards, referring doctors, experts, or staff any information derived from the Medicare data that could be used to deduce an individual doctor's identity, except to those who already had access to the files. And the newspaper could not name individual providers in its news stories unless it managed to learn their identities elsewhere, preventing the public from gaining access to critical information. Patients surely want to know if their doctors are performing an inordinate number of risky surgeries, medical boards want to investigate allegations of impropriety, and referring doctors want the best possible information about those physicians to whom they are entrusting their patients. But so long as the 1979 Injunction is in place, the public has no access to this vital information.

Anticipating a potential challenge to the 1979 Injunction, the Eleventh Circuit in 2009 provided a procedural roadmap for those demanding greater access to this data. *Alley v. HHS*, 590 F.3d 1195, 1204 (11th Cir. 2009). Following that roadmap, Dow Jones seeks to intervene in this action to ask the Court to vacate the 1979 Injunction, an option expressly reserved by Dow Jones when it acquired access to some of the data. This Court should grant this timely motion because: (1) Dow Jones has an interest in the 1979 Injunction; (2) this in-

terest will be impaired if intervention is denied and Dow Jones's ability to disseminate information it has already obtained or seeks to obtain from CMS continues to be restricted; and (3) no other party adequately represents Dow Jones's interest. Dow Jones is also petitioning the Court for a declaration and order that all Medicare claims data (aside from patient identities) must be released under FOIA, and that the Privacy Act does not prohibit CMS from releasing complete data or require it to impose restrictions on naming individual providers.

There is no legally supportable justification for maintaining a sweeping and obsolete injunction that for over thirty years has prevented the American public from knowing the true extent of Medicare waste, abuse and fraud. As such, this Court should grant Dow Jones's motion to intervene, and quickly turn to the merits of this important litigation.

BACKGROUND

A. This Court's 31-year-old injunction requires Medicare to suppress information about payments to providers.

In 1977, HEW (now HHS) released a list of providers or groups of providers whose Medicare reimbursements totaled $100,000 or more during 1975. HEW also announced plans to release 1977 reimbursement data for all Medicare providers, in order to serve the interest in open government recognized by FOIA. *See Florida Med. Ass'n*, 479 F. Supp. at 1297. In 1979, however, plaintiffs in this action, including the Florida Medical Association and AMA, successfully petitioned this Court for an order enjoining HEW from releasing annual Medicare payments to individually identified medical providers. *Id.* at 1311. This Court (Sr. District Judge Charles R. Scott) reasoned such information was "exempt from required disclosure under the FOIA because it would constitute a 'clearly unwarranted invasion

of personal privacy'" under 5 U.S.C. § 552(b)(6), and that HEW was "prohibited by the Privacy Act from disclosure, without the prior written consent of each affected individual." *Id.*

This Court thus enjoined HEW "from disclosing any list of annual Medicare reimbursements [sic] amounts, for any years, which would personally and individually identify those providers of services under the Medicare program who are members of the recertified class in this case." *Alley*, 590 F.3d at 1199-1200. The class includes all physicians licensed to practice in Florida and all AMA members who are not Florida physicians but are providers of Medicare services – a total nationwide ban. The Eleventh Circuit in 2009 in *Alley* ruled that this injunction is still in force and continues to bind HHS.

Recently, courts have articulated the proper procedure for revisiting the 1979 Injunction. In *Alley*, the Eleventh Circuit upheld the denial of a FOIA request for Medicare records it deemed covered by the injunction. But it noted that, "[i]f Alley believes the FMA injunction is invalid, overly broad, or outdated, she can challenge it in the Middle District of Florida after joining all necessary parties. If dissatisfied with that court's ultimate decision, she can appeal it to this Court." *Id.* at 1210.

Another court recently suggested that disclosure of Medicare reimbursement data may be appropriate where evidence of potential fraud or waste exists. In 2007, a D.C. district court ordered HHS to produce similar information in response to a FOIA request, finding that the interest in disclosure overwhelmed any privacy interests under FOIA Exemption 6 and the Privacy Act. *Consumers' Checkbook v. HHS*, 502 F. Supp. 2d 79, 85-86 (D.D.C. 2007). The D.C. Circuit reversed, in part because the majority found the respondents had "not provided any evidence of alleged fraud the requested data would reveal" as to outweigh any

alleged privacy interests. *Consumers' Checkbook v. HHS*, 554 F.3d 1046, 1049, 1054 (D.C. Cir. 2009). Yet one D.C. Circuit judge disagreed, noting that the information should be released even in the absence of direct evidence of fraud: "Because Medicare distributes extensive amounts of public funds, there is a special need for public oversight of HHS's activities in administering Medicare." *Id.* at 1059 (Rogers, J., concurring in part and dissenting in part) (internal quotations marks omitted). Judge Rogers wrote that:

> [T]he requested data would shed light on HHS's fraud-detection and fraud-prevention efforts. For instance, the data could identify providers who perform a suspiciously large number of procedures in a given time period or submit[ ] claims for procedures that are outside [their] own practice areas. The data could therefore facilitate public monitoring of HHS detection and prevention of fraud. Additionally, to the extent that consumer choice could be enhanced by knowing which physicians are potentially responsible for wasteful or even fraudulent claims, release of physician-identifying data is consistent with HHS's goal of improving consumers' decisions about which medical providers to patronize. The public could utilize the requested information in determining whether HHS is fulfilling this stated goal.

Id. at 1062 (internal citations and quotation marks omitted). Ultimately, however, Judge Rodgers would have remanded the case for further proceedings as to whether the 1979 Injunction barred release of the data. *Id.* at 1065.

Taken together, *Alley* made clear that third parties have a right to challenge the 1979 Injunction, and that this Court is the place to do so, while *Consumers' Checkbook* suggested that the balance could tip in favor of disclosure where evidence of potential fraud or waste exists. It is against this backdrop that the present Motion to Intervene arises.

B. Using the limited data disclosed by CMS, *The Wall Street Journal* uncovered evidence of waste, fraud, and abuse in the Medicare system.

A year of planning, analysis, and investigation by the *Journal* has uncovered evidence of Medicare providers who "are potentially responsible for wasteful or even fraudulent

claims," just as Judge Rogers foresaw. *Consumers' Checkbook*, 554 F.3d at 1062. But the *Journal* cannot fully and effectively investigate or report on this potential waste and fraud because of the 1979 Injunction.

For more than a year, editors at the *Journal* wanted to do an investigative series based on a set of databases known as the Limited Data Set Files (the "LDS Files"), which are maintained by CMS. Allen Decl. ¶ 2. In particular, the *Journal* sought access to the Carrier File, an enormous database of all fee-for-service Medicare Part B claims in the United States. The Carrier File is unique because it contains information about the direct billings of and reimbursements to individual providers. Although long sought by journalists because of its essentially limitless potential to help expose fraud, waste, and abuse in the Medicare system, no news organization has ever been permitted access to the entire Carrier File. *Id.* ¶¶ 3-4.

The *Journal* and the non-profit Center for Public Integrity ("CPI") teamed up in 2009 to investigate Medicare billings. As part of this partnership, the *Journal* and CPI drafted a FOIA request, submitted by CPI, requesting portions of the LDS Files. When HHS did not respond to the request, CPI filed a lawsuit under FOIA. The FOIA suit was voluntarily dismissed on January 27, 2010. As part of the settlement, Dow Jones and CPI negotiated to purchase from HHS a portion of the Carrier Standard Analytic File which contained all billings for a randomly selected 5% of Medicare recipients, as well as 5% samples of other Standard Analytic Files, such as those covering inpatient hospital stays and the purchase of durable medical equipment. In addition, Dow Jones and CPI received 100% of other LDS files, including a summary file of hospital billings called MEDPAR. *Id.* ¶¶ 5-6. As the analysis and reporting progressed, Dow Jones acquired additional data and a "Crosswalk"

file, which allowed decryption of provider information. *Id.* ¶ 7. Patients are anonymized in the LDS Files Dow Jones acquired. Tamman Decl. ¶ 17.

CMS agreed to disclose the LDS Files only on the condition that Dow Jones sign a standardized Data Use Agreement ("Agreement") providing that it would not disseminate information derived from the LDS Files if the information could be reasonably used to deduce an individual doctor's identity. Dow Jones successfully negotiated for, and expressly reserved, the rights to seek a court order permitting it to disclose this information and to report information it was able to independently confirm. *Id.*, Ex. A.

Reporters and editors at the *Journal* spent over eight months analyzing the Medicare databases, doing necessary follow-up reporting, and presenting the information to its readers. Some *Journal* reporters worked on this Series, full-time, for nearly half a year. Just the data crunching alone was a full-time job for one editor skilled in computer-based reporting. Only he was permitted to access the servers that housed trillions of bytes of data. *Id.* ¶¶ 7, 16.

The *Journal*'s investigation uncovered a wealth of evidence of possible fraud and abuse in the Medicare system, evidence that the *Consumers' Checkbook* court had found lacking on the facts before it. In a few cases, the *Journal* was able to name a provider in the Series because his or her identity was confirmed independent of the LDS Files. For example:

- A Florida physical therapist, Dr. Christopher G. Wayne, apparently took in more than $1.2 million from Medicare in 2008. This amounts to more than 24 times the Medicare income of the average family doctor.
- A doctor in Texas, Dr. Theresa Rice, billed Medicare nothing in 2007 for services she performed or supervised. But less than a year later, Medicare received claims totaling

over $11.6 million and paid out more than $7.1 million under her provider number. Medicare stopped paying in mid-2009, when federal investigators shut down the clinic where she worked. At least seven people have been indicted on charges of health-fraud connected to the clinic.

- A Brooklyn physical therapist, Mr. Aleksandr Kharkover, apparently billed Medicare for more than $2.5 million in 2008, and received more than $1.8 million. He said he sees patients only in their homes, raising questions as to whether he could have legitimately performed all the services for which he billed such huge amounts to Medicare.

The *Journal* originally identified these providers through the Carrier File and published their names and their billing figures only because they were confirmed independent of the Carrier File. Schoofs Decl. ¶¶ 4, 6; Allen Decl., Ex. F. But the cases in which the *Journal* was able to name individual providers in the articles are the exception, not the rule, because of the restrictions CMS placed on the *Journal*'s use of the Carrier File and other LDS Files.

In countless other cases, the *Journal* was unable to name the individual providers. For example, the *Journal* reported on each of the following:

- A family-practice doctor apparently received more than $2 million in 2008 from Medicare, making her one of the best-paid family-medicine physicians in the Medicare system. Her billing increased 16-fold from 2006 to 2007, and continued rising the following year. She averaged $3,239 in earnings per patient in 2008 – nearly 18 times the mean for family-medicine doctors, and the seventh highest among family physicians with 10 or more patients – and administered a wide array of sophisticated neurological treatments that had been flagged by antifraud monitors. Because this

information was obtained from the Carrier File, the *Journal* could not identify the doctor in the article. Her identity thus was hidden from readers and patients, referring doctors, and the state medical board, all of whom have an interest in knowing about potentially fraudulent billing practices. Schoofs Decl. ¶ 13; Allen Decl., Ex. B.

- From 2004 to 2008, a hospital in Kentucky performed the third-most spinal fusions on Medicare patients in the United States. The most hotly debated use of spinal fusion surgery centers on patients who suffer from aging disks. At this hospital, 24% of these fusion surgeries on Medicare patients were performed on patients who suffered from aging disks, compared with 17% nationally. Five of its surgeons are also among the largest recipients nationwide of payments from medical-device company Medtronic Inc. Due to this Court's injunction, the *Journal* was barred from disclosing details from the LDS Files of Medicare payments to these five surgeons, even though there is a substantial public and governmental interest in knowing whether a medical-device company's large payments to individual doctors correlate with whether those doctors are more likely to use its devices in procedures paid for by Medicare. Allen Decl. ¶ 19, Ex. E.
- In 2009, a Midwestern surgeon reported receiving between $400,000 and $1.3 million in payments from three spine-device makers. Using the LDS Files, the *Journal* found this surgeon performed 276 spinal fusions on Medicare patients in 2008, by far the most of any surgeon in the country. More than half of this surgeon's patients were residents of two counties with fusion rates four times the national average. There is a substantial public interest in identifying a surgeon who performed an extraordinary

number of spinal fusions – all funded by taxpayers – while also receiving up to $1.3 million from the companies that profit from these procedures. Yet, due to this Court's three-decade-old injunction, the *Journal* was barred from identifying the surgeon to its readers. Allen Decl. ¶ 20, Ex. E.

- A Florida internist took home more than $8.1 million from Medicare from 2007 through 2009, almost all of which came from physical therapy. From 2006 through 2008, more than 40% of this doctor's patients in the Carrier File were described as suffering from brachial neuritis, a rare nerve-and-muscle condition estimated to occur in about three out of every 100,000 Americans. The *Journal* could not name this doctor, whose patients may have been misdiagnosed or given incorrect or unnecessary treatment, because the paper was able to learn a crucial piece of information about his practice – that he billed so often for brachial neuritis – only from the Carrier File. Schoofs Decl. ¶ 14; Allen Decl., Ex. F.

In other cases, the *Journal* would identify providers using the LDS Files, only to be forced to "triage out" these providers and not investigate them further. Reporters would have needed to interview current and former employees and colleagues about the billing patterns in the data. Doing so would not have been possible because of the contractual restrictions arising from the 1979 Injunction. For example:

- One of the nation's highest Medicare earners for physical therapy in 2008 was a physician in his 80s whose specialty, according to Medicare records, is psychiatry. More than 85% of this doctor's Medicare income that year came from physical therapy, and his total Medicare income was more than 25 standard deviations above

that of the average of all "physical medicine & rehabilitation" physicians, whose practice – unlike that of a psychiatrist – would naturally include large amounts of physical therapy. This doctor declined to speak with the *Journal*. Blocked from talking with the doctor or his legal representative, the *Journal* would have had to interview current and former employees and/or colleagues. So despite weeks of reporting, including a visit to his clinic and another to his home, reporters were compelled by the contractual restrictions stemming from the 1979 Injunction to pursue other doctors. Schoofs Decl. ¶¶ 16-19.

- In 2008, Medicare's second highest earning doctor was an ophthalmologist. His Medicare reimbursements were more than six times those of the next highest earning ophthalmologist, and his income was more than 35 standard deviations above the mean for all ophthalmologists. Moreover, the amount of his total Medicare reimbursements more than doubled in just four years. Reporting on this doctor almost certainly would have required discussing his billing patterns with his colleagues and employees, something the *Journal* was barred from doing by the contractual restrictions. *Id.* ¶¶ 20-21.
- In 2008, a physician specializing in rehabilitation medicine gave more than 99% of his patients the exact same diagnosis: "abnormality of gait." The one other diagnosis he gave was cervicalgia – neck pain. Experts in rehabilitation medicine told a *Journal* reporter that such a high proportion of patients with one diagnosis is extremely unusual and that "abnormality of gait" is rarely given as a medical diagnosis. To report on this physician, the *Journal* would have had to interview

current and former employees, and would have had to discuss information received only from the LDS Files. This physician earned more than 99.9% of all providers in the Carrier File. *Id.* ¶¶ 22-23.

- One of the physical therapists who earned the most from Medicare in the Carrier File posed a crucial problem. It is impossible to derive anything more than a ballpark estimate of a provider's annual income by extrapolating from the 5% sample of the Carrier File. In the case of this physical therapist, however, the ballpark estimate varied widely from his claimed Medicare income. Multiplying his earnings in the 5% sample by 20, he appeared to have earned more than $1.6 million from Medicare in 2008. However, he informed the *Journal* that he earned considerably less than $1 million that year from Medicare, a discrepancy that is statistically possible. All this, as well as other features of his business, necessitated having 100% of Medicare records, not a mere 5% sample, in order to verify what he told the reporter and to tease out whether his billings were legitimate or potentially fraudulent. That is a major reason why the *Journal* could not pursue reporting on this provider. *Id.* ¶¶ 24-25.
- Medicare's 2008 highest earning "emergency medicine" specialist appears to do much more than emergency medicine. He was one of the nation's highest Medicare earners for home health care supervision and home health recertification. This doctor also billed Medicare for many other services, including physical therapy, and his web site prominently advertises procedures as "Penile Enlargement" and the "Brazilian Butt Lift." Because of the many and varied services this physician offered, the *Journal* wanted to analyze his billing in more detail and with greater precision than

the 5% sample allowed. A search of public records uncovered that this physician apparently had recent federal tax liens in excess of $70,000 and in 2004 had been reprimanded and fined by his state medical board for using abortifacient pills obtained under a false prescription to attempt to induce an abortion in a pregnant woman without her knowledge or consent. *Id.* ¶¶ 26-27.

These are just a few examples of what the *Journal* uncovered but which could not be reported because of the restrictions imposed by the 1979 Injunction. Government investigators and fraud experts consider billing totals that are two standard deviations above average for a particular specialty or treatment as grounds for investigation into potential fraud. Based on the 5% sample of the Carrier File, the *Journal* was able to identify approximately 75,000 providers with billing totals two standard deviations above average by procedure, and over 5,000 providers with billing totals *five* standard deviations above average by specialty. Tamman Decl. ¶ 11. Even that number does not capture those who engage in abuses that deviate less drastically from the norm.

The government appears slow to make full use of its databases to combat fraudulent behavior, likely hampered by limited resources in the face of an overwhelming task. Private scrutiny to spur government oversight – exactly what FOIA was designed to encourage – is what this project, if restrictions are lifted, can accomplish. Indeed, shortly after the first story ran, the *Journal* was contacted by senior government medical auditors in two states asking for advice on how to screen for abuse. Officials at the CMS – eager to monitor the system, but hamstrung by limited budgets, insufficient personnel, and restrictions like the 1979 Injunction – have invited the *Journal*'s reporters to make an internal presentation on how to

more effectively use the data. Similarly, the article on the nation's largest provider of home health services triggered separate investigations by the Department of Justice, the Senate Finance Committee and the Securities and Exchange Commission. There is also Congressional interest in probing conflicts of interest among spine surgeons and medical device makers following publication of the article about back surgery abuses. Allen Decl. ¶¶ 11-12.

The importance of the Series is seen in its popularity with readers, notwithstanding its complex subject matter. Readers accessed the Series well over 400,000 times on the *Journal*'s website as of January 12, 2011, and articles in the Series appeared on the front page of the *Journal*, which reaches more than the two million subscribers to the print edition. *Id.* ¶¶ 13-14. After the articles, reporters received emails from readers praising them for their work and thanking them for the public service they performed. In one such email, following the article that exposed urologists taking full advantage of Medicare rules for personal financial gain, a reader from New Jersey wrote that her husband had decided to cancel the radiation treatment he was scheduled to receive just two days later. After arranging for a second opinion, she said: "We know that in the final analysis it could be that these doctors will offer the same advice and treatment as the ones we had seen, but we now have confidence that the treatment prescribed will be what is best for my husband and not for the bottom line of a large group of practitioners who have a major investment in equipment that may be more geared to income than outcome." *Id.* ¶ 13.

C. The 1979 Injunction prohibits the *Journal* from fully investigating information in the LDS Files, and from reporting its findings.

Despite this success, the limits CMS imposed on the LDS Files prevented the *Journal* from fully reporting what it uncovered, and uncovering much more. The *Journal*

accordingly is pursuing the only remedy available to it under *Alley* and the Agreement, by seeking to intervene in this action and dissolve the injunction.

First, the 1979 Injunction limits the *Journal*'s ability to use the LDS Files. CMS provided the *Journal* with only a 5% sample of beneficiaries in the Carrier File and other Standard Analytic Files, because the agency fears that providing all the data would violate the 1979 Injunction against disclosing the annual Medicare earnings of individual physicians. With such a limited sample, it is impossible to simply multiply a provider's income derived from this 5% sample by 20 and get an accurate estimate of a provider's total Medicare income for a given year. It is also rarely if ever possible to compare a slice of a physicians' activities – such as how often he or she gave treatment A versus treatment B for a given diagnosis – against the norm for all physicians. The margin of error in the 5% databases is simply too great. As a result, many investigations of potential waste, fraud, and abuse are impeded because the *Journal* has been limited to a 5% sample of beneficiaries. The samples allowed the *Journal* to identify and investigate only the most egregious statistical outliers. Other, less flagrant anomalies are obscured. Schoofs Decl. ¶¶ 8-9.

Second, in order to obtain the LDS Files, CMS required Dow Jones sign the Data Use Agreement providing that it would not disseminate information derived from the LDS Files that would identify an individual provider and the provider's reimbursements from Medicare. Indeed, under the CMS "cell-size suppression policy," no data may be disclosed even for small practice groups of fewer than 11 providers. Thus, the *Journal* usually cannot disclose information from the LDS Files in the course of newsgathering for the Series. *Journal* reporters are not permitted to disclose information about particular providers from the LDS

Files when interviewing those who do not have access to the files – such as state medical boards, most of the providers' current or former staff, or referring doctors. Nor are they permitted to seek confirmation of information found in the LDS Files from sources that do not already have access to the files. In addition, because medical diagnoses and Medicare billing regulations are inherently complicated, *Journal* reporters find it necessary to consult others, ranging from expert statisticians to medical billing professionals, to help understand the data. But consultation is often prevented by the contractual duty not to disseminate information derived from the Carrier File and other LDS Files. Schoofs Decl. ¶¶ 10-11.

Third, the 1979 Injunction limits the *Journal*'s ability to report on what its reporters have found. Many patients would want to know whether their doctor performs an inordinate number of a risky surgeries in cases where other doctors generally recommend less drastic options. Many medical boards would want to examine such practices among their licensed physicians, as well as billing patterns that suggest financial abuse or fraud. And many referring doctors would want the best information about those physicians to whom they are entrusting their patients. But none of these groups can learn this information because of this Court's 1979 Injunction. Allen Decl. ¶¶ 15-25; Tamman Decl. ¶ 18; Schoofs Decl. ¶¶ 12-14.

ARGUMENT

A. The Eleventh Circuit recently ruled that third parties like Dow Jones *must* petition this Court in order to challenge the 1979 Injunction.

The Eleventh Circuit has made clear that this Court is the proper venue for requesting access to Medicare payment information covered by the 1979 Injunction. In *Alley*, a third party sought to overcome HHS's refusal to disclose this information by bringing a lawsuit in the Northern District of Alabama. The Eleventh Circuit found that the information requested

was covered by the 1979 Injunction and that "a FOIA lawsuit may not be used to collaterally attack an injunction prohibiting disclosure of certain records." 590 F.3d at 1204.

Critically, however, *Alley* noted this "does not mean there is no remedy for the party seeking those records." *Id.* Rather, the party may ask this Court to "modify or vacate the injunction barring disclosure," and if it refuses, "the party may appeal that refusal." *Id.* "A direct attack, instead of a collateral one, is the proper procedure." *Id.* The court concluded that if a third party "believes the FMA injunction is invalid, overly broad, or outdated, [it] can challenge it in the Middle District of Florida after joining all necessary parties." *Id.* at 1210. Thus, the Circuit made clear that interested parties may – indeed, must – come to this Court to vacate the 1979 Injunction. Dow Jones is an interested party *not only* because it is a media organization, but also because it has spent thousands of dollars, and thousands of hours, on data which it cannot fully use due to restrictions imposed by the 1979 Injunction.

B. Dow Jones may intervene as of right under Fed. R. Civ. P. 24(a).

Pursuant to Fed. R. Civ. P. 24(a)(2), this Court must permit a party to intervene when: (1) the motion is timely; (2) the party has an interest relating to the transaction which is the subject of the action; (3) the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest; and (4) the party's interest may not be adequately represented by existing parties. *See, e.g., Chiles v. Thornburgh*, 865 F.2d 1197, 1213 (11th Cir. 1989). Rule 24(a) is construed "liberally in favor of potential intervenors." *Southwest Ctr. for Biological Diversity v. Berg*, 268 F.3d 810, 818 (9th Cir. 2001). Dow Jones easily meets all of these requirements.

1. Dow Jones's motion to intervene is timely.

When considering a motion pursuant to Rule 24(a), the Court should assess timeliness based on all the surrounding circumstances, including (1) the length of time during which the intervenor knew or should have known of its interest in the case; (2) the extent of prejudice to existing parties as a result of the intervenor's failure to apply as soon as it knew or should have known of its interest; (3) the extent of prejudice to the would-be intervenor if its petition is denied; and (4) the existence of unusual circumstances militating either for or against the application being timely. *Stallworth v. Monsanto Co.*, 558 F.2d 257, 264-66 (5th Cir. 1977).

Dow Jones's motion is timely. The injunction itself is decades-old, but "nothing in Rule 24(a) precludes postjudgment or even post-appeal intervention." *Tweedle v. State Farm Fire & Cas. Co.*, 527 F.3d 664, 671 (8th Cir. 2008). It was only in 2009 that this Circuit made clear the 1979 Injunction still applied to FOIA requests for the LDS Files. The most recent article in the Series was published in late December. Dow Jones was able to obtain portions of the LDS Files only in mid-2010, and it was not until recently, after months of painstaking analysis and reporting, that the *Journal* learned of possible waste, fraud, and abuse – evidence that the *Journal* is greatly impeded from fully reporting due to this Court's 1979 Injunction. Since then, Dow Jones has taken swift and active steps to intervene.[3]

[3] Intervening in a case this old also involves logistical delays. Simply locating and obtaining a copy of the case file from National Archives and Records Administration took nearly a month. Time is of the essence in this case – as long as these critical records are kept secret a fresh violation of the right of access to government records occurs every day. The public is kept in the dark about whether its tax dollars are being wasted or well spent. *Cf. Elrod v. Burns*, 427 U.S. 347, 373 (1976) ("The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury.").

Moreover, even if there *had* been a substantial delay, no existing party to the case is prejudiced by intervention at this time rather than, for example, the very day in 2009 that the *Alley* decision instructed intervention was the proper procedure for challenging the 1979 Injunction. There has been no activity in this case for nearly thirty years. There is no briefing schedule to disrupt. Conversely, Dow Jones certainly will be harmed if its petition is denied. As the *Alley* decision made clear, coming to this Court is the *only* method for challenging the 1979 Injunction, which is in turn the *only* method of fully reporting on the important information contained in the LDS Files as part of the *Journal*'s ongoing, landmark Series.

Finally, there are unusual circumstances militating in favor of determining that the application is timely. With this decades-old injunction, this Court has imposed a nationwide gag order on full and robust discussion – informed by actual data – of the use of taxpayer dollars for Medicare reimbursements and whether the government has kept up with its oversight responsibilities. Medicare costs have grown exponentially over the past three decades, and it is unclear this Court even intended its order to be read so broadly and so indefinitely. Courts faced with similar injunctions have deemed timely motions to intervene filed decades after an injunction was entered. *See, e.g., Moses v. Washington Parish Sch. Bd.*, 379 F.3d 319, 321 (5th Cir. 2004) (private school permitted to intervene in desegregation case to seek relief from 1974 injunction enjoining state from providing school with material aid).

2. Dow Jones has an interest in the subject matter of this action, which no other party adequately represents, that will be impaired if intervention is denied.

It similarly is clear that Dow Jones has a deep and abiding interest relating to the transaction that is the subject of the action, and that this interest supports Dow Jones's inter-

vention. *See Chiles*, 865 F.2d at 1213-14. The *Journal* has attempted to access the LDS Files, first through CPI's FOIA request, and later by purchasing a portion of the files. This Circuit recently made clear that requests for Medicare reimbursement data are circumscribed by the 1979 Injunction. *Alley*, 590 F.3d at 1203-04. Thus, both as a press organization seeking public records, and one effectively restrained from reporting on information already in its possession and in which it has invested substantial editorial and financial resources, Dow Jones clearly has an interest in the 1979 Injunction. *See John Doe No. 1 v. Glickman*, 256 F.3d 371, 380 (5th Cir. 2001) (FOIA requester entitled to intervene as of right in action designed to prevent the government from disclosing the relevant information); *Campaign for Family Farms v. Glickman*, 200 F.3d 1180, 1184 (8th Cir. 2000) (FOIA requester permitted to intervene as a defendant in reverse FOIA action); *Nat'l Bus. Aviation Ass'n v. FAA*, 686 F. Supp. 2d 80, 84 (D.D.C. 2010) (FOIA requester, a media organization, permitted to intervene where private aviation association sued to enjoin the FAA's release of documents).

Similarly, Dow Jones is "so situated that the disposition of the action may as a practical matter impair or impede [its] ability to protect" its interest in obtaining and reporting on Medicare claims data. *See Chiles*, 865 F.2d at 1212 n.15. Indeed, the 1979 Injunction in this case already *has* impeded the *Journal*'s interests, because CMS interprets it as barring the release of more than 5% of the Carrier File and other Standard Analytic Files, and now barring the *Journal* from fully reporting on suspicious information about individual doctors found in the LDS Files. The decision in *Alley* noted that petitioning this Court is the *only* method for challenging the 1979 Injunction and thus gaining access to the important, newsworthy information contained in the LDS Files. *Alley*, 590 F.3d at 1204; *see also John*

Doe No. 1, 256 F.3d at 380 (FOIA requestor's interest may be impaired by action designed to prevent government from disclosing the relevant information). If this Court does not vacate the 1979 Injunction, CMS will continue to deny FOIA requests for records, refuse to sell the *Journal* more than 5% of the Standard Analytic Files, and impose restrictions on publication even of purchased data in the LDS Files. These restrictions will continue to impair reporting on the largest taxpayer-supported healthcare system, the claims made by individual doctors, the more systemic abuses caused by misguided incentives and regulations, and the adequacy – or inadequacy – of government oversight.[4]

Finally, Dow Jones's interest is not "adequately represented by existing parties." *See Chiles*, 865 F.2d at 1212 n.15. Although HHS and Dow Jones would become nominal co-defendants, their interests are in many ways adverse. Indeed, in light of the 1979 Injunction, HHS has actively *opposed* release of similar information in subsequent litigation. *See Alley*, 590 F.3d at 1200-01; *Consumers' Checkbook*, 554 F.3d at 1049-50. It did the same with the request by CPI and Dow Jones. It was only by promising not to release individual doctors' information (absent a court order permitting such release or independent verification) that Dow Jones was able to purchase portions of the LDS Files. CMS refused to release the entire Carrier File to Dow Jones under *any* circumstances. The crossclaim against HHS that is part of Dow Jones's proposed answer attests to the divergent interests of HHS and Dow Jones.

[4] There need not be *certainty* of wrongdoing for the public interest in disclosure under FOIA to trump privacy interests. An interest in investigating whether there has been wrongdoing is sufficient. *See Physicians Comm. for Responsible Med. v. Glickman*, 117 F. Supp. 2d 1, 5-6 (D.D.C. 2000) ("The asserted public interest is in learning *whether* a Committee member was financially beholden to a person or entity ... outweighs the privacy interest of the individual whose disclosure form was redacted.") (emphasis added); *see also Consumers' Checkbook*, 554 F.3d at 1054 (withholding information because plaintiff "has not provided *any* evidence of alleged fraud the requested data would reveal") (emphasis added).

Nor is there any indication that any other party to this decades-old suit would move the Court to revisit its 1979 Injunction. To the contrary, the last docket entry in this case was decades ago. The AMA, which successfully intervened in this suit in 1978, has vigorously opposed other recent requests for such information. *See Alley*, 590 F.3d at 1201; *Consumers' Checkbook*, 554 F.3d at 1060, 1062. Dow Jones's interest is distinct from that of *any* party because it is not just seeking release of information in the LDS Files. It also is seeking an order permitting it to disseminate information already in its possession, which it has spent months analyzing, at great cost. With no other party to represent its interests, Dow Jones has met all criteria pursuant to Rule 24(a) and should be allowed to intervene in this action.

C. Dow Jones also is entitled to intervene under Fed. R. Civ. P. 24(b).

Even if this Court believes that Dow Jones is not entitled to intervene as of right, Dow Jones asks this Court in the alternative to allow permissive intervention pursuant to Fed. R. Civ. P. 24(b). The rule states that "the court may permit anyone to intervene who ... has a claim or defense that shares with the main action a common question of law or fact." Fed. R. Civ. P. 24(b). As with Rule 24(a), the interest requirement in Rule 24(b) is liberally construed. *See Stallworth*, 558 F.2d at 269. This is particularly true in light of the public interest in access to government records.[5]

Dow Jones's claims "share[] with the main action a common question of law or fact." CMS interprets the 1979 Injunction as prohibiting the release of more than 5% of the

[5] *See, e.g., EEOC v. National Children's Center, Inc.*, 146 F.3d 1042, 1046 (D.C. Cir. 1998) (vacating denial of permissive intervention due to "this flexible approach and [a] longstanding 'tradition of public access to court records'") (internal cites omitted); *Jessup v. Luther*, 227 F.3d 993, 997 (7th Cir. 2000) (press and public have "well-established" right to intervene and demand access to court proceedings and records).

Standard Analytic Files, and prohibiting the *Journal* from fully reporting on information found in the LDS Files. In addition, as demonstrated under Rule 24(a), intervention under Rule 24(b) would not delay this proceeding or prejudice any rights of the existing parties.

Finally, the Eleventh Circuit's decision in *Alley* means *some* method of challenging the 1979 Injunction in this Court *must* be available, as it ruled that a third party "can challenge [the 1979 Injunction] in the Middle District of Florida after joining all necessary parties." *Alley*, 590 F.3d at 1210. Thus, if Dow Jones is not permitted to intervene as of right, it should be permitted to intervene pursuant to Rule 24(b). In either case, Dow Jones does not intend to seek any information that can be used to identify Medicare beneficiaries.

CONCLUSION

For the foregoing reasons, Dow Jones respectfully requests that the Court grant its motion to intervene pursuant to Rule 24 of the Federal Rules of Civil Procedure and permit Dow Jones to file the attached proposed answer, crossclaims and counterclaim, and otherwise fully participate in this case.

LOCAL RULE 3.01(g) CERTIFICATION

The undersigned counsel for Intervening Defendant Dow Jones & Company, Inc., pursuant to Local Rule 3.01(g), represents that counsel has attempted to identify who currently is counsel for the parties in this case and to confer with counsel in regard to the foregoing motion. Because this case has been dormant for decades, counsel either could not be identified or reached, or were unable at this time to represent whether they would consent to the motion. Dow Jones will file a supplementary certification as the parties make their positions clear.

Dated: January 25, 2011

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 25th day of January, 2011, a copy of the foregoing was furnished via U.S. mail to:

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EXHIBIT A OMITTED

(PROPOSED ANSWER AND ATTACHMENTS)

EXHIBIT B

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,

Plaintiffs,

v. Case No. 78-178-Civ-J-S

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,

Defendants,

DOW JONES & COMPANY, INC.
1211 Avenue of the Americas
New York, NY 10036

Intervening Defendant.
_____/

DECLARATION OF MICHAEL ALLEN IN SUPPORT OF DOW JONES & COMPANY, INC.'S MOTION TO INTERVENE

I, Michael Allen, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am a Deputy Page One Editor at *The Wall Street Journal* ("the *Journal*"), where I have worked for 24 years. I have previously served as the *Journal*'s Latin America Editor, Assistant Foreign Editor, Editor of the newspaper's *Texas Journal* edition and Deputy Dallas Bureau Chief, among other duties. As Deputy Page One Editor, I help oversee the investigative journalism that appears on Page One of the *Journal*. Over its more than 100-year history, the *Journal* has earned a reputation as one of the preeminent American newspapers, in part because of its willingness to serve the public interest by exposing improprieties in government and business alike. During my 8 years on Page One, the *Journal* has been awarded 6 Pulitzer Prizes. I make this declaration in support of the Motion to Intervene of Dow Jones & Company ("Dow

Jones"), publisher of the *Journal*. I have personal knowledge of the facts contained herein, except those matters stated on information and belief.

Obtaining the Limited Data Set Files

2. For more than a year, editors at the *Journal* wanted to do an investigative series based on a set of databases known as the Limited Data Set Files (the "LDS Files"), which are maintained by a Department of Health and Human Services ("HHS") agency, the Centers for Medicare & Medicaid Services ("CMS"). The LDS Files offer the clearest and most comprehensive view of the nation's vast healthcare system, and the government's underfunded and thus often inadequate management of it. If made public, they would allow taxpayers to better understand this vast and complex government system that spends one-eighth of the entire federal budget.

3. Among the LDS Files, in particular the *Journal* sought access to a database known as the Carrier Standard Analytic File (the "Carrier File"). This enormous database contains all fee-for-service Medicare Part B claims in the United States. Whereas other LDS Files, like the inpatient Standard Analytic Files, generally reflect the billings of hospitals or other large institutions, the Carrier File is particularly valuable because it contains information about the direct billings of, and reimbursements to, individual providers. It long has been sought by journalists who focus on computer-assisted reporting because of its essentially limitless potential to help expose fraud, waste, and abuse in the Medicare system.

4. To my knowledge, no news organization has ever been permitted access to the entire Carrier File. My colleagues and I knew we would face significant obstacles receiving all, or even a portion, of the Carrier File. Still, the File was so important that we decided to try and obtain it.

5. The *Journal*'s efforts to obtain the LDS Files, including the Carrier File, are discussed in more detail in the declaration of Maurice Tamman, which also is being submitted in support of Dow Jones's Motion to Intervene. Briefly, the *Journal* and the non-profit Center for Public Integrity ("CPI") teamed up in 2009 to investigate Medicare billings. As part of this partnership, on June 30, 2009, CPI submitted a request to the Department of Health and Human Services ("HHS") under the Freedom of Information Act ("FOIA"), requesting portions of the LDS Files. When HHS did not respond to the request, CPI filed a lawsuit under FOIA to obtain the information.

6. The FOIA suit was voluntarily dismissed on January 27, 2010. But, as part of the settlement, Dow Jones and CPI were able to negotiate to purchase from HHS a portion of the Carrier File which contained all billings for a randomly selected 5% of Medicare recipients, as well as 5% samples of other Standard Analytic Files, such as those covering inpatient hospital stays and the purchase of durable medical equipment, such as wheelchairs. In addition, Dow Jones and CPI received 100% of other LDS files, including a summary file of hospital billings called MEDPAR.

7. We were able to obtain these files because Dow Jones and CPI signed a standardized Data Use Agreement ("Agreement") providing that Dow Jones would not disseminate information derived from the LDS Files if the information could be reasonably used to deduce an individual doctor's identity. We expressly reserved the right to seek a court order permitting us to disclose this information and expressly reserved the right to report information we were able to independently confirm. A copy of the Agreement is attached as Exhibit A to the Tamman Declaration. As the analysis and reporting progressed, we acquired additional data and

a "Crosswalk" file, which allowed decryption of provider information, as detailed in Mr. Tamman's Declaration. *Id.* ¶ 9.

The Series: *Secrets of the System*

8. The *Journal* used the data we acquired from CMS to produce five front-page articles in the *Journal* as part of a series, which remains ongoing, entitled *Secrets of the System* (the "Series"). A sixth front-page article, which predated the series, relied on an analysis of CMS data provided by a third party. As Deputy Page One Editor, I have overseen the Series, produced by several veteran investigative reporters and experts on database reporting. These include John Carreyrou, an investigative reporter who previously served as Health Editor of the *Journal* and who was on a team of reporters who won a 2003 Pulitzer Prize for the *Journal*; Maurice Tamman, an editor specializing in computer-assisted reporting; and Mark Schoofs, an investigative reporter who received a Pulitzer Prize and other awards for his reporting. This team has already spent over eight months analyzing the Medicare databases, doing the necessary follow-up reporting and presenting the information. Some of our reporters worked on this Series, full-time, for nearly half a year.

9. Each article in the Series relied on the LDS Files to a varying extent. Attached as Exhibits A-F are true and correct copies of the articles in the Series:

- Exhibit A is an April 27, 2010 article entitled *Home Care Yields Medicare Bounty.*
- Exhibit B is an October 26, 2010 article entitled *In Medicare's Data Trove, Clues to Curing Cost Crisis.*
- Exhibit C is an October 27, 2010 article entitled *Physician Panel Prescribes The Fees Paid by Medicare.*
- Exhibit D is a December 8, 2010 article entitled *A Device to Kill Cancer, Lift Revenue.*
- Exhibit E is a December 20, 2010 article entitled *Top Spine Surgeons Reap Royalties, Medicare Bounty.*

- Exhibit F is a December 22, 2010 article entitled *Confidentiality Cloaks Medicare Abuse.*

10. The Series raised questions as to whether the government is using the data at its disposal in the LDS Files to combat fraud. It exposed extreme examples of potential fraud, waste, and abuse by Medicare providers. The Series analyzed the possible relationship between treatments recommended by providers and side payments they received from interested companies, as well as the fact that individual providers often continued to receive Medicare reimbursements even in the face of blatant misconduct.

11. The response to *Secrets of the System* has been phenomenal. Shortly after the first article ran, government medical auditors in two states contacted our reporters asking for advice on how to screen for abuse. Officials at CMS, eager to police Medicare funding but often lacking resources to do so, also invited our reporters to make an internal presentation on how to make the data more accessible.

12. I understand that the *Journal*'s April 27, 2010 article, *Home Care Yields Medicare Bounty*, which focused on Amedisys, the nation's largest provider of home health services, triggered separate investigations by the Department of Justice, the Senate Finance Committee and the Securities and Exchange Commission. I understand that there also is Congressional interest in probing potential conflicts of interest among spine surgeons and medical device makers following the *Journal*'s December 20, 2010 article. Finally, the *Journal* has also been contacted for information regarding a separate Senate hearing into Medicare fraud.

13. After the articles, our reporters were deluged with emails from readers praising them for their work and thanking them for the public service they performed. In one such email, following the December 8, 2010 article that exposed urologists' apparent use of Medicare rules for financial gain, a reader from New Jersey wrote that her husband had decided to cancel the radiation treatment he was scheduled to receive just two days later. "The article made us realize

that my husband was not joining an exclusive men's club but rather was embarking on a serious journey to deal with a serious disease," she wrote. After arranging for a second opinion, she added: "We know that in the final analysis it could be that these doctors will offer the same advice and treatment as the ones we had seen, but we now have confidence that the treatment prescribed will be what is best for my husband and not for the bottom line of a large group of practitioners who have a major investment in equipment that may be more geared to income than outcome."

14. The readership of these articles has been substantial. Readers accessed the Series well over 400,000 times on the *Journal*'s website as of January 12, 2011, and articles in the Series appeared on the front page of more than the two million copies of the print edition. In particular: the April 26 article received 27,910 page views; the October 25 article received 76,470 page views; the October 26 article received 65,629 page views; the December 7 article received 77,999 page views; the December 20 article received 108,828 page views; and the December 22 article received 64,642 page views. It was covered extensively by the mainstream and healthcare press.

Limitations Imposed by the 1979 Injunction

15. The Series has been a success. But the limits HHS imposes on access to the LDS Files, based on the injunction from 1979 in this case, have significantly interfered with our reporting in two key ways.

16. First, because of the injunction, HHS provided us data from the LDS Files *only* on the condition that the *Journal* would not disseminate information derived from the files that could reasonably be used to deduce an individual doctor's identity, absent a judicial determination permitting such dissemination.

17. For this reason, HHS enforces what is known as a "cell-size suppression policy." Under this policy, no data may be disclosed for a group of fewer than eleven individuals. Billing data from the LDS Files for a medical practice with eleven doctors may be disclosed, but data for an individual doctor, or a group of ten doctors, may not be disclosed. *See* Tamman Decl., Ex. A, ¶ 9. Thus, the *Journal* was never able to identify in its articles Medicare payment data for individual providers or groups of less than eleven providers, unless the information was obtained independent of the LDS Files.

18. The cell suppression policy has significantly inhibited the *Journal*'s reporting. As discussed in more detail in the declaration of Mark Schoofs, which also is being submitted in support of Dow Jones's Motion to Intervene, the name of a story's subject is a crucial piece of information. Without it, investigators, referring doctors, and patients have no idea that a particular provider may have engaged in billing practices indicative of waste, fraud, or abuse. And without it, we frequently cannot do necessary follow-up reporting.

19. For example, the December 20, 2010 article, *Top Spine Surgeons Reap Royalties, Medicare Bounties*, reported on Norton Hospital in Louisville, Kentucky. From 2004 to 2008, Norton Hospital performed the third-most spinal fusions on Medicare patients in the United States. The most hotly debated use of spinal fusion surgery centers on patients who suffer from aging disks, a condition known as degenerative disk disease. Norton performed 2,475 fusions for Medicare between 2004 and 2008. Of these fusions, 24% were performed on patients who suffered from aging disks, compared with 17% nationally. The *Journal* could report this statistic, notwithstanding the HHS cell-size suppression policy discussed above, because Norton has 27 surgeons. But it could *not* report on how many of these controversial surgeries are performed by the five Norton surgeons who happen to be among the largest recipients

nationwide of payments from medical-device company Medtronic Inc. Due to this Court's injunction, the *Journal* was barred from disclosing details from the LDS Files of Medicare payments to these five surgeons, even though there is a substantial public and governmental interest in knowing whether a medical-device company's large payments to these providers correlate with dramatically increased use of this controversial (taxpayer-funded) procedure.

20. The same article discussed a Midwestern surgeon who reported receiving between $400,000 and $1.3 million in payments from three spine-device makers. Using the LDS Files, the *Journal* found this surgeon performed 276 spinal fusions on Medicare patients in 2008, by far the most of any surgeon in the United States. More than half of this surgeon's patients were residents of two counties with fusion rates four times the national average. There is a substantial public interest in identifying a surgeon who performed an extraordinary number of spinal fusions – all funded by taxpayers – while also receiving up to $1.3 million from the companies that profit from these procedures. Yet, due to this Court's three-decade-old injunction, the *Journal* was barred from identifying the surgeon.

21. Because of the 1979 Injunction, the *Journal* may not, in the course of newsgathering for the articles, disclose information from the LDS Files to those without access to the information contained in them. We are not permitted to disclose information from the LDS Files when interviewing state medical boards, staff, or referring doctors about particular providers. Nor are we permitted to seek confirmation of information found in the LDS Files from sources that do not already have access to the files. We cannot even ask most administrative staff in doctors' practices to confirm financial information, making it easy for doctors to escape scrutiny by merely refusing to take our calls.

22. The 1979 Injunction has inhibited our coverage in a second significant way. Because of the 1979 Injunction, CMS would provide the *Journal* with only a random 5% sample of the Carrier File *even though* we agreed not to identify individual providers. To my knowledge, no media organization has previously obtained even this 5% sample. Even so, the Journal's reporting was seriously hamstrung by having only such a small subset of the data.

23. The *Journal*'s December 8, 2010 article, *A Device to Kill Cancer, Lift Revenue*, shows the limitations of the 5% sample. The article focuses on urology groups that buy intensity-modulated radiation therapy ("IMRT") equipment and then refer their patients to their in-house staff for treatment at a cost of up to $40,000 per patient – treatment some doctors have criticized as far less cost-effective than other options. The *Journal* was unable to form an accurate picture of self-referring urology groups' treatment patterns from the 5% sample. Rather, the only way to reliably investigate and report on that practice was to acquire 100% of these groups' billings from HHS. We were able to subsequently obtain – for an additional fee – 100% of the database for tax identification numbers associated with 57 of the largest urology practices in several states. Because of the large size of the practices, the Agreement did not prohibit the *Journal* from publishing their billing data.

24. Having access to *all* the relevant data for this story was invaluable. For example, a doctor at one large practice with 103 doctors, Long Island-based Integrated Medical Professionals PLLC, indicated to the *Journal* that that group treated an estimated 17% of patients with IMRT. The *Journal* initially had no means to rebut this calculation. Only after the *Journal* obtained access to 100% of the relevant data was the newspaper able to ascertain that this was not accurate – between its launch in mid-2006 and the end of 2008, Integrated Medical actually administered IMRT to 601, or 53%, of 1,132 Medicare patients recently diagnosed with prostate

cancer. The *Journal* was also able to calculate that Integrated Medical received $26.7 million from Medicare for the care of those 601 patients. If Integrated Medical's urologists had not owned radiation equipment and had referred these patients for radiation treatment outside of their practice, Medicare would have paid them only $2.6 million. The *Journal* was able to identify Integrated Medical only because the group includes more than ten providers.

25. This investigation would have been impossible with only a 5% sample of the relevant data. The *Journal* would not have had the information needed to debunk Integrated Medical's claim that it treated only an estimated 17% of patients with IMRT. Other similar investigations of potential waste, fraud, or abuse are impossible because the *Journal* is limited to a 5% sample. It is impossible, for example, to simply multiply a provider's income derived from this 5% sample by 20 and get an accurate estimate of a provider's total Medicare income. One reason is that the sample contains 5% of patients, not providers. Any given *provider* may have more or less than 5% of patients in the random sample, and there is no way to determine this from the sample. Receiving all of the data would greatly enhance our newsgathering, without in any way compromising patient confidentiality.

26. While we believe the Series has already had an important impact and performed an invaluable public service, the secrecy that surrounds how scarce taxpayer money is spent (and misspent) on the nation's health – and how the government gatekeepers are minding the public till – has hindered or prevented even more penetrating scrutiny. The Series is ongoing, with more articles planned and in the works. The need for the complete LDS Files, without the limitations imposed based on the 1979 Injunction, is pressing.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on January 21, 2011

Michael Allen

EXHIBIT A

THE WALL STREET JOURNAL.

Home Care Yields Medicare Bounty

By Barbara **Martinez**
2,130 words
27 April 2010
The Wall Street Journal
J
A1
English

Home health care -- treating sick patients in their homes rather than paying for costly hospitalizations -- is the fastest growing area of the health-care industry, aimed at saving billions of dollars every year.

But an analysis by The Wall Street Journal of Medicare payments to home health-care companies in recent years raises questions about whether some companies -- including the sector's largest, **Amedisys** Inc. -- are taking advantage of the Medicare reimbursement system. The results show that the number of in-home therapy visits tracks Medicare financial incentives.

Founded in 1982 by William Borne, a 52-year old registered nurse, **Amedisys** derives 90% of its revenue from Medicare reimbursements. As Medicare spending on home health surged over the past decade, the company has seen its sales skyrocket with revenue of $1.5 billion last year, up from $88 million in 2000. Among health-care stocks, **Amedisys** has been a star, soaring to $60 a share yesterday from less than $1 in 2000.

Medicare reimbursements are determined in part by the number of at-home therapy visits each patient receives, with an extra fee kicking in as soon as a patient hits a certain number of visits. Between 2000 and 2007, Medicare paid companies a flat fee of about $2,200 for up to nine home therapy visits. It paid an additional reimbursement of roughly $2,200 if the therapy surpassed nine visits. That incentive was designed so that agencies didn't "stint" on therapy visits, says Laurence Wilson, the director of chronic-care policy group at the Centers for Medicare and Medicaid Services, the agency that runs Medicare.

According to The Journal analysis, which was based on publicly available Medicare records, **Amedisys** provided many of its patients just enough therapy visits to trigger the extra $2,200 payment. In 2005, 2006 and 2007, very few **Amedisys** patients received nine therapy visits while a much higher percentage got 10 visits or more. In 2007, for instance, only 2.88% of patients got nine visits, while 9.53% of patients got 10 visits.

"I was told 'we have to have ten visits to get paid,'" says Tracy Trusler, a former **Amedisys** nurse for two years in Tennessee, who has since left the company. Her supervisors, she says, asked her to look through patients' files to find those who were just shy of the 10-visit mark and call their assigned therapists to remind them to make the extra appointment.

"The tenth visit was not always medically necessary," Ms. Trusler says.

Kevin LeBlanc, a spokesman for **Amedisys**, says the company didn't take advantage of the system and that the company's home visits "are in line with the industry trends."

He said **Amedisys** in general focuses on sicker patients than the industry average, and therefore patients that require more care. "**Amedisys**' clinical patterns are representative of the patient population we focus on, namely those patients suffering from complex, chronic and co-morbid medical issues," he said.

The number of visits eligible for the extra reimbursement has a significant impact on home-health providers' receipts from Medicare and thus on overall revenue. While **Amedisys** doesn't break out the amount of revenue from the extra Medicare payment, the company says between 55% and 60% of its patients receive home therapy. In 2007, according The Journal's analysis, 28.5% of the patients who received therapy got 10 to 12 visits, thereby triggering the extra $2,200 Medicare payment. Such cases are highly profitable because they cost the company less than $80 per visit.

Medicare reimbursements for the entire home health-care industry are coming under increased scrutiny. The federal agency that advises Congress on Medicare payment issues, the Medicare Payment Advisory

Commission, or MedPAC, warned last month that home health "overpayments contribute to the insolvency" of the Medicare trust fund as well as premium increases that beneficiaries must pay.

Medicare changed its reimbursement rules in January 2008 in an attempt to blunt the incentive for home health-care visits it created. It eliminated the $2,200 bonus payment at 10 visits and now pays an extra fee of a couple of hundred dollars at six, 14 and 20 therapy visits. "What we felt we could do is try to create some better incentives in the system for providing the level of service that beneficiaries actually needed," says Mr. Wilson from Medicare.

It wasn't until the change was made that MedPAC noticed the questionable home visit patterns. In its March report, the agency said that the industry-wide percentage of therapy visits in the 10-to-13 range dropped by about a third after the policy change in 2008.

The pattern of clustered visits around reimbursement targets is continuing: MedPAC found the number of therapy visits numbering six, 14 and 20 increased after the policy was changed in 2008.

During a MedPAC meeting in December, Arnold Milstein, a MedPAC commissioner, questioned whether all the home visits were appropriate. "Looking at the great speed with which the volume of services adapts to payment changes, which are breathtaking, it does suggest that there may be a problem with certifying the appropriateness of these services," Mr. Milstein said, according to a transcript of the meeting.

Based on the report, MedPAC suggested for the first time last month that the Secretary of Health and Human Services "review home health agencies that exhibit unusual patterns of claims for payment."

The Journal analysis found a similar pattern: In 2008, the percentage of **Amedisys** patients getting 10 visits dropped by 50%, while the percentage that got six visits increased 8%. The percentage of patients getting 14 visits rose 33% and the percentage getting 20 visits increased 41%.

The **Amedisys** spokesman said any suggestion the company may have increased its number of therapy visits to receive higher reimbursements is "both incendiary and inaccurate."

Amedisys provided its own analysis of the 2007 Medicare data that came out very close to The Journal's, but said the results don't suggest a drive to reach 10 visits. **Amedisys** says its analysis showed its proportion of visits numbering 13 or more -- for which there was no financial incentive -- was higher than the rest of the industry, showing that it provided the visits people needed without regard to the reimbursement.

Amedisys provided 37% of its patients with 13 or more visits in 2007, compared with 31% of patients who got 13 or more visits in the rest of the industry, according to The Wall Street Journal analysis.

Amedisys, based in Baton Rouge, La., is the largest company in the home health-care sector. Mr. Borne, founder and chief executive of **Amedisys**, borrowed $1,500 in 1982 and started the company in his living room as a nursing-staff business.

Amedisys grew into a full-fledged home-health agency in the 1990s, as Mr. Borne says he came to recognize the importance of home health in addressing the nation's health-care costs. Religion was another driver. Mr. Borne says he is a "religious and spiritual person," and that his "passion for health care is driven by these beliefs."

As **Amedisys** grew, Medicare, which at the time reimbursed home-health agencies on an unlimited, per-visit basis, was becoming burdened with fast-rising costs. In 1998, the agency put caps on its payments.

Medicare spending on home-health services dropped from $17 billion to less than $9 billion between 1997 and 2000, says William Dombi, vice president at the National Association for Homecare and Hospice, the industry's lobbying group. The result was swift: Nearly a third of home-health agencies went out of business in the same period, according to Mr. Dombi.

Amedisys, too, was badly wounded, with net losses widening to $24.9 million in 1998 from $1.2 million the previous year. Mr. Borne says he didn't have enough money to file for bankruptcy, so he trudged on.

In 2000, Medicare rolled out its new reimbursement system. It began paying a flat sum of about $2,200 for a 60-day period of care, no matter how many times a nurse went to a patient's home. The fee also included up to nine visits from occupational, physical or speech therapists. Doctors need to sign off on the number of visits in order for the company to be reimbursed.

Through 2007, an agency would receive the additional $2,200 if it sent a therapist to a patient's home 10 or more times during the same period.

The generous Medicare reimbursements are one reason the home health-care industry has grown so swiftly, according to MedPAC. There are now more than 10,400 home-health agencies in the U.S., up nearly 50% since 2002.

After the new reimbursement system was implemented in 2000, **Amedisys**'s fortunes improved markedly. Its profits rose and its stock soared. Today, **Amedisys** has a market value of $1.7 billion.

Mr. LeBlanc said many factors contributed to **Amedisys**'s rapid growth, including "our significant investment in the best and most innovative technologies, our strategic acquisitions of compatible companies, our expansion into other therapies and by providing the best quality care for our patients at a lower cost."

He emphasized that the number of home therapy visits is driven not by the company but by doctors orders. "The final decision as to how much care the patient needs ultimately is authorized by the physician, not the home health-care provider," he said in an email.

However, doctors aren't required to see a patient in person to recommend them for home health-care or examine their progress. Some rely on home therapists to provide guidance on the number of visits a patient requires.

"Generally, I leave it up to the therapist because that's what they're best at," said Jeff Esslinger, an internal medicine doctor in Cartersville, Ga., who is one of **Amedisys**' medical directors. Typically, a therapist will visit and evaluate a patient at home, recommending how many weeks of therapy the patient will need, Mr. Esslinger said. "It's pretty rare for me to disapprove of what they do."

To conduct its analysis, The Journal enlisted Henry Dove, a professor at Yale University's School of Public Health and an expert in analyzing Medicare data. Mr. Dove mined Medicare's database to determine how often between 2005 and 2008 various home-health companies sent therapists to patients' homes during a 60-day period of care, and whether the number of visits coincided with Medicare financial incentives.

Mr. Dove found the pattern of clustering visits at reimbursement trigger points was industry wide. The three other publicly traded home-health companies saw similar movements from 2007 to 2008. LHC Group Inc., for instance, saw the percentage of patients getting 10 visits in 2008 drop by 64% from 2007. For Gentiva Health Services Inc., the 10-visit percentage fell 27%, and at Almost Family Inc., the percentage fell 39%.

A spokesman for LHC said the company agreed with The Journal's analysis but noted that the majority of its patients didn't receive therapy -- and therefore the company didn't qualify for the bonus payments. He added that "the shift in therapy visits noted in your data resulted from a change in the types of patients we cared for," such as more orthopedic patients, "and not a change in treatment patterns."

Gentiva's spokesman said its decisions are "based on clinical protocols that are driven by what patients need and what their doctors order." He added that between 2007 and 2008, Gentiva rolled out programs that tended to be more therapy intensive. Thus, it received more bonuses.

Steven Guenthner, chief financial officer of Almost Family, said that when Medicare revised its reimbursement rates in 2000 -- creating a bonus of about $2,200 for patients reaching 10 therapy visits -- the policy had "a serious flaw." The rates encouraged home health agencies, including Almost Family, to seek out patients who had illnesses that required at least 10 visits, Mr. Guenthner said. Almost Family focused on hip and knee problems because those patients tend to need 10 to 13 therapy visits, he said.

Illnesses that require fewer visits may not get as much attention under the Medicare reimbursement rules. "It's not that we turned down patients," Mr. Guenthner said. "It's where you focus your scarce resources." The combination of limited home health resources to attract patients and the government's reimbursement policy "was like a moth to a flame," he said.

MedPAC, in its latest report, suggests requiring face-to-face exams by doctors going forward.

(See related letter: "Letters to the Editor: Providers Follow the Incentives Given" -- WSJ May 12, 2010)

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EXHIBIT B

Secrets of the System

In Medicare's Data Trove, Clues to Curing Cost Crisis

By Mark Schoofs and Maurice Tamman

October 26, 2010
Page One

Somewhere in the New York City area there is a family-practice doctor who, government records suggest, pocketed more than $2 million in 2008 from Medicare, the federal insurance program for the elderly.

That made her one of the best-paid family-medicine physicians in the Medicare system. But more noteworthy than the sum is her pattern of billing, which strongly suggests abuse or even outright fraud, according to experts who have examined her records.

This doctor didn't do typical family medicine. Instead, she administered a wide array of sophisticated tests, including polysomnography sleep analyses, nerve conduction probes and needle electromyography procedures—some of which have been flagged by federal antifraud authorities for special scrutiny. As a doctor of osteopathy, she has certifications for family practice and a hands-on treatment called "manipulative therapy," but none in neurology. She denies wrongdoing.

The Wall Street Journal is prohibited from naming this physician despite the fact that the paper detected her by mining a database paid for by taxpayers. Known as the Medicare claims database, it is a computerized record of the bills Medicare pays for medical treatment, and it is widely considered the single best source of information on the U.S. health-care system.

Other major insurance pools—including Medicaid, the government program for poor Americans, and individual private plans—provide insight into small slices of the American populace. Medicare, by contrast, insures virtually all Americans 65 and older—a population that consumes roughly a third of all of medical spending.

Federal investigators use the database to find fraud; academic researchers mine it to compare the cost and utilization of various services; and consultants make a business out of analyzing the data for a wide variety of health-care companies. In ways large and small, it offers an unparalleled look at why America's health-care costs are spiraling.

The Journal focused on one family-practice doctor with extremely high billing and found she had performed in 2008 an unusual array of 29 sophisticated diagnostic tests. Some of these have been flagged by federal authorities as being frequently abused. The numbers here are derived from a 5% sample of Medicare beneficiaries.

For instance, a background check of the 25 other doctors in the nation who performed more than 20 of the same sophisticated tests as the New York-area physician shows that six have links to alleged fraud or have run into professional trouble. Two were charged this year with Medicare fraud, and two others worked in the same company as the defendants. Another has been sued by an insurance company for billing fraud. And a sixth has been disciplined by a state medical board three times since 2008 for misconduct. All denied wrongdoing or declined to answer questions (see chart).

But the Medicare data come with a severe limitation: While the services and earnings of hospitals and other institutional providers can be publicly identified, such information is kept strictly confidential for doctors and other individual providers. The reason is that the American Medical Association, the doctors' trade group, successfully sued the government more than three decades ago to keep secret how much money individual physicians receive from Medicare. The AMA has continued to defend this ruling, including in two cases in which federal appeals courts issued decisions last year.

This means the American public is barred from examining in detail how Medicare spends roughly an eighth of its funds, about $62.5 billion in 2009. While that may seem like a small piece, health-care experts point out that physicians have disproportionate power to direct spending in all the other areas of the system because they admit patients into hospitals, prescribe drugs and order procedures and equipment.

The AMA stands by its position and says little would be accomplished by publishing individual physician billing information.

What's more, the vast majority of doctors are honest and, far from getting rich off Medicare, tend to believe it pays poorly.

"The AMA has zero tolerance for health fraud, and we are working with the U.S. government to fight it," said Dr. Jeremy Lazarus, the Colorado psychiatrist who chaired the task force that developed the AMA's principles on use of doctor data. "We support the release of information that will help physicians improve the care they provide, but the release of personal physician payment data does not meet that standard, and physicians, like all Americans, have the right to privacy and due process."

The Wall Street Journal, in conjunction with the nonprofit Center for Public Integrity, attempted for nearly a year to obtain the database. As part of the effort, the CPI filed a lawsuit against the Department of Health and Human Services, which houses the Medicare program. The Journal and CPI wanted the data at no cost; the government wanted $100,000 for eight years of data. In a settlement, The Journal and CPI obtained the requested data at a substantially reduced fee. They later obtained a decryption key to identify individual providers but signed a contract agreeing not to publish such identities in most cases.

The database, technically known as the Carrier Standard Analytic File, focuses on doctors and others paid on a fee-for-service basis. It contains 5% of all beneficiaries, and includes all doctor claims that Medicare paid directly in association with their care.

But even with these limitations, the power of the database is clear. If it were fully available, with doctors clearly identified, the public could expose countless ways in which some health-care providers misuse or waste taxpayer dollars, health-care advocates say. The database could even provide some information on physician quality. Especially in the digital age, the database could be a powerful tool for holding the $500 billion Medicare program accountable.

"It's very hard to defend ignorance and willful hiding of data in the 21st Century," said former House Speaker Newt Gingrich, who has called for the database to be public as long as patients are kept confidential. "Our estimate is that the federal government, in Medicare and Medicaid alone, loses between $70 billion and $120 billion a year to crooks. You ought to be able to identify those."

Joseph A. Califano Jr., who tried to make Medicare payments to physicians public when he was secretary of Health, Education and Welfare under President Jimmy Carter, agrees. "Just the publicity, the embarrassment—aside from the actual prosecution of fraud—would have a tremendous impact" on fraudulent billing, he said. He added that opening the database could help state professional review boards "reveal incompetence in many cases, and I think that would improve the level of medical care." He said that patients should be kept private.

Mr. Califano's experience shows how effectively doctors have resisted such disclosure. In March 1977, amid a national debate over the cost of health care, the Carter administration

released a list of all doctors who received Medicare reimbursements of $100,000 or more during 1975. The media covered it, publishing the names of highly paid doctors. The top earner was New York ophthalmologist Charles D. Kelman, practicing on East 58th Street, who billed $412,757, the equivalent of nearly $1.7 million today.

The AMA responded by saying the list was riddled with errors—a charge later upheld by the Comptroller General. A Michigan doctor was listed as earning $115,000 from Medicare, when he actually earned only $15,000. "My wife must think I have an apartment on the side and a mistress as well," he quipped at the time.

Reimbursements attributed to individual physicians often went to group practices. Dr. Kelman, for example, told The New York Times that two other doctors as well as optometrists and technicians shared in reimbursements attributed to him alone.

The AMA and individual doctors also fumed that publicizing physician incomes could stigmatize high earners and generally deter doctors from treating Medicare patients. They said the list provided no way to distinguish between a hard-working doctor and a crass fraudster.

The Carter administration issued an apology for the errors. But it also said it would release the names of providers who received Medicare payments during 1977, and the amounts.

To block publication, the Florida Medical Association filed suit in Florida, and that suit was joined by the AMA.

"It has long been a fundamental value in our society that, in the absence of a compelling state interest to the contrary, a person's financial affairs are nobody's business but his own," the AMA argued in court papers.

U.S. District Court Judge Charles Scott weighed two competing interests: that of the providers, whose privacy he said would indeed be invaded, and that of the public, which had an "important interest" in knowing how much taxpayer money was spent reimbursing Medicare providers. Judge Scott ruled that the public interest could be served by scrubbing disclosures of doctor names. So, he permanently barred the government from disclosing reimbursements that "would personally and individually identify" providers.

Technically, the ruling applied only to physicians licensed to practice in Florida and all members of the AMA who participate in Medicare and who would be identified. But in practice, the government has interpreted the ruling to bar identifying any individual provider, from nurses to physical therapists, in the Medicare claims database.

Over the ensuing three decades, this ruling has withstood all challenges. Last year, in a suit the AMA joined, a federal appeals court blocked identifying even the Medicare services individual physicians provided, on the grounds that publicly available fee schedules could be used to deduce how much Medicare paid the doctors.

In a case brought by the nonprofit group Consumers' Checkbook, the federal appeals court for the District of Columbia fortified the AMA's position. While ruling that doctors have a "substantial" interest in keeping secret the amount they receive from taxpayers, the court declared that the taxpayers' interest in knowing who was getting their money was, under the Freedom of Information Act, "non-existent" or "negligible at best."

Consumers' Checkbook argued that the database could be used to fish out Medicare fraud and abuse. Law enforcement officials and other anti-fraud experts widely regard the database as one of the best tools for identifying fraud, precisely because it can be mined for aberrant billing patterns. But the appeals court boxed Consumers' Checkbook into a Catch 22, ruling that the group had to have evidence of fraud before it could use the database to find that fraud. In the court's words, Consumers' Checkbook "has not provided any evidence of alleged fraud the requested data would reveal."

Today, a billion and a quarter claims pour into Medicare each year for Part A—which includes hospital, skilled nursing facilities and hospice—and Part B, including fee-for-service physician services, and durable medical equipment. There are more than 14,000 diagnoses and more than 7,000 medical procedures, most designated by Current Procedural Terminology, or CPT, codes. Code 75992, for example, is "Transluminal atherectomy, peripheral artery, radiological supervision and interpretation."

A full set of one year's data—with doctors' names encrypted and only 5% sampling available for physician claims and durable medical equipment—costs about $18,300.

Consultants, from one-person boutiques to large corporations such as Thomson Reuters, make a business out of putting this data into an easily understandable form and answering clients' questions.

Hospice care, for example, used to be provided mostly by local, not-for-profit outfits. Now, more than half of the Medicare-licensed hospice providers are for profit, according to Cordt Kassner, whose one-man consulting firm, Colorado-based Hospice Analytics, serves a variety of hospice providers and state hospice associations. Mr. Kassner said he spends about $10,000 per year purchasing Medicare claims data.

One of his clients is Michigan-based Great Lakes Home Health & Hospice, which served about 27,000 patients last year, according to the company, including 16,500 home health-care and 1,500 hospice patients. Great Lakes CEO William Deary says he used the data to identify relatively under-served cities. In 2007, Mr. Deary's company opened an office

in one such city, Lansing, and in doing so "increased our hospice revenue by 88% in 36 months," he said.

For government fraud investigators, the database is a gold mine. Even the 5% sample obtained by The Journal illustrates its potential for highlighting unusual billing activity. The newspaper mined the database for 2008 outliers within specialties, including family medicine. Of the approximately 75,000 providers in this specialty, the family doctor who performed the battery of sophisticated sleep, nerve, and other tests was one of the top billers, with reimbursements of $142,522.12 on 44 patients.

Multiplying that 5% sample figure by 20 results in an estimated $2.8 million in total fees for this doctor for the year, although the wide statistical margin of error means it's impossible to pinpoint the exact number. A person with knowledge of the matter said the doctor's Medicare fees totalled $2.2 million in 2008.

Interviewed on a rainy Friday afternoon at work, the doctor acknowledged taking in more than $2 million from Medicare that year. She added that she ran a clinic with many employees and high overhead.

Within the 5% sample, this doctor is an outlier in several ways. Her billing shot up 16-fold from 2006 to 2007, and continued rising the following year. She averaged $3,239 in earnings per patient in 2008—nearly 18 times the mean for family-medicine doctors, and the 7th highest among family physicians with 10 or more patients.

Counting only diagnostic tests performed on at least two patients, the doctor performed or supervised 29 separate sleep, neurological, ultrasound and other diagnostic tests. Looking across all 811,785 providers in the 5% database, no other provider of any specialty conducted all 29 of those tests in 2008.

The Journal asked several fraud and billing experts to review spreadsheets showing this provider's billing from the 5% database. Her identity was kept private.

"The conspicuously large number of diagnostic tests appear medically improbable," said Kirk Ogrosky, a former federal prosecutor who specialized in Medicare fraud and is now a partner at Arnold & Porter.

The range of tests is "just so unusual, I don't see how that could be otherwise explained" than through abuse or fraud, said David Sand, medical director of HMS Inc., a company that helps numerous states control costs and root out fraud and abuse in the Medicaid system. The "breadth and depth of medical knowledge" required to do such an array of tests "defies comprehension," he said.

The New York-area physician, in the interview, denied any wrongdoing and said she only administered tests "recommended by the [medical] literature." She added: "I read a lot of literature."

After an audit by a Medicare contractor a year or two ago, she says she closed the office she was using at the time. She said she no longer does most of the 29 diagnostic tests she performed in 2008.

She does still practice medicine—in fact, she works out of at least three offices in two states. And she said she still has patients on Medicare and Medicaid. In the interview, she spoke about a range of treatment options, including one she used in her home country: leeches. She doesn't use leeches here "because of malpractice." In any case, Medicare doesn't have a specific billing code for leeches.

—James Oberman contributed to this article

EXHIBIT C

DOWJONES

THE WALL STREET JOURNAL.

Secrets of The System: Physician Panel Prescribes The Fees Paid by Medicare

By Anna Wilde **Mathews** and Tom McGinty
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Three times a year, 29 doctors gather around a table in a hotel meeting room. Their job is an unusual one: divvying up billions of Medicare dollars.

The group, convened by the **American Medical Association**, has no official government standing. Members are mostly selected by medical-specialty trade groups. Anyone who attends its meetings must sign a confidentiality agreement.

Yet the influence of the secretive panel, known as the Relative Value Scale Update Committee, is enormous. The Centers for Medicare and Medicaid Services, which oversee Medicare, typically follow at least 90% of its recommendations in figuring out how much to pay doctors for their work. Medicare spends over $60 billion a year on doctors and other practitioners. Many private insurers and Medicaid programs also use the federal system in creating their own fee schedules.

The **RUC**, as it is known, has stoked a debate over whether doctors have too much control over the flow of taxpayer dollars in the $500 billion Medicare program. Its critics fault the committee for contributing to a system that spends too much money on sophisticated procedures, while shorting the type of nuts-and-bolts primary care that could keep patients healthier from the start -- and save money.

"It's indefensible," says Tom Scully, a former administrator of the Medicare and Medicaid agency who is now a lawyer in private practice. "It's not healthy to have the interested party essentially driving the decision-making process."

Plenty of factors contribute to the spiraling costs of Medicare, which rose nearly 9% in 2009. Sheer demographics will add millions of new beneficiaries each year as the baby boomers begin turning 65. Other areas of Medicare -- including the prescription-drug benefit and nursing-home expenses -- are growing faster than payments to doctors.

Moreover, the **RUC**'s recommendations in theory affect only how doctors' piece of the Medicare pie is divided, not how big it is. **RUC** chairwoman Barbara Levy says the panel is moving aggressively to correct evaluations that lead to higher-than-appropriate payments for some services. By the start of November, the Medicare agency is due to come out with its doctor fees for next year, likely incorporating the **RUC**'s most recent recommendations.

"We've made tremendous change in the last few years," says Dr. Levy, a Seattle-area gynecologist. "The **RUC** is not a perfect process, it's just the best that's out there."

Still, the impact of the decisions made by the doctors on the **RUC** goes well beyond physician fees for cardiac surgery or back procedures. When Medicare pays more for something, doctors have an incentive to do more of that something -- with all the associated costs for hospitals, lab tests and drugs.

"Overvalued codes can lead to spending growth," says Jonathan Blum, deputy administrator for the Centers for Medicare and Medicaid Services.

A Wall Street Journal analysis of Medicare and **RUC** data suggests that services were paid too generously in some cases because the fees were based on out-of-date assumptions about how the work is done. The analysis found more than 550 doctor services that, despite being mostly performed outpatient or in doctors' offices in 2008, still automatically include significant payments for hospital visits after the day of the procedure, which would typically be part of an inpatient stay.

For instance, one operation to treat male urinary incontinence wraps in payment for 118 minutes of hospital

visit time after the day of surgery, though 2008 Medicare data show it is done around 80% of the time outpatient or in a doctor's office. Stephanie Stinchcomb, manager of reimbursement for the American Urological Association, says the surgery used to be largely inpatient; its payment was last updated based on a RUC evaluation in 2003. It's not clear if a new analysis will find doctors should now be paid less for it, she says.

The RUC's Dr. Levy says the committee is already recommending changes for services that have moved to an outpatient setting.

The AMA, along with groups representing doctor specialties, formed the RUC in 1991. That's when Medicare was moving to its current system of setting doctor fees, which bases estimates of the cost of a service on the physician work and related expenses involved, as well as a small amount for liability. The panel's main focus is to estimate how much work it takes a physician to perform a given task.

In sessions that can stretch 12 hours or longer each day, the committee walks through dozens of services. The discussions can be mind-numbing -- a subcommittee once debated whether to factor tissues into the payment for a psychoanalysis session.

Committee leaders like Dr. Levy have long emphasized that members need to look beyond the interests of their specialties, and she distributed red baseball caps with "RUC" printed on them at the beginning of her term last year. Past efforts at bonding activities include a bowling night where the physicians were randomly assigned to teams. The breakdown of votes is kept secret, and it takes two-thirds of the 26 voting panelists to endorse a value for a service.

The stakes are heightened by Medicare law that says if services get a boost in their values, the money is supposed to come out of existing services' reimbursement. The Medicare agency makes such tweaks to attain so-called "budget neutrality" and also aims to hit overall spending goals set by law. However, its projections are often exceeded due largely to increases in the number of services performed. Congress has stepped in to authorize higher-than-targeted spending.

"This system pitted specialty against specialty, surgeons against primary care," says Frank Opelka, a surgeon and former RUC alternate member who is vice chancellor at Louisiana State University Health Sciences Center in New Orleans.

Primary-care groups have pushed for more representation on the committee, and their leaders have argued its results are weighted against their interests.

Dr. Levy says the committee is an expert panel, not meant to be representative, adding: "The outcomes are independent of who's sitting at the table from one specialty or another."

A recent analysis for the Medicare Payment Advisory Commission, or MedPAC, a Congressional watchdog, calculated how much American doctors would make if all their work was paid at Medicare rates. It found that the primary-care category did the worst, at around $101 an hour. Surgeons did better, at $161. Specialists who did nonsurgical procedures, such as dermatologists, did the best, averaging $214, and $193 for radiologists.

The imbalance has stoked fears of a shortage of primary-care doctors, as well as a relative shortfall in the amount of primary-care services patients receive, compared to specialist procedures. "The fee schedule we use to pay physicians in Medicare leads to the wrong mix of services and the wrong mix of doctors," says Robert Berenson, vice chair of MedPAC and a researcher at the Urban Institute. "It produces increased spending for Medicare and for the rest of the system."

Out-of-whack Medicare doctor payments are supposed to be corrected in a required review every five years. MedPAC says in the three previous reviews, the RUC endorsed boosts for 1,050 services, and decreases for just 167. Many recommendations on which services to examine came from doctor societies. The upshot may be that payments don't keep up with medical realities when procedures become easier or faster, MedPAC said.

The Medicare payment for placing cardiac stents in a single blood vessel stems from a 1994 RUC analysis. Medicare paid doctors for 326,000 of those procedures in 2008, at a cost of around $205 million. Compared to the mid-1990s, cardiologists say, stenting today is more routine and may often be less stressful.

The example used to set the code's value is "way out of date," says David L. Brown, a cardiologist at SUNY-Stony Brook School of Medicine. "In those days, stents were used when you were having a catastrophic event or thought you might have a catastrophic event." Stents and the catheters used to thread them into arteries are now smaller and easier to use, he says. The time varies by patient, but Dr. Brown says he required around 45 minutes on average to perform a single-vessel stenting. The RUC's valuation suggests a

two-hour procedure.

The American College of Cardiology feels the service is "fairly valued," says James Blankenship, who represents the society on the **RUC** and is director of cardiology at Geisinger Medical Center. He concedes that two hours is "probably a little bit too long," but argues that the procedure may be harder because cardiologists now take on challenging patients who might once have gotten bypass surgeries.

The **RUC**'s Dr. Levy says that the **RUC** has reduced values for nearly 400 services in the past and it is now reviewing hundreds more.

In 2006, Medicare phased in a payment for applying a skin substitute that used a new **RUC** evaluation. The estimate of doctor work was built around an example of treating a teenager with an extensive burn, who's seen in an operating room. The procedure was estimated to take 25 minutes, and payment wrapped in the cost of four doctor visits, including one for hospital discharge.

By 2008, according to Medicare data, the code was being billed by podiatrists 74% of the time, and they were applying the skin substitute to ulcers, not burns. Moreover, 53% of the procedures were outpatient and 44% done in doctors' offices. Some podiatrists suggest 25 minutes is longer than the procedure typically takes, though this can vary. Lee Rogers, associate medical director of the amputation-prevention center at Valley Presbyterian Hospital in Los Angeles, says he requires seven minutes on average.

"I can't believe that's the vignette they based this code off of," he says.

At a national podiatric meeting in July, podiatrist James Stavosky showed slides highlighting that doctors who treated a stubborn foot ulcer with Dermagraft, a skin substitute used when billing that code, could make $3,137.54 -- substantially more than with rival products paid for under different codes. Dr. Stavosky says the slides were his idea and he wasn't paid for the talk by Advanced BioHealing Inc., the maker of Dermagraft. The company confirms that.

The Medicare agency has proposed lopping its reimbursement for the Dermagraft procedure, and the **RUC** has suggested that the AMA committee that creates billing codes review the matter. Medicare's Mr. Blum says the agency is becoming "much more prescriptive" in working with the committee, prodding the panel to detect, and suggest fixes for, payments based on out-of-date assumptions. He adds that the agency has already made payment changes to "correct historical biases against primary-care professionals" and plans more such moves.

The **RUC** relies heavily on surveys performed by doctor specialty groups, requiring as few as 30 responses. The surveyed doctors estimate the time, stress, skill and other factors based on a hypothetical case that's supposed to represent a typical patient. They compare services to other, similar ones to help figure out relative difficulty. A blank example provided to The Wall Street Journal noted that the survey "is important to you and other physicians because these values determine the rate at which Medicare and other payers reimburse for procedures."

William Hsiao, the Harvard professor who led the original physician-work research used to set Medicare fees, argues the approach is almost guaranteed to inflate the values used to calculate fees.

"You do not turn this over to the people who have a strong interest in the outcome," he says. "Every society only wants its specialty's value to go up. . . . You cannot avoid the potential conflict."

A study published this June in the journal Medical Care Research and Review found the procedure times used by the **RUC** to calculate values may sometimes be exaggerated. The mean times for several types of surgeries were substantially shorter in a database drawn from hospital surgical records.

For instance, the time used by the **RUC** for carpal tunnel surgery -- which was performed 106,000 times on Medicare patients in 2008, at a cost of around $44 million in doctor fees -- is 25 minutes. According to Sullivan Healthcare Consulting Inc., which maintains the hospital database, the median time among teaching hospitals in recent years, based on 2,602 cases, was about one-third shorter, at 17 minutes. The figure for community hospitals, with 4,093 cases, was 18 minutes.

According to documents provided by the **RUC**, the 25-minute figure is based on 39 surveys of surgeons, out of 150 sent out by groups representing hand surgeons, orthopedic surgeons and plastic surgeons.

Robert H. Haralson III, former medical director for the American Academy of Orthopaedic Surgeons, says Medicare's payment isn't too high, because the surgery is a more intense procedure than the current value implies. In a letter to the medical journal, **RUC** leaders said the article was "outdated" and questioned use of the surgical database, which classifies procedures in a different way than the **RUC**. Dr. Levy says the doctor surveys serve as "a beginning point" for the committee's experts.

Mr. Blum of the Medicare agency says that for now, "we are comfortable" with the RUC process. The federal health-care overhaul requires the government to insure that the doctor-fee values adopted by Medicare are accurate. "We're not going to rubber-stamp recommendations," he says.

(See related letters: "Letters to the Editor: RUC Is the Wave of the Future for American Medicine" -- WSJ Nov. 1, 2010)

Document J000000020101027e6ar00044

EXHIBIT D

THE WALL STREET JOURNAL.

Secrets of the System: A Device to Kill Cancer, Lift Revenue

By John Carreyrou and Maurice Tamman
2,803 words
8 December 2010
The Wall Street Journal
J
A1
English

Roughly one in three Medicare beneficiaries diagnosed with prostate cancer today gets a sophisticated form of radiation therapy called IMRT. Eight years ago, virtually no patients received the treatment.

The story behind the sharp rise in the use of IMRT -- which stands for intensity-modulated radiation therapy -- is about more than just the rapid adoption of a new medical technology. It's also about financial incentives.

Taking advantage of an exemption in a federal law governing patient referrals, groups of urologists across the country have teamed up with radiation oncologists to capture the lucrative reimbursements IMRT commands from Medicare.

Under these arrangements, the urologists buy radiation equipment and hire radiation oncologists to administer it. They then refer their patients to their in-house staff for treatment. The bulk of Medicare's reimbursements goes to the urologists as owners of the equipment.

There are now at least 37 such urology groups in 16 states, ranging in size from a few physicians to more than 100. Critics, including some independent radiation oncologists who are losing business, say the urology groups steer many patients toward IMRT for financial gain, drawn by Medicare payments that can reach $40,000 per patient, depending on the state.

The urology groups deny this. They say they offer their patients a full range of treatment options, and their growing use of IMRT merely mirrors a national trend driven by patient demand. Integrating IMRT into their practices allows them to better coordinate patients' care, they say.

Expensive new procedures like IMRT play no small role in the relentless rise of Medicare expenditures. This year, the federal health-insurance program for the elderly and disabled is expected to spend $524 billion on the care of its 47 million beneficiaries -- a 40% increase from 2006. The Congressional Budget Office recently projected that federal spending on Medicare could double as a share of gross domestic product to as much as 7% by 2035.

In 2008, the last year for which data is available, Medicare spent an estimated $1 billion or more on IMRT, largely for the treatment of prostate cancer.

Urology groups' ownership of IMRT equipment is just one example of what is known as "self-referral," the practice by which doctors refer patients for treatments in which they stand to make a financial gain. Other examples include doctors' ownership of sophisticated imaging machines, which has been linked to their over-utilization. Some medical researchers estimate that overbilling through such arrangements costs taxpayers tens of billions of dollars a year.

Opening the Medicare claims database could potentially curb overbilling by exposing physician practices to public scrutiny. Portions of the database are currently accessible for a fee, but information pertaining to individual doctors and their private practices is kept strictly confidential under a three-decade-old court ruling.

The Wall Street Journal, together with the nonprofit Center for Public Integrity, obtained a 5% sample of all Medicare billing, but was unable to form an accurate picture of self-referring urology groups' treatment patterns from the sample. The Journal subsequently obtained 100% of these groups' billings from the Department of Health and Human Services for an additional fee. The Journal agreed not to publish billings of individual doctors. Instead, it is restricted to analyzing groups of 10 or more physicians.

More than 190,000 American men are diagnosed with prostate cancer each year. How -- and even whether -- to treat the disease has long been controversial because prostate cancer tends to grow slowly. Many victims are more likely to die from other causes.

Treatment options range from IMRT, which costs Medicare as much as $40,000 for a full course of radiation in places such as New York, to a cheap approach known as "watchful waiting," which means simply monitoring the cancer with regular office visits and tests. Medicare pays up to $16,000 for a prostatectomy -- surgery to remove the prostate -- and as much as $19,000 to implant radioactive seeds to kill cancerous cells.

IMRT has become popular with patients because it is less invasive than surgery or seed implants. It is widely recognized as superior to the type of external radiation it replaced because it targets only the tumor, limiting damage to healthy tissue. But it has become a source of heated debate among health-care professionals, some of whom argue that it isn't being used in a cost-effective manner.

"Overtreatment with IMRT is a fact," says James Mohler, a urologist at Roswell Park Cancer Institute in Buffalo, N.Y., who chairs a physicians committee that sets national treatment guidelines for prostate cancer. Dr. Mohler cited a 2006 study in the Journal of the National Cancer Institute that found that 45% of American men with prostate cancer who received external radiation were being overtreated.

A Journal analysis of Medicare claims suggests that IMRT usage is significantly higher in the five states where most of the urology groups that own radiation equipment are located. These states -- New York, Florida, Pennsylvania, New Jersey and Texas -- are home to 22 of the 37 self-referral groups identified by the Journal. The average IMRT usage for recently diagnosed prostate-cancer patients was 42% in those states in 2008. By contrast, the national average was about a third.

New York is home to the largest urology self-referral group in the nation, Long Island-based Integrated Medical Professionals PLLC. Created in July 2006, Integrated Medical has grown to 103 doctors across six counties and owns 11 linear accelerators, the massive machines used to deliver radiation.

Integrated Medical is headed by a urologist named Deepak Kapoor. "Is radiation a line of business for us? Yes," Dr. Kapoor said in a July interview at the group's main radiation facility. But, he added, IMRT wasn't the practice's most profitable activity, and use of the treatment was driven by patients, not by the practice's doctors.

Asked during the interview what proportion of its prostate-cancer patients Integrated Medical treats with IMRT, Dr. Kapoor said he didn't track such data closely, but said he would be "comfortable" with an estimate of "one out of six," or 17%.

An analysis of Integrated Medical's Medicare claims later performed for the Journal suggested a much higher rate. Between its launch in mid-2006 and the end of 2008, Integrated Medical administered IMRT to 601, or 53%, of 1,132 Medicare patients recently diagnosed with prostate cancer, the Journal analysis found.

Integrated Medical received $26.7 million from Medicare for the care of those 601 patients, according to the Journal's calculations. If Integrated Medical's urologists hadn't owned radiation equipment and had referred these patients for radiation treatment outside of their practice, Medicare would have paid them only $2.6 million.

After being presented with the Journal's data, Dr. Kapoor denied earlier giving a one-in-six estimate, and said he believed Integrated Medical's utilization rate for IMRT was in "line with what's practiced in the community." He added that financial considerations never influenced IMP's treatment decisions.

In a subsequent email he called the Journal's methodology "severely flawed and inaccurate," and said it understates the national utilization rate. "Any suggestion, inference, or innuendo that implies that IMP's treatment of patients with prostate cancer is based on anything other than the best interests and personal choice of each, individual patient is blatantly false," he wrote. He also wrote that Integrated Medical's IMRT use was boosted by a large number of treatments of patients who were referred by outside physicians.

The consensus among prostate-cancer experts is that few patients aged 80 and older should undergo radiation because the risks of treating them outweigh the benefits. Their advanced age makes them far likelier to die from other causes, so the course of action typically recommended for them is watchful waiting or, sometimes, hormone therapy.

Integrated Medical administered IMRT to 91 male Medicare patients aged 80 and older over the period the Journal examined. That amounted to 35% of the Medicare patients 80 and older diagnosed with prostate cancer that Integrated Medical treated. The group received $3.7 million in IMRT payments from Medicare for these patients. Dr. Kapoor said more than 80% of those patients suffered from intermediate to high-risk cancer, justifying more aggressive treatment, and all were offered -- and declined -- watchful waiting.

By contrast, the proportion of prostate-cancer patients 80 and older who were treated with IMRT was between 13% and 24% in a half-dozen states where no self-referral groups existed in 2008, the Journal found.

Integrated Medical treats far fewer patients with cheaper radiation seeds than with IMRT because seeds cause more side effects, Dr. Kapoor said. Some prostate-cancer experts dispute that assertion, and research studies have shown little difference between the two. Dr. Kapoor said the large difference in costs between IMRT and seed implants was not a factor he and his colleagues took into account in their treatment decisions.

"Our credo in medicine is not, 'spend the least money,' " he said. "It's, 'first do no harm.' "

IMRT was first developed in the 1990s. It improved upon older radiation technology with a combination of new software and hardware that could mold a radiation beam to match the shape of a tumor.

Medicare started paying for IMRT in 2002, setting its reimbursement rate for the procedure high to take into account the costs of the technology and the added personnel required to administer it. The price of a new linear accelerator can exceed $1.5 million.

The new Medicare reimbursement coincided with urologists' loss of a major source of income. Throughout the 1990s, many urologists had supplemented their revenues through an arrangement with the maker of Lupron, a hormone drug for prostate cancer. Under the arrangement, Lupron producer TAPPharmaceutical Products Inc. sold urologists the drug at a steep discount, while the urologists in turn billed Medicare for the full price.

The arrangement ended in 2001 when several urologists were indicted and TAP Pharmaceutical paid more than $840 million to settle a Justice Department investigation. Deprived of the Lupron profits, some urologists' incomes declined by as much as one-half, according to several urologists who were practicing at the time.

IMRT emerged as the perfect income substitute, says Mark Harrison, a radiation oncologist based in McAllen, Texas, who first had the idea of integrating IMRT into a urology practice.

After consulting lawyers, Dr. Harrison determined that administering IMRT in urologists' offices would fall within an exception to the so-called Stark law, which bars doctors from referring Medicare patients to facilities in which they have a financial interest.

The exception -- which was included in part to accommodate prestigious multispecialty institutions such as the Mayo Clinic -- allows doctors to provide "ancillary" services in their offices during a patient's visit, such as lab tests.

Armed with his legal opinions, Dr. Harrison created a company called Urorad Healthcare LP in 2004 to advise urology groups on how to set up and run radiation facilities. In its marketing materials, Urorad told urologists that buying IMRT equipment could "potentially double their practice revenue."

In one presentation titled "FAQ'S," Urorad projected a practice's annual return on investment at $425,000 per doctor, if each urologist in the practice treated an average of one-and-a-half new patients a month.

With the disappearance of Lupron profits "and rising overhead, urologists need to seriously begin considering new revenue sources, and there is no better revenue source available to urologists than IMRT," the document stated.

Dr. Harrison, who acknowledges writing the marketing pitches, says the returns they cite are offset by the big up-front cost of building a radiation center, which he says can reach $5 million. "Urologists take significant risks" by taking out large bank loans to pay for the facilities, he says.

Dr. Harrison says Urorad has helped 15 urology groups build IMRT centers over the past six years, and generated revenues of $10 million in 2009. He says he is proud of the role his company has played in urologists' adoption of IMRT because "it's brought a good treatment to a lot of people."

Urorad's first clients included two Texas urology groups, one in McAllen and another in San Antonio. Texas has since become one of the centers of the movement, with six big urology groups that own linear accelerators and employ radiation oncologists.

Last year, Juan Reyna, who heads one of the Urorad-counseled Texas groups, Urology San Antonio, teamed up with Integrated Medical's Dr. Kapoor to create a Washington, D.C., lobbying organization called Access to Integrated Cancer Care.

The impetus for AICC's creation was a July 2009 proposal by the Centers for Medicare and Medicaid Services to reduce Medicare's payments for radiological services. Radiation therapy, originally included among the services targeted for payment reductions, faced a cut of up to 44%.

AICC hired the law firm Sonnenschein Nath and Rosenthal to lobby against the cuts, paying it $160,000 in the fourth quarter of 2009, according to the Center for Responsive Politics.

AICC warned that the cuts would deprive patients in rural areas of quality cancer care. A group of five congressmen echoed that concern in a letter to Health and Human Services Secretary Kathleen Sebelius, warning of "catastrophic results for cancer patients across the country."

The letter's authors – Democrats Charles Gonzalez, Ciro Rodriguez, Henry Cuellar, Steve Israel and Joe Sestak -- represent districts in Texas, New York and Pennsylvania, three of the states with the highest concentration of self-referral urology groups.

AICC also found a receptive ear in the Congressional Black Caucus, which wrote Ms. Sebelius on Oct. 9, 2009, protesting the cuts on the grounds that they would further reduce African-American men's already-limited access to cancer care.

Three weeks later, CMS issued its final ruling on Medicare payment changes, largely exempting radiation therapy from the cuts. AICC called the decision "an enormous victory."

But scrutiny of the urology groups is mounting, spurred by the American Society for Radiation Oncology, or ASTRO, which has denounced urologists' practice of referring patients for treatment in facilities they own as unethical. ASTRO's members also have a financial stake in the issue, since self-referral urology groups compete directly with them for radiation business.

In April, House Ways and Means Committee Chairman Sander Levin (D-Mich.) and two other congressmen asked the U.S. Government Accountability Office to study what impact self-referral groups are having on Medicare spending.

The experience of Lane County, Ore., may help answer that question.

In late 2007, the county's biggest urology practice, the Oregon Urology Institute, hired a radiation oncologist from Colorado and opened a new radiation center, marketing it as "the only facility in Oregon focused exclusively on prostate cancer."

The new facility soon coincided with a surge in Lane County's prostate-cancer treatment costs. According to the Journal's analysis, Lane County's Medicare billing for prostate cancer more than doubled in 2008 to $3.8 million.

The increase was driven by a more than fivefold jump in the county's IMRT costs. Oregon Urology accounted for most of the 55 IMRT treatments of Medicare beneficiaries that year in Lane county. Oregon Urology increased its Medicare revenues from the treatment of prostate cancer nearly six-fold in 2008 to $1.8 million, even though the number of prostate-cancer patients it treated only rose 14% to 183 patients.

Bryan Mehlhaff, a urologist at Oregon Urology, said he was surprised to hear that his practice had increased the county's costs so much.

"We don't over-order tests and procedures" he said in a telephone interview. He added that Oregon Urology's new IMRT business was especially brisk in 2008 because some patients delayed their treatments until the new technology became available, creating "pent-up demand."

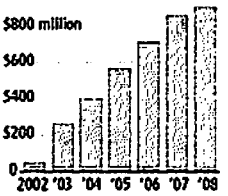
Terry Fitzpatrick, Oregon Urology's administrator, said an increase in prostatectomies following a local hospital's purchase of a surgical robot may also have contributed to Lane County's higher prostate-cancer treatment costs in 2008. Oregon Urology's surveys show that 99.5% of the patients treated with IMRT rated their care excellent, he added.

That may be so, says Christine Cha, regional medical director of radiation oncology at the Providence Cancer Center in Portland. But she says that if Lane County's experience is replicated across the country as baby boomers flood into the Medicare program in coming years, "how are we going to pay for that?"

(See related letters: "Letters to the Editor: Is Radiation Treatment for Prostate Cancer Overused?" – WSJ December 18, 2010)

Chain Reaction

Medicare payments for Intensity-Modulated Radiation Therapy (IMRT)



Note: Most IMRT treatment is believed to be for prostate cancer.

Source: WSJ analysis of CMS data

Document J000000020101208e6c80004b

EXHIBIT E

THE WALL STREET JOURNAL.

Secrets of the System: Top Spine Surgeons Reap Royalties, Medicare Bounty

By John Carreyrou and Tom McGinty
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20 December 2010
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Norton Hospital in Louisville, Ky., may not be a household name nationally. But five senior spine surgeons have helped put it on the map in at least one category: From 2004 to 2008, Norton performed the third-most spinal fusions on Medicare patients in the country.

The five surgeons are also among the largest recipients nationwide of payments from medical-device giant Medtronic Inc. In the first nine months of this year alone, the surgeons -- Steven Glassman, Mitchell Campbell, John Johnson, John Dimar and Rolando Puno -- received more than $7 million from the Fridley, Minn., company.

Medtronic and the surgeons say the payments are mostly royalties they earned for helping the company design one of its best-selling spine products.

Corporate whistleblowers and congressional critics contend such arrangements -- which are common in orthopedic surgery -- amount to kickbacks to stoke sales of medical devices. They argue that the overuse of surgical hardware ranging from heart stents to artificial hips is a big factor behind the soaring costs of Medicare, the government medical-insurance system for the elderly and disabled.

Medtronic says it can't develop new medical products that improve patients' lives without the help of surgeons. It says the royalties it pays them are legitimate but it doesn't give detailed information about what intellectual property each recipient contributes. It says it doesn't pay its collaborating surgeons royalties on the devices they personally use in their patients, removing any financial incentive for them to do more surgeries than necessary.

Norton's Dr. Glassman cited this policy as a safeguard against any conflict of interest and said the royalties he and his colleagues receive are "legitimate." He added that they inform their patients of their financial ties with Medtronic. Norton Hospital said it has policies "to prevent direct conflicts of interest." The other Norton surgeons didn't respond to requests for comment put to them through Norton and Dr. Glassman.

Using a Medicare database that tracks hospitals' billing, The Wall Street Journal was able to ascertain that Norton is among the most aggressive practitioners of spinal fusion in the country.

Spinal fusion has become one of medicine's most controversial procedures. It involves fusing together two or more vertebrae to alleviate back pain, usually with the help of metal plates, rods and screws implanted in the patient's back. Tens of thousands of dollars of hardware can go into a single surgery.

Medtronic is the biggest maker of spinal implants. Last year, its spine business generated world-wide sales of $3.5 billion, accounting for half of the roughly $7 billion spinal-implant market.

Conservative spine surgeons argue that a spinal fusion is appropriate only for a small number of conditions, such as spinal instability, spinal fracture or a severe curvature of the spine known as scoliosis, and that financial incentives have caused the procedure to become overused.

Others say it's a useful tool to treat patients who have debilitating back pain and have tried other options like physical therapy to no avail.

The Journal consulted several experts to determine which back conditions are commonly thought to require a fusion and which are subject to the most debate. The most hotly debated use of spinal fusion surgery centers on patients who merely suffer from aging disks, a condition known as degenerative disk disease.

One health insurer, the nonprofit Blue Cross and Blue Shield of North Carolina, announced in September that it would stop paying for spine fusions performed on such patients beginning on Jan. 1. The insurer said that the procedures are "considered not medically necessary."

The Journal mined hospitals' Medicare claims to see what proportion of fusions performed fall in this category. Due to a three-decade-old court ruling guarding the confidentiality of physician information, the paper is barred from disclosing what it found regarding the five Norton surgeons.

Critics of the court ruling and of the privacy policies of the federal Medicare program argue that making such information public would help taxpayers understand where their money is going, and potentially deter abusive or wasteful practices.

But the Journal is permitted to disclose its findings for Norton Hospital as a whole, where 27 surgeons performed one or more spine fusions in 2008.

At Norton, spinal fusions on patients who only suffered from aging disks accounted for 24% of the 2,475 fusions the hospital performed for Medicare between 2004 and 2008, compared with 17% nationally.

This placed it 11th in percentage terms out of 60 hospitals that performed 1,000 or more spine fusions in those years, and fourth in raw count. Norton ranked third nationally in the overall numbers of spine-fusion surgeries.

In emailed responses to questions, Dr. Glassman said he and his four colleagues "do not overuse spine fusion procedures," and argued that the diagnostic codes the Journal based its analysis on "do not convey indication for spinal fusion with the specificity that you are attributing to this data."

Citing studies he has published in medical journals, Dr. Glassman added that he and his colleagues were "leaders among spine surgeons nationally in comparative effectiveness research" and in developing ways to measure the outcomes of spinal fusions.

Spinal fusion as it's currently practiced is a relatively recent addition to American medicine. The use of spinal implants to help the fusion of vertebrae was pioneered by surgeons in France in the 1980s. The U.S. Food and Drug Administration approved their use in 1995, ushering in a fast-growing medical industry in the U.S.

Medtronic became the market leader in 1998 when it acquired Memphis-based Sofamor Danek Inc., itself the product of an earlier merger between a French and an American company.

According to the Journal's analysis of Medicare claims, the procedure went from costing Medicare $343 million in 1997 to $2.24 billion in 2008. Adjusted for inflation, that's nearly a 400% increase. A large portion of that money flowed back to device makers, whose expensive implants eat up most of Medicare's reimbursement for the procedure.

Spinal implants became big profit generators for device makers. The screws used to drill into bone, known as pedicle screws, sell for $1,000 to $2,000 apiece but cost less than $100 to make. A bone-growth protein used to help vertebrae fuse can sell for more than $5,000 a pack, depending on the size.

"You can easily put $30,000 worth of hardware in a person during a fusion surgery," says Charles Rosen, a spine surgeon at the University of California, Irvine School of Medicine who created a group called the Association for Medical Ethics to combat what it sees as conflicts of interest in spine surgery.

Some recent studies have suggested poor outcomes for spinal fusion. A study published in the Journal of the American Medical Association, or JAMA, in April found that Medicare patients with a condition called spinal stenosis who had more than two vertebrae fused, a procedure known as a complex fusion, were nearly three times more likely to have life-threatening complications than patients who had a less invasive procedure known as a decompression.

Spinal stenosis is a narrowing of the spine which puts pressure on the spinal cord or spinal nerves.

Another study of workers' compensation cases published this year in the online edition of the journal Spine showed that patients who had a spinal fusion were much less likely to return to work within two years after their surgery than a group of patients with similar conditions who didn't have surgery, and that 27% of them had to be re-operated on.

Their rate of permanent disability was more than five times as high as the patients whose spines weren't fused, and their daily intake of powerful narcotic painkillers increased by 41% after surgery.

The study's lead authors, Trang Nguyen and David Randolph of the University of Cincinnati College of Medicine, said magnetic resonance imaging scans of the spines of eight of the 725 patients who had a fusion "were perfectly normal," suggesting their surgeries were unnecessary.

Other studies have focused on the benefits of fusions. At the annual meeting of the American Academy of Orthopaedic Surgeons in Las Vegas in February 2009, Norton's Dr. Glassman presented a study on lumbar fusions that showed a significant improvement in fused patients' back pain, leg pain and other quality-of-life measures, both one and two years after their surgery. The study suggested the

improvement was even greater in patients older than 65.

For surgeons, the financial incentives to perform spine fusions can be strong. Though hospitals often lose money on the procedure when it's performed on Medicare patients due to the high cost of the implants, the surgeons themselves can get paid as much as $12,000 per surgery.

Complex fusions, the procedure studied in the JAMA paper, are reimbursed by Medicare at a sharply higher rate than decompressions, to account for the elaborate spinal devices used and the longer length of surgery. Complex fusions increased 15-fold among Medicare beneficiaries with spinal stenosis from 2002 to 2007, according to the JAMA study.

A big part of many surgeons' income lies in their consulting and royalty arrangements with device makers, although disclosure of these arrangements remains piecemeal for now. Medtronic began releasing information about its payments to surgeons on its website in June, after coming under intense scrutiny from Sen. Charles Grassley (R., Iowa).

Five other makers of orthopedic devices have disclosed their payments to surgeons who perform hip and knee replacements following a probe by U.S. prosecutors that resulted in a $311 million settlement in 2007. A new federal law included in the federal health-care overhaul mandates disclosures of all such physician payments by 2013.

At the North American Spine Society's annual conference in Orlando, Fla., in October, more than 250 spine surgeons self-disclosed financial relationships with spine-device manufacturers under a policy adopted by the professional group. Many reported receiving hundreds of thousands of dollars or more from multiple device makers, in addition to having private investments in numerous companies.

One surgeon at a hospital in the Midwest disclosed receiving between $400,000 and $1.3 million in royalty, consulting and other payments from three spine-device makers. Using the Medicare-claims database, the Journal found this surgeon performed 276 spinal fusions on Medicare patients in 2008, by far the most of any surgeon in the country.

According to the Journal's analysis, 38% of those fusions were performed on patients with aging disks. More than half of this surgeon's patients were residents of two counties with fusion rates four times the national average.

Due to privacy constraints, the Journal is barred from naming this surgeon.

Alexander Vaccaro, a spine surgeon at Thomas Jefferson University Hospital in Philadelphia, disclosed receiving between $415,000 and $2.03 million in royalties from six device makers in 2009, and between $165,000 and $666,000 in consulting fees from nine device makers. Dr. Vaccaro also disclosed owning stock in 28 companies, mostly medical-device makers.

Medtronic's website shows that the company paid Dr. Vaccaro $1.28 million in royalties in the first three quarters of 2010.

Cultivating good relations with surgeons like Dr. Vaccaro is valuable to device makers because they often perform more than 100 spine fusions a year and use thousands of dollars of implantable devices during each surgery. They can also influence the clinical practices of their peers by speaking at medical conferences or authoring research papers in medical journals.

Based on the Journal's analysis, Dr. Vaccaro's hospital performed 1,177 spine fusions on Medicare beneficiaries from 2004 to 2008. It received a total of $30.6 million from Medicare for those surgeries, ranking it 20th among all U.S. hospitals by the amount of Medicare dollars collected for the procedure. Thomas Jefferson ranked No. 4 among hospitals that perform the highest proportion of complex fusions.

Asked about his extensive financial relationships with device makers, Dr. Vaccaro said: "It looks crazy, I agree." But he said he has no say in which spine products his hospital uses. Dr. Vaccaro said he doesn't receive royalties from Medtronic on devices he personally implants. He added that he tells his patients about his relationships with device makers in the consent form he makes them sign before operating on them.

Not all spine surgeons with industry ties do so. When Timothy Roberson, a 48-year-old former tire-factory worker, had his spine fused by surgeon Kevin Foley at Memphis's Methodist University Hospital in August 2000, he says Dr. Foley didn't tell him of his relationship with Medtronic.

Mr. Roberson says the disks above his fused vertebrae wore out within 18 months of the operation because of the extra stress they had to bear -- a risk of fusion surgery. To deal with the pain, he had a pump implanted in his stomach that he refills with narcotics every five weeks.

Mr. Roberson sued Dr. Foley for malpractice, but the litigation was initially over an unrelated issue. He alleged in his suit that he lost the use of his biceps after being left prone on the operating table with his arms elevated for nearly seven hours before the surgery started.

The case was tried three times, and by the third Mr. Roberson added allegations that the surgery had damaged his back. The first two trials ended in hung juries; Dr. Foley won the third in 2008.

Dr. Foley has had royalty-bearing agreements with Medtronic since 1996. The company paid him more than $27 million from 2001 to 2006, according to internal Medtronic documents reviewed by the Journal. On its website, the company discloses paying him another $13 million in royalties in the first three quarters of this year alone.

Dr. Foley's attorney, Buckner Wellford, said there was no reason for Dr. Foley to disclose his Medtronic relationship to Mr. Roberson because the pedicle screws he used in the surgery, though made by Medtronic, weren't invented by Dr. Foley and earned him no royalties. Mr. Wellford adds that the fusion surgery Dr. Foley performed on Mr. Roberson was successful and didn't cause his current back condition.

Asked whether he ever tells his patients of his ties to Medtronic, Dr. Foley responded in an email that he doesn't receive any royalties from Medtronic on devices he has contributed to when they are implanted in patients by himself, members of his practice or hospitals where he has admitting privileges.

Brian Henry, a spokesman for Medtronic, says the company applies that policy to all its collaborating surgeons, thereby eliminating the temptation for them to do more surgeries to earn more royalty income.

Two former Medtronic employees have alleged in separate whistleblower lawsuits that the royalty agreements are intended to disguise the fact that the payments the company makes to surgeons are really kickbacks for using Medtronic devices.

One of the suits was filed in U.S. District Court in Memphis, Tenn., in 2002 by a former counsel at Medtronic's spine division. After the Justice Department joined the suit, Medtronic settled the case for $40 million in 2006 while denying wrongdoing. The other suit was subsequently dismissed.

Most of the settled suit remains sealed, but the Journal reviewed an unredacted copy. It says the five surgeons at Kentucky's Norton Hospital became Medtronic's biggest spine client after they signed consulting and royalty deals with the company in early 2001.

Medtronic declined to comment on the suit. In an email, Dr. Glassman said he had no knowledge of it but added that the Medtronic royalties were "for legitimate contributions to the development of" a Medtronic device used to treat scoliosis and other conditions.

Medtronic doesn't specify how it awards royalties and consulting fees to surgeons involved in the invention of new devices. It says surgeons' device-development work goes beyond mere consulting when the company deems that they are contributing valuable intellectual property to a product. But that intellectual property doesn't necessarily have to be patented, it says.

A search of spine-device patents awarded to the Norton surgeons turned up about a dozen total for Drs. Puno, Johnson, Campbell and Dimar, most owned by companies other than Medtronic. The search turned up no patents for Dr. Glassman.

From 2004 to 2008, Medicare paid Norton Hospital $48 million for the 2,475 spinal fusions it performed on Medicare patients during those five years, according to the Journal analysis.

Norton and Medtronic both declined to say how much of that money went to pay for Medtronic devices. But, through a hospital spokesman, Dr. Glassman and his colleagues acknowledged "predominantly" using Medtronic devices in their surgeries.

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Courtney Banks contributed to this article.

(See related letters: "Letters to the Editor: Spine Surgeons Reap Royalties, Praise and Criticism" – WSJ Dec. 27, 2010)

Document J000000020101220e6ck00028

EXHIBIT F

Confidentiality Cloaks Medicare Abuse

The Wall Street Journal
December 22, 2010
Page A1

By Mark Schoofs and Maurice Tamman

Christopher G. Wayne doesn't look like a typical family-practice doctor. Known to admirers as the "Rock Doc," he wears his hair spiked, punk style, and festoons himself with chains, bangles and leather bracelets.

He uses his upscale Miami Beach home as a production studio for Playboy photo spreads, and his MySpace page shows him posing with celebrities such as Paris Hilton and Aerosmith's Steven Tyler.

There's something else about Dr. Wayne that doesn't resemble a normal family-practice doctor: his earnings from Medicare, the government insurance program for the elderly and disabled. Dr. Wayne took in more than $1.2 million from Medicare in 2008, according to a person familiar with the matter, a large portion of it from physical therapy. That's more than 24 times the Medicare income of the average family doctor, according to a Wall Street Journal analysis of Medicare-claims data.

The regimen of physical therapy Dr. Wayne said he usually provided—30 minutes each of heat packs, massage, electrical stimulation and ultrasound—is also unusual.

Stephen Levine, a former board member of the American Physical Therapy Association, said those services are usually used in conjunction with more sophisticated forms of therapy, such as neuromuscular reeducation. Used on their own, with rare exceptions, "it's a form of abuse," said Mr. Levine. "Wouldn't we all love to...have someone rub our backs and have the government pay for it—but it's just not appropriate," he added.

Dr. Wayne, a 50-year-old osteopath, denies abusing the system and hasn't been accused of wrongdoing by authorities. He says his regimen "does wonders" if used

correctly. He adds that he gave physical therapy to "patients who needed it, with appropriate diagnoses, and I should get paid for it."

Medicare administrators apparently felt otherwise. In 2009 he says he was placed on heightened scrutiny and eventually sold his business. But not until he had received more than $2.6 million from Medicare between 2007 and 2009, according to the person familiar with the matter.

Physical therapy, which cost Medicare almost $3.5 billion in 2008, offers a case study in how Medicare polices its payments. Even when Medicare identified providers whose physical-therapy billing raised red flags, it kept paying thousands or even millions of dollars, sometimes for years, The Wall Street Journal found. Among the cases:

• A physical therapist in Brooklyn who billed for so much therapy—more than $2.5 million in 2008 alone—that it would have been virtually impossible for him to have performed it all within state and Medicare guidelines, fraud experts say. Medicare has continued to pay him, shelling out nearly a million dollars through July of this year.

• A second doctor in Florida who pocketed more than $1.8 million from Medicare in 2007, much of it from physical therapy on patients with an extremely rare condition. Even after a Medicare antifraud contractor flagged this doctor, the agency paid him at least $6.7 million over more than two years.

• A Houston doctor whose Medicare billing under her provider number spiked from zero to more than $11.6 million in less than a year. At the time, this doctor was being investigated for misconduct in a company owned by a Nigerian with an alleged history of fraud.

There are plenty of reasons why Medicare often fails to stop questionable payments up front. To protect law-abiding doctors and hospitals—the vast majority—Medicare is required to pay nearly everybody within 30 days. Medicare says it is reluctant to suspend payments to providers who may have made honest mistakes, out of concern that beneficiaries might go without needed treatment. Law-enforcement agencies and Medicare contractors, overwhelmed by the sheer volume of Medicare fraud cases, can't investigate and prosecute them all. Sometimes, prosecutors and investigators ask Medicare to keep paying so as not to tip off targets of an investigation.

But a central problem is that Medicare hasn't fully exploited its most valuable resource: its claims database, a computerized record of every claim submitted and every dollar paid out.

"That's really the crux of the issue," said Kimberly Brandt, who led Medicare's antifraud efforts from 2004 through June of this year. She said the program is "definitely on the right path" to making better use of its database, "but it's not going to be a flip of the switch or an easy transition."

The Wall Street Journal originally identified Dr. Wayne and the other medical providers discussed in this article through a Medicare database that is much more limited than the one available to fraud investigators. The database, obtained in conjunction with the nonprofit Center for Public Integrity, contains records only through 2008, and includes the claims of just 5% of randomly selected Medicare beneficiaries.

Under a three-decade-old court decision protecting physician privacy, Medicare is prohibited from releasing to the public details of doctors' billings. The Journal agreed not to publish individual physician billing information obtained solely through the database as part of its arrangement with the Centers for Medicare and Medicaid Services, or CMS. Billing figures for doctors named in this article were obtained from the providers themselves or from others familiar with their businesses.

Some law-enforcement veterans argue that the government should release billing data to the public as a deterrent to fraud and abuse, so long as patient confidentiality isn't compromised. Kirk Ogrosky, a former assistant U.S. attorney specializing in health-care fraud and now a partner at the law firm Arnold & Porter LLP, says law enforcement can't do all the work on its own. He adds that when doctors "understand their billing information is public and people can examine it, that deters them from overbilling."

Peter Budetti, the head of CMS's new antifraud arm, says Medicare is moving away from its traditional "pay-and-chase" approach, in which it tries to recover improper payments already out the door. He says he'd like to emulate the credit-card industry, which has developed software to flag suspicious charges before paying them. "Fraud prevention is our new emphasis," he said.

The main responsibility for flagging fraudsters lies with a network of private contractors that are tasked with mining the data.

There are occasional false alarms. About two years ago, a claim for a prostate exam performed on a woman raised suspicions, according to executives at one Medicare contractor. It turned out to be a legitimate case because the patient had undergone a sex-change operation.

The final line of defense is law enforcement. The Bush and Obama administrations have expanded multiagency strike forces—called HEAT, for Health Care Fraud Prevention and Enforcement Action Teams—into new cities beyond their original base in southern Florida. In contrast to most previous efforts, these teams mine claims data to decide which cities, types of fraud, and providers to target. Since March 2007, federal health-fraud prosecutors with these strike forces have charged more than 850 defendants for alleged frauds exceeding $2 billion in billings, according to the government.

Overall, the highest-dollar schemes have involved pharmaceutical and drug-company fraud, followed by hospital scams, according to data from the Health and Human Services inspector general. Recently, physical-therapy abuse has cropped up on the federal radar screen. Law-enforcement authorities were so alarmed by the physical-therapy billing patterns in Brooklyn that they deployed a special strike force there. In Florida's Miami-Dade County, a known Medicare-fraud hot spot, 2009 per-patient expenditures on outpatient therapy were triple the national average, according to CMS.

A Journal analysis of the 5% database focused on the physicians and physical therapists in private practice who performed the most physical-therapy treatments per patient. Only 3% of providers administered 90 or more treatments per patient; the national average was about 40. That top 3% accounted for more than 14% of all Medicare physical-therapy expenditures from 2003-2008, or an estimated total of nearly $1.3 billion. While some of that billing would be legitimate, said Mr. Levine, much of it would likely be abusive or fraudulent.

One Florida physician—not Dr. Wayne—made almost all his money from physical therapy, according to the Journal's analysis of the 5% database. According to separate billing totals reviewed by The Wall Street Journal, this internal-medicine doctor took home more than $8.1 million from Medicare from 2007 through 2009.

The Journal cannot name this doctor because the paper was able to learn a crucial piece of information about his practice—the type of disorder he billed for—only from the database, not from any other source.

From 2006 through 2008, more than 40% of this doctor's patients in the database were described as suffering from brachial neuritis. That's a rare nerve-and-muscle condition estimated to occur in about three out of every 100,000 Americans. In 2008, the Florida doctor earned at least 25% more from brachial neuritis patients than any other provider, according to the Journal's database analysis.

A contractor in charge of ferreting out fraud in Florida—SafeGuard Services LLC, owned by Hewlett-Packard Co.—flagged this doctor for heightened scrutiny at least as early as June 2007. But it wasn't until September 2009 when Medicare stopped paying nearly all of his claims, according to a government official with knowledge of the matter. During that time, Medicare paid out more than $6.7 million to this doctor, according to the billing totals reviewed by the Journal.

Officials from SafeGuard and CMS declined to comment, citing the policy against discussing any particular provider.

In the 1990s, this doctor filed for bankruptcy. On a recent morning a Porsche and a late-model Mustang sat in the driveway of his spacious middle-class home. Asked about his medical practice, the doctor said, "I don't have anything to say to you," and shut his door.

The Journal's analysis suggests one center of intensive physical-therapy billing is Houston. That's where Dr. Theresa Rice works. Dr. Rice, who is in her late 70s and received her medical degree in the Philippines, has been licensed to practice medicine in Texas since 1981, public records show.

In 2004, she was convicted of shoplifting $748 in jewelry from a Foley's department store. In an interview, Dr. Rice at first denied the conviction, saying there must have been a computer error. After being told that the Journal had her booking photo, she admitted that she had shoplifted. "I lied to you," she said.

In 2007, the Texas Medical Board began probing Dr. Rice for her involvement in a business owned by a Nigerian businessman "who has a history of fraudulent activity, and is sought by authorities under several known aliases," according to a Medical Board document. Dr. Rice approved home health services based on patient assessments made by an unqualified physician assistant, and she could provide no medical records for those patients, the Board found.

Dr. Rice said she was duped in that case, an explanation the Medical Board accepted. She was fined $1,500 and required to take a course in medical ethics, according to the Medical Board document.

Dr. Rice billed Medicare nothing in 2007 for services she performed or supervised, according to a person familiar with her business. But starting in October 2008, billing under her provider number skyrocketed. In less than a year, Medicare received claims totaling over $11.6 million and paid out more than $7.1 million.

Medicare stopped paying in mid-2009, when federal investigators shut down the clinic where she worked, City Nursing. That clinic was owned by a different Nigerian businessman, Umawa Imo. At least seven people have been indicted on health-fraud charges connected to the clinic, in what a senior law-enforcement official called the largest physical-therapy fraud in Houston history. The alleged scheme involved several people of Nigerian descent as well as at least two American doctors, according to the federal indictment and law-enforcement officials. Medicare paid out about $27 million over 28 months, according to the indictment.

Dr. Rice wasn't indicted and maintains she was duped again. Mr. Imo has pleaded not guilty to health-care fraud and conspiracy charges. His lawyers said he is innocent and trusted the people running the clinic.

Short of an audit or investigation, there is often no way to tell who actually performs physical therapy. That's because doctors who "directly" supervise physical therapists—meaning the doctor is in the same office suite at the same time the therapy is being performed—don't need to state on the claim form who administered the therapy. It's billed as if the doctor performed it.

In the case of City Nursing, the clinic where Dr. Rice worked, an affidavit for a search warrant alleges there was only one physical therapist. The indictment charges that patients were paid to sign documents saying they had received physical therapy that never happened.

Dr. Rice is now working at a storefront operation called Clinica de la Familia. A CMS spokesman said she's no longer eligible to get paid by Medicare and declined to provide further details. Of her current clinic, Dr. Rice said, "We are not doing any fraudulent thing."

Federal authorities say that in Brooklyn, physical-therapy abuse appears to be especially rife among Russian immigrants. A Journal analysis of the 5% database shows that eight of Medicare's 30 top-earning physical therapists work in Brooklyn. Seven of them have names that seem Russian or from neighboring nations.

Brooklyn physical therapist Aleksandr Kharkover billed Medicare for more than $2.5 million in 2008, according to a person familiar with his business, and received more than $1.8 million.

On an autumn weekday at about 9:00 in the morning, two Journal reporters arrived at Mr. Kharkover's home, a brick bungalow. He appeared in a white T-shirt emblazoned with the slogan, "Freedom isn't free." Asked if billing $2.5 million to Medicare fit with his records, he replied, "I'd say that fits."

Mr. Kharkover and two people familiar with his practice said he sees patients only in their homes. Fraud experts say this makes it virtually impossible for him to have legitimately billed such high amounts.

New York State allows a physical therapist to supervise only two assistants on home visits, and the therapist must be in the same home at the same time as his assistants, according to New York State and Medicare officials. Unless Mr. Kharkover held therapy sessions in which several patients congregated in one home, he would effectively be limited to billing little more than what he himself could perform.

Under generous assumptions, a single therapist could earn $1 million from Medicare in a year by working 12.5 hours a day, seven days a week, with no time off. Medicare paid Mr. Kharkover more than $960,000 in the first seven months of this year, according to the person familiar with his business.

CMS and its main New York antifraud contractor, SafeGuard Services, declined to comment on Mr. Kharkover.

Mr. Kharkover declined a second interview. His attorney, Montell Figgins, said his client is a "successful businessman," adding that "there is no reason to believe my client was doing anything illegal."

As for Dr. Wayne, he said he expanded physical therapy at his clinic near Miami's design district because his patients needed it. Medicare regulations require that

physical therapists billing under a physician must have completed an accredited physical-therapy education program. But Dr. Wayne said he trained his "office girls" to do the work in part because hiring full-fledged physical therapists was too expensive.

Referring to Medicare's therapist-education requirement, he said, "I interpret that as, 'If I train them in physical therapy, that should be good enough.'"

Dr. Wayne acknowledged grossing $1.1 million or $1.2 million from Medicare in 2008, and estimated his take-home that year from his clinic was roughly $400,000. He said his Medicare reimbursements plummeted after March 2009, when he says Medicare tightened scrutiny of his billing. According to the person familiar with the matter, Medicare paid only about 12.5% of his claims in the second half of 2009.

Dr. Wayne said he is appealing many of the denied claims, but that the drop in Medicare reimbursements and other business issues led him to sell his practice and caused him financial distress. On a recent evening, he opened envelopes from a bank, and said they were notices of bounced checks.

Still, full-scale replicas of medieval knights' armor greet guests at his home, and hanging on the walls are what he said are two original Picassos, several Dalis and photographs by Helmut Newton. Also present recently was Eliza Carson, a Playboy model who said she's 20 years old. She barely glanced up from texting on her phone as she asked Dr. Wayne how he managed to keep his hair spiky when he sleeps. He explained that he uses an airplane pillow.

Dr. Wayne now works in a pain-management clinic in Fort Lauderdale. He said he doesn't have a board certification in pain management, and said the clinic accepts only cash. Of his patients at the clinic, Dr. Wayne said, "I write their pain prescriptions, and they're gone."

—James Oberman, Anton Troianovski and Gina Chon contributed to this article.

EXHIBIT C

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,

Plaintiffs,

v. Case No. 78-178-Civ-J-S

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,

Defendants,

DOW JONES & COMPANY, INC.
1211 Avenue of the Americas
New York, NY 10036

Intervening Defendant.
_____/

DECLARATION OF MAURICE TAMMAN IN SUPPORT OF DOW JONES & COMPANY, INC.'S MOTION TO INTERVENE

I, Maurice Tamman, pursuant to 28 U.S.C. § 1746, declare as follows:

1. Since 2008, I have been a News Editor at *The Wall Street Journal* ("the *Journal*"), published by Dow Jones & Company ("Dow Jones"). Before that, I was an online editor and investigative reporter with the *Sarasota Herald Tribune* and have worked at three other newspapers including the *Atlanta Journal-Constitution.* For most of my 20-year career, I have worked as an investigative reporter using data to build stories covering issues as diverse as election irregularities, banking problems, and real estate property and taxation trends. I focus on computer assisted reporting, which entails using computers to gather and analyze data necessary to write news stories. I make this declaration in support of Dow Jones's Motion to Intervene. I have personal knowledge of the facts contained herein, except those matters stated on information and belief.

The 2009 Freedom of Information Act Request

2. In 2009, the non-profit Center for Public Integrity ("CPI") and the *Journal* agreed to team up to investigate waste, fraud, and abuse in Medicare billings. We decided that the best source of this information was a set of databases known as the Limited Data Set Files (the "LDS Files"). The LDS Files are maintained by a Department of Health and Human Services ("HHS") agency, the Centers for Medicare & Medicaid Services ("CMS"). Like many journalists who focus on computer assisted reporting, I have long sought access to the LDS Files because they constitute the most comprehensive, most authoritative resource for reporting on Medicare payments and the ways in which oversight of the system may be flawed.

3. The Carrier Standard Analytic File (the "Carrier File") is the most valuable of these databases, because it includes complete, nationwide records of Medicare Part B fee-for-service billing and payments. It contains data on more claims than any other Medicare file, and it is the only LDS File containing direct physician billings. While the other LDS Files contain records of hospitals and large institutions, records in the Carrier File provide the most information on individual providers – the treatments they bill for and how much they are reimbursed. We viewed the Carrier File, in particular, as vital to our investigation.

4. I understand that this case originally arose because the Department of Health, Education & Welfare released a partial list of Medicare billings of individual providers for the year 1975. This information likely came from the Carrier File. To my knowledge, no news organization has ever been permitted access to the entire Carrier File, or even a 5% sample of the file. But this information is made available, in another format, to researchers.

5. By a Freedom of Information Act ("FOIA") request dated June 30, 2009 ("FOIA Request"), CPI requested copies of portions of certain LDS Files – MEDPAR, a file with

summaries of billings by hospitals, for 1997 through 2008; Denominator files for 1999 through 2008, which include detailed information on all Medicare beneficiaries with patient identities encrypted; and Standard Analytic Files for 1999 through 2008, including the Carrier File, hospital in-patient and out-patient claims files, a hospice claims file, a skilled nursing care facility claims file, a home health care claims file, and a durable medical equipment claims file. I assisted CPI in formulating the FOIA Request.

6. When HHS did not respond to the FOIA Request, CPI filed a lawsuit under FOIA to obtain the information. *Center for Public Integrity v. HHS*, # 1:09-cv-01878-RBW (filed 10/02/2009). I was involved with the settlement negotiations with HHS. I am informed and believe that HHS indicated that it could not release the requested file to the *Journal* due to the injunction issued by this Court in 1979 in this case, prohibiting the release of Medicare reimbursement amounts which would personally and individually identify providers ("1979 Injunction"). HHS indicated, however, that it could sell the *Journal* a sample of the Carrier File and other Standard Analytic Files with the identities of Medicare providers encrypted, as well as 100% of the MEDPAR and Denominator files, subject to restrictions dictated by the 1979 Injunction. CPI voluntarily dismissed its suit. As part of the settlement of the FOIA action, Dow Jones and CPI arranged to purchase from HHS a portion of the LDS Files. Once CPI and the Journal obtained the Files, each institution pursued its own reporting lines independent of the other. In essence, our cooperation was limited to obtaining the Files.

About the Limited Data Set Files

7. The LDS Files are extremely difficult to analyze because they are enormous and maintained in an archaic format. A 5% sample of the Carrier File for 2008 has about 42 million rows, each with 612 variables. It is about 38 gigabytes even before being imported into a

database. A decade of the 5% Carrier File data would be about 400 million records and be about 350 gigabytes before being imported. Ten years of LDS Files, after being imported and reformatted, would take up about four terabytes – four trillion bytes – of disk space.

8. When the CPI suit was dismissed, Dow Jones and CPI arranged to purchase a portion of the LDS Files. Dow Jones and CPI negotiated a $12,000 fee for an amended version of the original request described above – the entire MEDPAR file for 1997, 2004-2008; the entire Denominator files for 1999, 2001, 2003-2008; and a 5% sample of the Carrier File and other Standard Analytic Files for years 1999, 2001, 2003-2008.

9. In addition, because the Carrier File as originally provided included only encrypted information on providers, Dow Jones and CPI subsequently arranged to purchase a "Crosswalk" file, which allowed decryption of provider information, for $2,000. Dow Jones and CPI subsequently purchased inpatient and outpatient data from 2004-2008 for $2,000. Dow Jones alone later purchased additional data on 100% of claims for tax ID numbers associated with the largest urology practices in the country – plus 100% of the in-patient and out-patient Standard Analytic Files for 2008 and 2009 – for $9,700. In total, Dow Jones and CPI have paid over $25,000 for portions of these LDS Files.

The Series: *Secrets of the System*

10. Since March 2010, the *Journal* has relied on the LDS Files to produce a series of front-page articles entitled *Secrets of the System* (the "Series"). Copies of articles in the Series are attached as Exhibits to the Declaration of Michael Allen, which also is being submitted in support of Dow Jones's Motion to Intervene ("Allen Declaration"). They are further described in the Declaration of Mark Schoofs ("Schoofs Declaration"), also being filed in support of Dow Jones's intervention.

11. As reported in the Series, and discussed in the Allen and Schoofs Declarations, the *Journal*'s investigations found significant evidence of potential waste, fraud, and abuse in Medicare billing. For example, I understood that government investigators and fraud experts consider billing totals that are two standard deviations above average for a particular specialty or treatment as meriting investigation for potential fraud – in a normal statistical distribution, 95% of a given sample will be within two standard deviations. Based on the 5% sample of the Carrier File, among 811,000 providers, I was able to identify approximately 75,000 providers with billing totals two standard deviations above average by procedure, and over 5,000 providers with billing totals *five* standard deviations above average by specialty.

Restrictions on the use of the Limited Data Set Files

12. But HHS placed significant limitations on our use of the data. *First*, HHS had agreed to provide us *only* with claims for a random 5% sample of patients in the Carrier File and other Standard Analytic Files. I understood that one reason CMS does not provide 100% of the data is because the agency fears that doing so would violate the 1979 Injunction. One senior CMS official explained that if a person with access to the file managed to deduce who a particular provider was, then that person would know that provider's Medicare earnings.

13. Our ability to report on possible abuse in the Medicare system has been significantly hampered by the fact that we were permitted only a 5% sample of the Carrier File and other Standard Analytic Files. It is impossible, for example, to simply multiply a provider's income derived from the sample to get an accurate estimate of a provider's total Medicare income. This is because the sample contains 5% of patients, not providers. Any given *provider* may have more or less than 5% of patients in the random sample, and there is no way to determine this from the sample. As noted in the Allen and Schoofs Declarations, this allowed us

to spot only those anomalies large enough to appear in a 5% sample. I believe that many instances of potential fraud, abuse, and waste are obscured. As discussed in the Allen Declaration, the only instance where we were eventually able to obtain 100% of the provider billings – for 57 of the nation's largest urology practices – proves the value of the complete file. We were able to rebut unfounded claims about billings with the facts from these records.

14. *Second*, acquisition of the LDS Files was subject to a standardized Data Use Agreement ("Agreement") that required Dow Jones and CPI not to disseminate information derived from the LDS Files if it could be used to deduce an individual doctor's identity. Attached as Exhibit A is a true and correct copy of the Data Use Agreement and Attachment. Though Dow Jones negotiated an addendum which narrowed the Agreement – making clear that we could report on provider identities or any other information that was obtained independent of the LDS Files, and that we could request a judicial determination permitting publication of data from the files – we realized that the Agreement nevertheless would significantly hamstring our reporting efforts.

15. One term of the Agreement was compliance with HHS's so-called cell-size suppression policy. Under this policy, no data may be disclosed for a group of fewer than 11 individuals. Thus, billing data from the LDS Files for a medical practice with 11 providers may be disclosed, but data for an individual provider, or a group of 10 providers, may not be. *See* Ex. A, ¶ 9. We thus were unable to publish Medicare payment data for individual providers or groups of less than eleven providers, unless the information was obtained independent of the LDS Files.

16. *Third*, the 1979 Injunction led HHS to impose particularly onerous security measures on any organization that receives the data. For example, because of the Agreement, the

LDS Files are kept on servers in a locked room, to which I have the only key. Any request for information from the LDS Files must go through me, as custodian of the data. This, too, significantly inhibits our ability to examine and report on the data.

17. I do not believe any of these limitations are necessary to protect *patient* privacy. Indeed, releasing the LDS Files would pose no danger to patient privacy, because patients are anonymized in the data and their identities are encrypted. We are not seeking, and we do not want any more patient information.

18. We agreed to sign the Agreement as modified because we retained the right to seek judicial relief from these restrictions, and because this Court's 1979 Injunction has blocked journalists' access to Medicare data nationwide for decades. Indeed, I understand that any time *any* provider information is included in LDS Files – whether or not related to income – the government routinely obscures this information due to the 1979 Injunction.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on January 24, 2011

Maurice Tamman

EXHIBIT A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0734

DATA USE AGREEMENT

DUA # 20348

(AGREEMENT FOR USE OF CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DATA CONTAINING INDIVIDUAL IDENTIFIERS)

CMS agrees to provide the User with data that reside in a CMS Privacy Act System of Records as identified in this Agreement. In exchange, the User agrees to pay any applicable fees; the User agrees to use the data only for purposes that support the User's study, research or project referenced in this Agreement, which has been determined by CMS to provide assistance to CMS in monitoring, managing and improving the Medicare and Medicaid programs or the services provided to beneficiaries; and the User agrees to ensure the integrity, security, and confidentiality of the data by complying with the terms of this Agreement and applicable law, including the Privacy Act and the Health Insurance Portability and Accountability Act. In order to secure data that reside in a CMS Privacy Act System of Records; in order to ensure the integrity, security, and confidentiality of information maintained by the CMS; and to permit appropriate disclosure and use of such data as permitted by law, CMS and the Center for Public Integrity and Dow Jones & Company, Inc. (Requestor) enter into this agreement to comply with the following specific paragraphs.

1. This Agreement is by and between the Centers for Medicare & Medicaid Services (CMS), a component of the U.S. Department of Health and Human Services (HHS), and the Center for Public Integrity and Dow Jones & Company, Inc. (Requestor) hereinafter termed "User."

2. This Agreement addresses the conditions under which CMS will disclose and the User will obtain, use, reuse and disclose the CMS data file(s) specified in section 5 and/or any derivative file(s) that contain direct individual identifiers or elements that can be used in concert with other information to identify individuals. This Agreement supersedes any and all agreements between the parties with respect to the use of data from the files specified in section 5 and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any grant award or other prior communication from the Department of Health and Human Services or any of its components with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by the CMS point-of-contact or the CMS signatory to this Agreement shown in section 20.

3. The parties mutually agree that CMS retains all ownership rights to the data file(s) referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by CMS.

4. The User represents, and in furnishing the data file(s) specified in section 5 CMS relies upon such representation, that such data file(s) will be used solely for the following purpose(s).

Name of Study/Project: Publication of Report(s) Analyzing Medicare Reimbursement for Possible Medicare Fraud and Patterns of Reimbursement

CMS Contract No. (if applicable)

The User represents further that the facts and statements made in any study or research protocol or project plan submitted to CMS for each purpose are complete and accurate. Further, the User represents that said study protocol(s) or project plans, that have been approved by CMS or other appropriate entity as CMS may determine, represent the total use(s) to which the data file(s) specified in section 5 will be put.

The User agrees not to disclose, use or reuse the data covered by this agreement except as specified in an Attachment to this Agreement or except as CMS shall authorize in writing or as otherwise required by law. sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement. The User affirms that the requested data is the minimum necessary to achieve the purposes stated in this section. The User agrees that, within the User organization and the organizations of its agents, access to the data covered by this Agreement shall be limited to the minimum amount of data and minimum number of individuals necessary to achieve the purpose stated in this section (i.e., individual's access to the data will be on a need-to-know basis).

5. The following CMS data file(s) is/are covered under this Agreement.

File	Years(s)	System of Record
(all files in ASCII format)		
Medpar (100%)	2004-2008	
Inpatient Standard Analytic Files (5%)	1997, 1999, 2001, 2003	
Denominator (100%)	2004-2008	
Denominator (5%)	1999, 2001, 2003	
Standard Analytic Files* (5%)	1999, 2001, 2003-2008	
*SNF, HHA, Hospice, Outpatient, Carrier, DME		

6. The parties mutually agree that the aforesaid files(s) (and/or any derivative file(s)), including those files that directly identify individuals or that directly identify bidding firms and/or such firms' proprietary, confidential or specific bidding information, and those files that can be used in concert with other information to identify individuals, may be retained by the User until January 22, 2015, hereinafter known as the "Retention Date." The User agrees to notify CMS within 30 days of the completion of the purpose specified in section 4 if the purpose is completed before the aforementioned retention date. Upon such notice or retention date, whichever occurs sooner, the User agrees to destroy such data. The User agrees to destroy and send written certification of the destruction of the files to CMS within 30 days. The User agrees not to retain CMS files or any parts thereof, after the aforementioned file(s) are destroyed unless the appropriate Systems Manager or the person designated in section 20 of this Agreement grants written authorization. The User acknowledges that the date is not contingent upon action by CMS.

   The Agreement may be terminated by either party at any time for any reason upon 30 days written notice. Upon notice of termination by User, CMS will cease releasing data from the file(s) to the User under this Agreement and will notify the User to destroy such data file(s). Sections 3, 4, 6, 8, 9, 10, 11, 13, 14 and 15 shall survive termination of this Agreement.

7. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it. The safeguards shall provide a level and scope of security that is not less than the level and scope of security requirements established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Systems (http://www.whitehouse.gov/omb/circulars/a130/a130.html) as well as Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" (http://csrc.nist.gov/publications/fips/fips200/FIPS-200-final-march.pdf); and, Special Publication 800-53 "Recommended Security Controls for Federal Information Systems" (http://csrc.nist.gov/publications/nistpubs/800-53-Rev2/sp800-53-rev2-final.pdf). The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, bidder identifiable or deducible information derived from the file(s) specified in section 5 is prohibited. Further, the User agrees that the data must not be physically moved, transmitted or disclosed in any way from or by the site indicated in section 17 without written approval from CMS unless such movement, transmission or disclosure is required by a law.

8. The User agrees to grant access to the data to the authorized representatives of CMS or DHHS Office of the Inspector General at the site indicated in section 17 for the purpose of inspecting to confirm compliance with the terms of this agreement.

9. The User agrees not to disclose direct findings, listings, or information derived from the file(s) specified in section 5, with or without direct identifiers, if such findings, listings, or information can, by themselves or in combination with other data, be used to deduce an individual's identity. Examples of such data elements include, but are not limited to geographic location, age if > 89, sex, diagnosis and procedure, admission/discharge date(s), or date of death.

   The User agrees that any use of CMS data in the creation of any document (manuscript, table, chart, study, report, etc.) concerning the purpose specified in section 4 (regardless of whether the report or other writing expressly refers to such purpose, to CMS, or to the files specified in section 5 or any data derived from such files) must adhere to CMS' current cell size suppression policy. **This policy stipulates that no cell (e.g. admittances, discharges, patients, services) 10 or less may be displayed.** Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less. By signing this Agreement you hereby agree to abide by these rules and, therefore, will not be required to submit any written documents for CMS review. If you are unsure if you meet the above criteria, you may submit your written products for CMS review. CMS agrees to make a determination about approval and to notify the user within 4 to 6 weeks after receipt of findings. CMS may withhold approval for publication only if it determines that the format in which data are presented may result in identification of individual beneficiaries.

10. The User agrees that, absent express written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement to do so, the User shall not attempt to link records included in the file(s) specified in section 5 to any other individually identifiable source of information. This includes attempts to link the data to other CMS data file(s). A protocol that includes the linkage of specific files that has been approved in accordance with section 4 constitutes express authorization from CMS to link files as described in the protocol.

11. The User understands and agrees that they may not reuse original or derivative data file(s) without prior written approval from the appropriate System Manager or the person designated in section 20 of this Agreement.

12. The parties mutually agree that the following specified Attachments are part of this Agreement:

    Attachment A

13. The User agrees that in the event CMS determines or has a reasonable belief that the User has made or may have made a use, reuse or disclosure of the aforesaid file(s) that is not authorized by this Agreement or another written authorization from the appropriate System Manager or the person designated in section 20 of this Agreement, CMS, at its sole discretion, may require the User to: (a) promptly investigate and report to CMS the User's determinations regarding any alleged or actual unauthorized use, reuse or disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by CMS, submit a formal response to an allegation of unauthorized use, reuse or disclosure; (d) if requested by CMS, submit a corrective action plan with steps designed to prevent any future unauthorized uses, reuses or disclosures; and (e) if requested by CMS, return data files to CMS or destroy the data files it received from CMS under this agreement. The User understands that as a result of CMS's determination or reasonable belief that unauthorized uses, reuses or disclosures have taken place, CMS may refuse to release further CMS data to the User for a period of time to be determined by CMS.

    The User agrees to report any breach of personally identifiable information (PII) from the CMS data file(s), loss of these data or disclosure to any unauthorized persons to the CMS Action Desk by telephone at (410) 786-2850 or by e-mail notification at **cms_it_service_desk@cms.hhs.gov** within one hour and to cooperate fully in the federal security incident process. While CMS retains all ownership rights to the data file(s), as outlined above, the User shall bear the cost and liability for any breaches of PII from the data file(s) while they are entrusted to the User. Furthermore, if CMS determines that the risk of harm requires notification of affected individual persons of the security breach and/or other remedies, the User agrees to carry out these remedies without cost to CMS.

14. The User hereby acknowledges that criminal penalties under §1106(a) of the Social Security Act (42 U.S.C. § 1306(a)), including a fine not exceeding $10,000 or imprisonment not exceeding 5 years, or both, may apply to disclosures of information that are covered by § 1106 and that are not authorized by regulation or by Federal law. The User further acknowledges that criminal penalties under the Privacy Act (5 U.S.C. § 552a(i) (3)) may apply if it is determined that the Requestor or Custodian, or any individual employed or affiliated therewith, knowingly and willfully obtained the file(s) under false pretenses. Any person found to have violated sec. (i)(3) of the Privacy Act shall be guilty of a misdemeanor and fined not more than $5,000. Finally, the User acknowledges that criminal penalties may be imposed under 18 U.S.C. § 641 if it is determined that the User, or any individual employed or affiliated therewith, has taken or converted to his own use data file(s), or received the file(s) knowing that they were stolen or converted. Under such circumstances, they shall be fined under Title 18 or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $1,000, they shall be fined under Title 18 or imprisoned not more than 1 year, or both.

15. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement and acknowledges having received notice of potential criminal or administrative penalties for violation of the terms of the Agreement.

16. On behalf of the User the undersigned individual hereby attests that he or she is authorized to legally bind the User to the terms this Agreement and agrees to all the terms specified herein.

Name and Title of User *(typed or printed)*			
David Kaplan ., as Editorial Director of	Maurice Tamman, Editor		
Company/Organization			
Center for Public Integrity	Dow Jones & Company, Inc.		
Street Address			
910 17th Street NW, 7th Floor	1211 Avenue of the Americas 5th Floor		
City	State	ZIP Code	
Washington, DC 20006	New York, NY	10036	
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*		
(202) 466-1300	(212) 416-4327; Maurice.Tamman@wsj.com		
	1/24/2010		

17. The parties mutually agree that the following named individual is designated as Custodian of the file(s) on behalf of the User and will be the person responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian or may require the appointment of a new custodian at any time.

The Custodian hereby acknowledges his/her appointment as Custodian of the aforesaid file(s) on behalf of the User, and agrees to comply with all of the provisions of this Agreement on behalf of the User.

Name of Custodian *(typed or printed)*			
David Donald, Data Editor	Maurice Tamman		
Company/Organization			
Center for Public Integrity	Dow Jones & Company, Inc.		
Street Address			
910 17th Street NW, 7th Floor	1211 Avenue of the Americas 5th floor		
City	State	ZIP Code	
Washington, DC 20006	New York, NY		
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*		
(202) 481-1247 ddonald@publicintegrity.org	(212) 416-4327; Maurice.Tamman@wsj.com		
Signature	1/24/2010		

18. The disclosure provision(s) that allows the discretionary release of CMS data for the purpose(s) stated in section 4 follow(s). (To be completed by CMS staff.) _____

19. On behalf of N/A the undersigned individual hereby acknowledges that the aforesaid Federal agency sponsors or otherwise supports the User's request for and use of CMS data, agrees to support CMS in ensuring that the User maintains and uses CMS's data in accordance with the terms of this Agreement, and agrees further to make no statement to the User concerning the interpretation of the terms of this Agreement and to refer all questions of such interpretation or compliance with the terms of this Agreement to the CMS official named in section 20 (or to his or her successor).

Typed or Printed Name	Title of Federal Representative
Signature	Date
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*

20. The parties mutually agree that the following named individual will be designated as point-of-contact for the Agreement on behalf of CMS.

On behalf of CMS the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

Name of CMS Representative *(typed or printed)* Spike Duzor		
Title/Component Director,		
Street Address 7500 Security Blvd.		Mail Stop
City Baltimore	State MD	ZIP Code 21244-1870
Office Telephone *(Include Area Code)* 410-786-1794	E-Mail Address *(If applicable)* Lawrence.Duzor@cms.hhs.gov	
A. Signature of CMS Representative SPIKE DUZOR		Date 2/19/2010
Concur/Nonconcur — Signature of CMS System Manager or Business Owner		Date 2/19/2010
Concur/Nonconcur — Signature of CMS System Manager or Business Owner		Date
Concur/Nonconcur — Signature of CMS System Manager or Business Owner		Date

Attachment A

This Attachment supplements the Data Use Agreement between the Centers for Medicare & Medicaid Services ("CMS") and the Users. To the extent that this Attachment is inconsistent with any terms in the Data Use Agreement, this Attachment modifies and overrides the Data Use Agreement.

Use of the information

A-1. Users are the Center for Public Integrity ("CPI"), a nonprofit journalism organization based in Washington, D.C., and Dow Jones & Company, Inc., ("Dow Jones") which publishes *The Wall Street Journal* and other publications (collectively, "Users"). CPI and Dow Jones, which is a news organization, intend to use the requested information as a newsgathering tool. Information derived from the files specified in section 5 of the Data Use Agreement may be included in published reports and otherwise disseminated, in a manner consistent with the Section A-2.

A-2. Users will not disseminate information derived from the files specified in section 5 of the Data Use Agreement, with or without direct identifiers, if such findings, listings, or information can, by themselves or in combination with other data, be used to deduce an individual's identity, or in a cell size of 10 or less as defined in Section 9 of the Data Use Agreement, in the absence of a judicial determination permitting or compelling such dissemination notwithstanding the Data Use Agreement. Users may disseminate information, including but not limited to geographic location, age, sex, diagnosis and procedure, admission/discharge date(s), or date of death, provided that the information is not so specific that an individual's identity could be deduced.

A-3. Termination of the Data Use Agreement pursuant to Section 6 must be for good cause.

A-4. Nothing in the Data Use Agreement prejudices Users' ability to challenge, at any time in the future, the legal basis for denying public access to, or prohibiting dissemination of, information derived from the files specified in section 5, or any other information.

A-5. Nothing in the Data Use Agreement, including but not limited to Section 9, prohibits Users from discussing or reporting on specific individuals or incidents in a manner consistent with section A-2.

A-6. Nothing in the Data Use Agreement, including but not limited to Section 9, prohibits the Users from obtaining and disseminating any information whatsoever that is obtained independent of the Data Use Agreement, whether or not the information also could be derived from the files specified in section 5 of the Data Use Agreement.

A-7. Users are expressly authorized to undertake further investigation into events and individuals related to the files specified in section 5 in a manner consistent with section

A-2. This includes, but is not limited to, reviewing other records, interviewing individuals, and attempting to link the files specified in section 5 to other files.

A-8. Nothing in the Data Use Agreement grants CMS, or any other person or entity, any authority to review or restrain any report or communication by Users before its dissemination to the public.

Integrity of the newsroom and work product

A-9. Nothing in the Data Use Agreement, including but not limited to sections 8 and 13, requires Users to allow representatives of CMS, DHHS Office of the Inspector General, or anyone else, physical access to Users' newsrooms or any other premises.

A-10. Nothing in the Data Use Agreement, including but not limited to sections 8 and 13, requires Users to allow representatives of CMS, DHHS Office of the Inspector General, or anyone else, access to their unpublished work product or any other documents or communications derived from or related to the files specified in section 5 of the Data Use Agreement.

Potential penalties

A-11. Users acknowledge having received notice of potential criminal or administrative penalties for violation of the terms of the Data Use Agreement. By acknowledging this notice, however, Users do not concede the constitutional validity of any cited statute or regulation, or that any cited statute or regulation may properly be applied to the files specified in section 5. Users expressly reserve their rights and defenses under the First Amendment, the Freedom of Information Act, and all other applicable laws.

_____

For: Centers for Medicare & Medicaid Services

_____

For: Dow Jones & Company, Inc.

_____

For: Center for Public Integrity

EXHIBIT D

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,
Plaintiffs,
v. Case No. 78-178-Civ-J-S

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,
Defendants,

DOW JONES & COMPANY, INC.
1211 Avenue of the Americas
New York, NY 10036

Intervening Defendant.
_____/

DECLARATION OF MARK SCHOOFS IN SUPPORT OF DOW JONES & COMPANY, INC.'S MOTION TO INTERVENE

I, Mark Schoofs, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am an investigative reporter at *The Wall Street Journal* ("the *Journal*"), published by Dow Jones & Company ("Dow Jones"). Since 2000, I have covered public health, crime, science and other issues for the *Journal*. I received the Pulitzer Prize for International Reporting in 2000 for an eight-part series on AIDS in Africa at *The Village Voice*, and I have twice won the Science Journalism prize from the American Association for the Advancement of Science (publishers of the journal *Science*). I also contributed to the *Journal*'s coverage of the September 11 attacks, which was awarded the 2002 Pulitzer Prize for Breaking News. I graduated *cum laude* from Yale University in 1985 with a B.A. in Philosophy. I make this declaration in support of Dow Jones's Motion to Intervene. I have personal knowledge of the facts contained herein, except those matters stated on information and belief.

The Series: *Secrets of the System*

2. Since April 2010, I have contributed to a series of articles entitled *Secrets of the System* (the "Series"). The Series, which appears on the front page of the *Journal*, focuses on the use and misuse of taxpayer dollars in the Medicare system. It relies primarily on a set of databases known as the Limited Data Set Files (the "LDS Files"), which are maintained by a Department of Health and Human Services ("HHS") agency, the Centers for Medicare & Medicaid Services ("CMS"). In particular, we rely on the Carrier Standard Analytic File (the "Carrier File"), a huge database with all fee-for-service Medicare Part B claims in the United States.

3. I have worked on this Series over the course of the past year. For eight months, I worked almost exclusively, full-time, investigating Medicare information using the LDS Files. Copies of articles in the Series that I co-authored with my colleague Maurice Tamman are attached as Exhibits to the Declaration of Michael Allen ("Allen Decl."), the editor of the Series, which also is being submitted in support of Dow Jones's Motion to Intervene. I am continuing to work on future articles to be published as new installments of the ongoing Series.

4. Our articles named several doctors with suspicious Medicare billings. For example, in a December 22, 2010 article entitled *Confidentiality Cloaks Medicare Abuse*, Mr. Tamman and I reported on Dr. Christopher G. Wayne, a Florida physical therapist known as the "Rock Doc" who we believe and I am informed took in more than $1.2 million from Medicare in 2008. Allen Decl., Ex. F. This amounts to more than 24 times the Medicare income of the average family doctor. The same article reported on Dr. Theresa Rice, who, we reported, billed Medicare nothing in 2007 for services she performed or supervised. But starting in October 2008, I am informed, Medicare received claims totaling over $11.6 million and paid out more

than $7.1 million under her provider number. Medicare stopped paying in mid-2009, when federal investigators shut down the clinic where she worked. At least seven people have been indicted on charges of health care fraud connected to the clinic. The December 22, 2010 article also reported on Brooklyn physical therapist Aleksandr Kharkover, who I am informed and believe billed Medicare for more than $2.5 million in 2008, and received more than $1.8 million. Mr. Kharkover told me he sees patients only in their homes, raising questions as to whether he could have legitimately performed all the services for which he billed such huge amounts to Medicare.

5. In addition to disclosing the suspicious billings of particular providers, the LDS Files also helped us report on whether government agencies, overwhelmed and underfunded, have identified and prosecuted all instances of potential fraud. In at least one case we identified in the Series, we did not find evidence that a criminal investigation had taken place prior to our reporting. In many other instances, government agencies discovered or investigated the likely fraud only after millions of taxpayer dollars had already been paid out in Medicare reimbursements.

6. But the cases discussed, in which we were able to identify individual doctors by name in our story, are the exception, not the rule, because of restrictions placed on our use of the LDS Files. We originally identified Dr. Wayne, Dr. Rice, and Mr. Kharkover through the Carrier File. But in each case, restrictions on the LDS Files meant that we were able to disclose the names of these providers *only* because we obtained the relevant information independent of the LDS Files. In many other cases, we were unable to do so.

HHS Imposes Limitations on the Use of Data

7. The Carrier File and other LDS Files have been an invaluable resource in reporting the Series, but their potential value has been limited in three key ways. I am informed and believe that each of these restrictions stems from the injunction issued by this Court in 1979 in this case, prohibiting the release of Medicare reimbursement amounts which would personally and individually identify providers ("1979 Injunction").

8. *First*, the 1979 Injunction limits our ability to fully use the LDS Files. As explained in more detail in the declaration of my co-author, Maurice Tamman, which also is being submitted in support of Dow Jones's Motion to Intervene, HHS would provide the *Journal* with only a 5% sample of beneficiaries in the Carrier File and other Standard Analytic Files. I am informed by a senior and long-serving CMS official with oversight of the data that one reason CMS does not provide 100% of the data is because the agency fears that doing so would violate the 1979 Injunction against disclosing the annual Medicare earnings of individual physicians. CMS's reasoning was that if a person with access to the file managed to deduce who a particular physician was, then that person would immediately know that doctor's Medicare earnings.

9. With such a limited sample, it is impossible to simply multiply a provider's income derived from this 5% sample by 20 and get an accurate estimate of a provider's total Medicare income for a given year. It is also virtually impossible to do any "fine-grain" analysis. We found that it is rarely if ever possible to compare a slice of a physician's activities – such as how often he or she gave treatment A versus treatment B for a given diagnosis – against the norm for all physicians. The margin of error in the 5% databases is simply too great. As a result, many investigations of potential waste, fraud, and abuse are impeded because the *Journal* has

been limited to a 5% sample of beneficiaries. The samples allowed us to identify and investigate only the most egregious statistical outliers. Other, subtler anomalies are obscured.

10. *Second*, in order to obtain the LDS Files, HHS required Dow Jones to sign a Data Use Agreement ("Agreement") providing that it would not disseminate information derived from the LDS Files that could be used to deduce an individual provider's identity. A copy of the Agreement is attached as Exhibit A to the Tamman Declaration. Indeed, under the HHS "cell-size suppression policy," no data may be disclosed even for small practice groups of fewer than 11 providers. *See id.* ¶ 9. Thus, billing data from the LDS Files for a medical practice with 11 doctors may be disclosed, but data for an individual doctor, or a group of 10 doctors, may not be disclosed.

11. This Agreement significantly limits our newsgathering ability. Because of the cell-size suppression policy, we typically cannot disclose information from the LDS Files in the course of our newsgathering for the Series. We are not permitted to disclose information about particular providers from the LDS Files when interviewing those who do not have access to the files – such as state medical boards, most of the providers' current or former staff, or referring doctors. Nor are we permitted to seek confirmation of information found in the LDS Files from sources that do not already have access to the files. In addition, because medical diagnoses and Medicare billing regulations are inherently complicated, my colleagues and I find it necessary to consult others, ranging from expert statisticians to medical billing professionals, to help understand the data. But consultation is often impeded or prevented by our contractual duty not to disseminate physician-identifiable information derived from the Carrier File and other LDS Files.

12. *Third*, the 1979 Injunction limits our ability to report on what we have found. The Agreement's restrictions limit the *Journal*'s reporting, and thus keep critical information from patients, state medical boards, and referring doctors. Many patients would want to know whether their doctor performs an inordinate number of a risky surgeries in cases where other doctors generally recommend less drastic options. Many medical boards would want to examine such practices among their licensed physicians, as well as billing patterns that may suggest financial abuse or fraud. And many referring doctors would want the best information about those physicians to whom they are entrusting their patients. But none of these groups can learn this information because of this Court's 1979 Injunction.

13. For example, in an October 26, 2010 article entitled *In Medicare's Data Trove, Clues to Curing Cost Crisis*, we reported on a family-practice doctor who apparently received more than $2 million in 2008 from Medicare, making her one of the best-paid family-medicine physicians in the entire Medicare system. Allen Decl., Ex. B. Analyzing the Carrier File, her billing increased 16-fold from 2006 to 2007, and continued rising the following year. She averaged $3,239 in earnings per patient in 2008 – nearly 18 times the mean for family-medicine doctors in the Carrier File, and the seventh highest among family physicians with 10 or more patients. A family practitioner, she administered a broad array of sophisticated tests, some flagged for special scrutiny by anti-fraud authorities. Because this information was obtained from the Carrier File, the Agreement prevented us from identifying the doctor in our article. This meant that we were prevented from sharing her identity with our readers – and with patients, referring doctors, and the state medical boards in the two states where she practices medicine, all of whom have an interest in knowing about potentially fraudulent billing practices and/or potentially unnecessary medical services, some of which could harm patients.

14. Similarly, a December 22, 2010 article reported on a Florida internist who took home more than $8.1 million from Medicare from 2007 through 2009, almost all of which came from physical therapy. Allen Decl., Ex. F. From 2006 through 2008, more than 40% of this doctor's patients in the Carrier File were described as suffering from brachial neuritis, a rare nerve-and-muscle condition estimated to occur in about three out of every 100,000 Americans. The *Journal* could not name this doctor, whose patients may have been misdiagnosed or given incorrect or unnecessary treatment, because the newspaper learned that he billed so often for brachial neuritis from the Carrier File.

Stories the *Journal* Could not Pursue Because of the Injunction

15. In addition, *Journal* reporters pursued more providers with suspicious Medicare billing patterns than the paper could publish. Below are five examples drawn from the 5% Carrier File sample. In each case, mining the Carrier File was what first drew the *Journal*'s attention to these providers. In each case, I had little choice but to "triage out" these providers, and did not investigate them further. One reason is that I almost certainly would have needed to interview current and former employees and colleagues, such as nurses and other office staff, about the billing patterns in the data. But doing so would not have been possible because of our contractual duties arising from the 1979 Injunction. For example, through traditional newsgathering methods, we could sometimes obtain from sources other than the Carrier File a physician's total Medicare billings and/or earnings for a particular year. However, in no case were we able to obtain from any source other than the database the detailed pattern of a particular physician's diagnoses and/or treatments, patterns that are often critical to understanding potential fraud. The inability to discuss such information with most sources constituted a severe limitation to our reporting, forcing us to focus on providers whose billing

patterns were so egregious that we would need little if any "fine-grain" analysis of the data, and little if any information from anyone other than the providers themselves.

16. *First*, one of the nation's highest Medicare earners for physical therapy in 2008 was a physician in his 80s whose specialty, according to Medicare records, is psychiatry. More than 85% of this doctor's Medicare income that year came from physical therapy, and his total Medicare take was more than 25 standard deviations above that of the average of all "physical medicine & rehabilitation" physicians, whose practice – unlike that of a psychiatrist – would naturally include large amounts of physical therapy.

17. The pattern of diagnoses this physician gave his patients is also improbable. In 2007, he gave his patients only six diagnoses – an extraordinarily small number. Ninety-three percent of his patients had osteoarthritis of the lower leg. Combined, the other 5 diagnoses applied to only 17% of his patients. Some patients had multiple diagnoses. Lumbago – a very common back problem among older Americans – took a dubious drop in this doctor's practice, falling from more than 3/4 of his patients in 2005 to zero in 2007.

18. Visiting his clinic, *Journal* reporters found that patients – almost all from one ethnic group – are driven in by medical van. Food is served – unusual for a doctors' office – and a variety of medical and social services are offered. Patients appear to stay for hours. Law-enforcement officials specializing in healthcare fraud informed me that bringing in patients by van is common among Medicare fraudsters, who need patients to make their billing seem legitimate, and that serving food – especially among elderly and lower-income patients – can amount to a kickback.

19. This doctor declined to speak with the *Journal*, and his lawyer initially took my call and said he would get back with me but then declined to return subsequent telephone calls

on the matter. Blocked from talking with the doctor or his legal representative, I believed I would have had to interview current and former employees and/or colleagues but the restrictions imposed by HHS because of the 1979 Injunction would prevent such interviews. So despite weeks of reporting, including a visit to his clinic and another to his home, I felt compelled to pursue other doctors.

20. *Second*, in 2008, Medicare's top-earning physician turned out to be a doctor who was later indicted by federal authorities for health care fraud and charged by state authorities with engaging in organized criminal activity, a felony, for her role in a clinic that allegedly dispensed narcotics without a valid medical need – in short, for being involved in an alleged "pill mill." The second highest earning doctor was an ophthalmologist. He earned more than six times what the next highest earning ophthalmologist took in from Medicare, and his take was more than 35 standard deviations above the mean for all ophthalmologists. Moreover, his total Medicare earnings more than doubled in just four years.

21. More than 40% of this doctor's 2008 Medicare income came from just one, highly reimbursed procedure: the injection of a drug to treat macular degeneration. Compared to all ophthalmologists who performed the injection in 2008, his earnings for the procedure were almost eight and a half standard deviations above the mean, and nearly 22 standard deviations above the median. Reporting on this doctor almost certainly would have required discussing his billing patterns with his colleagues and employees, something we were barred from doing by our contractual obligations stemming from the 1979 Injunction.

22. *Third*, in 2008, a physician specializing in rehabilitation medicine gave more than 99% of his patients the exact same diagnosis: "abnormality of gait." The one other diagnosis he gave was cervicalgia – neck pain. Experts in rehabilitation medicine told me that such a high

proportion of patients with one diagnosis is extremely unusual and that "abnormality of gait" is rarely given as a medical diagnosis. Instead, the cause of the gait problem – such as stroke or diabetes or a broken bone – would normally be given.

23. Another unusual pattern in this doctor's billing is that he provided therapy to almost none of his patients. The overwhelming majority of his billing was for examination and evaluation, often in the setting of a nursing home. Federal fraud investigators say that a common scheme involves physicians using nursing homes to find patients whom they use to bill Medicare. This can be particularly effective because many nursing-home residents are confused or sick, and therefore unlikely to blow the whistle on questionable or potentially fraudulent care. To report on this physician, I believed I would have had to interview current and former employees of the nursing home, where I almost certainly would have had to discuss information I received only from the LDS Files. This physician earned more than 99.9% of all providers in the Carrier File.

24. *Fourth*, one of the physical therapists who earned the most from Medicare in the Carrier File posed a crucial problem. As discussed above, it is impossible to derive anything more than a ballpark estimate of a provider's annual income by extrapolating from the 5% sample of the Carrier File. In the case of this physical therapist, however, the ballpark estimate varied widely from what he claimed was his Medicare income. Multiplying his earnings in the 5% sample by 20, he appeared to have earned more than $1.6 million from Medicare in 2008. However, he informed me that he earned considerably less than $1 million that year from Medicare, a discrepancy that is large but statistically possible. In addition, because of the state in which he practiced and the type of practice he operated, he was allowed to supervise four

physical therapy assistants, all of whom could legitimately have billed under his provider number.

25. All this, as well as other features of his business, necessitated having 100% of the Carrier File, not a mere 5% sample, in order to verify what he told me and to tease out whether his billing was legitimate or potentially fraudulent. That is a major reason why I was unable to pursue reporting on this provider.

26. *Fifth*, Medicare's 2008 highest earning "emergency medicine" specialist does not appear to do much emergency medicine. He was one of the nation's highest Medicare earners for home health recertification – a procedure that allows patients to receive Medicare home health benefits – and for supervising home health care. Home health is an area flagged by federal authorities as experiencing high amounts of Medicare fraud.

27. This doctor also billed Medicare for many other services, including physical therapy, and his web site prominently advertises such procedures as "Penile Enlargement" and the "Brazilian Butt Lift." Because of the many and varied services this physician offered, we wanted to analyze his billing in more detail and with greater precision than the 5% Carrier File sample allowed. In short, this was a case where the lack of 100% data constituted a major obstacle to our reporting. A search of public records uncovered that this physician apparently had recent federal tax liens in excess of $70,000 and in 2004 had been reprimanded and fined by his state medical board for using abortifacient pills obtained under a false prescription to attempt to induce an abortion in a pregnant woman without that woman's knowledge or consent.

28. As these examples show, the Series represents only the beginning of the *Journal*'s ability to fully utilize the Carrier File and other LDS Files to identify abuses in the system and thus help contain the country's spiraling medical costs. If my colleagues and I had full access to these analytical tools, we would be able to expand on our reporting to further highlight the scope of Medicare fraud and waste, inform the public about those who are reaping undue financial advantage at taxpayer and patient expense, and assist the government officials charged with policing this vast healthcare system. Indeed, several high-level federal officials charged with rooting out healthcare fraud informed me that they lack the resources to investigate and prosecute all the fraud they suspect.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on January 24, 2011

Mark Schoofs

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,

Plaintiffs,

v. Case No. 3:78-cv-178-99 MMH-MCR

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,

Defendants,

DOW JONES & COMPANY, INC.,

Intervening Defendant.
_____/

NOTICE OF SUPPLEMENTAL EXHIBITS

Intervening Defendant, Dow Jones & Company, Inc. ("Dow Jones"), publisher of *The Wall Street Journal* (the "*Journal*"), respectfully submits the attached supplemental exhibits in support of Dow Jones's Motion to Intervene and Motion to Reopen Case (collectively referred to hereafter as the "Motions"). [Docs. 1, 7] In support of the Motions, Dow Jones filed copies of the articles comprising the *Journal's Secrets of the System* series, which was named as a finalist for the Pulitzer Prize. In order to provide a complete record for this Court, Dow Jones is filing the remaining articles recently published by the *Journal* as a part of the *Secrets of the System* series, as well as proposed legislation which has arisen as a result of the *Secrets of the System* series.

1. Mark Schoofs, Maurice Tamman, and Brent Kendall, *Mediare-Fraud Crackdown Corrals 114*, THE WALL STREET JOURNAL, February 18, 2011, a true and correct copy of which is attached hereto as Exhibit A.

2. Mark Schoofs and Maurice Tamman, *Bills Push Medicare Data Access*, THE WALL STREET JOURNAL, March 3, 2011, a true and correct copy of which is attached hereto as Exhibit B.

3. John Carreyrou and Tom McGinty, *Medicare Records Reveal Troubling Trail of Surgeries*, THE WALL STREET JOURNAL, March 29, 2011, a true and correct copy of which is attached hereto as Exhibit C.

4. Mark Schoofs and Maurice Tamman, *Senators Push to Open Database on Medicare*, THE WALL STREET JOURNAL, April 8, 2011, a true and correct copy of which is attached hereto as Exhibit D.

5. John Carreyrou and Tom McGinty, *Hospital Bars Surgeon From Operating Room*, THE WALL STREET JOURNAL, April 13, 2011, a true and correct copy of which is attached hereto as Exhibit E.

6. Medicare Data Access for Transparency and Accountability Act, S. 756, 112th Cong. (2011), a true and correct copy of which is attached hereto as Exhibit F.

Dated: April 18th, 2011

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on April 18, 2011, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system which will send a notice of electronic filing to the following:

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Department of Health and Human Services f/k/a Department of Health, Education and Welfare

s/ Michael G. Tanner
Attorney

THE WALL STREET JOURNAL.
WSJ.com

U.S. NEWS | FEBRUARY 18, 2011

Medicare-Fraud Crackdown Corrals 114

Officials Say Nine-City Sweep, Involving $240 Million in Alleged Schemes, Is the Biggest Such Roundup in U.S. History

By MARK SCHOOFS, MAURICE TAMMAN And BRENT KENDALL

(See Corrections & Amplifications item below.)

A health-care crime sweep Thursday netted 114 defendants on charges related to Medicare fraud, in what Attorney General Eric Holder called the largest such takedown in U.S. history.

The defendants—charged in nine metropolitan areas including Los Angeles, Brooklyn, Detroit and Miami—were allegedly involved in more than 40 schemes, almost all of which were unrelated to one another, officials said. Altogether, the schemes attempted to defraud the government of more than $240 million, according to law enforcement officials.

Several of the cases appear to involve doctors or other health-care practitioners acting alone or with few alleged co-conspirators. One of these, Brooklyn physical therapist Aleksandr Kharkover, had been featured in a December Wall Street Journal article on possible financial abuse involving physical therapy, a growing area of Medicare fraud.

Secrets of the System Series

Soaring Medicare costs threaten to overwhelm the federal budget, yet American taxpayers are blocked from seeing exactly where their money goes. Under a three-decade-old court order, Medicare can't publish the billings of individual physicians who participate in the program. In this series, The Wall Street Journal explores Medicare's vast databases and shows how they can be used to expose potential fraud and waste.

- **Methodology: How the Journal Crunched the Numbers**
- **In Medicare's Data Trove, Clues to Curing Cost Crisis** (10/25/2010)
- **Physician Panel Prescribes the Fees Paid by Medicare** (10/26/2010)
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- **A Device to Kill Cancer, Lift Revenue** (12/7/2010)
- **Top Spine Surgeons Reap Royalties, Medicare Bounty** (12/20/2010)
- **Confidentiality Cloaks Medicare Abuse** (12/22/2010)

Mr. Kharkover, accused of being involved in one of at least three separate alleged physical-therapy rings broken up this morning, billed Medicare about $11.9 million from January 2005 through July 2010, according to the indictment. During that time period, Medicare paid out $7.3 million, according to a person familiar with the investigation. He is accused of having billed for physical-therapy services that were never performed and weren't medically necessary.

Mr. Kharkover's lawyer, Montell Figgins, said his client "looks forward to his day in court where he'll be able to set the record straight. Mr. Kharkover is a good man and a well-respected doctor."

The publisher of The Wall Street Journal, Dow Jones & Co., filed court papers last month to overturn a court injunction that blocks the public from seeing the Medicare billing records of individual doctors.

In 1979, citing privacy rights, the American Medical Association won a suit against the government to keep secret the amounts of

More

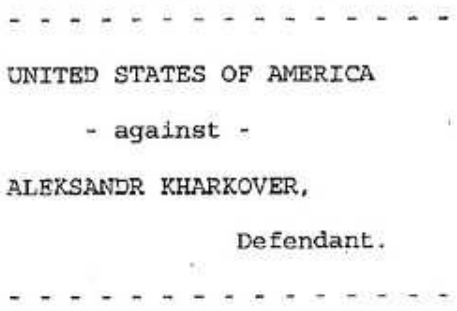
Using a Computer to Fight Medicare Fraud

money individual doctors get paid by Medicare. The court's ruling still stands.

The Journal suit was filed on the grounds that releasing the records would enable state medical boards, nonprofit organizations, universities and newspapers to act as watchdogs over the $500 billion Medicare program.

Indictments

See indictments on charges related to Medicare fraud.



UNITED STATES OF AMERICA

- against -

ALEKSANDR KHARKOVER,

Defendant.

Click image above to see indictment in United States of America against Aleksandr Kharkover.

United States of America vs. Justina Amuche Okehie et al.

United States of America vs. Amadi et al.

United States of America vs. Nunez et al.

United States of America against Kovalienko et al.

United States of America against Boris Sachakov, M.D.

United States of America v. Errol Sherman, D.P.M.

"The fact that you can have an operation this large with cases that aren't connected shows the extent of the problem," said a senior law-enforcement official involved in these investigations. Medicare fraud is "so rampant," he said, "there's no way in hell you can prosecute your way out of this problem, no way. The answer is not prosecution—the answer is more effective monitoring of the money that goes out."

The arrests were announced in Washington by Mr. Holder and Health and Human Services Secretary Kathleen Sebelius. The investigations were carried out by the Medicare Fraud Strike Force—a multiagency effort led by the HHS Office of the Inspector General, the Federal Bureau of investigation, and U.S. attorneys from the Department of Justice—that targets Medicare and Medicaid fraud. More than 700 state, federal and local agents were involved in the cases, said Mr. Holder, who also announced that the Strike Force was expanding operations to nine cities from seven.

"Prosecution is important after the fact," Ms. Sebelius said. "What we'd like to do is also set up much higher firewalls before the fact and actually stop this money from going out the door."

She said the health-care overhaul passed last year gives the government new tools to detect fraud, and President Barack Obama's budget proposal includes new support for fraud-prevention efforts. She said the agency was setting up new checks to screen providers before they are accepted into the system and building data systems that gather all billing information into one place, "which has never been available before."

The alleged schemes varied widely. Two rings—one in Miami and another in Dallas—allegedly paid kickbacks and bribes to Medicare beneficiaries to induce them to purport to have received home-health services that weren't medically necessary and weren't performed, according to indictments.

In the Dallas area, one Ollie Futrell was taped allegedly negotiating with Medicare beneficiaries on how much of a kickback they would receive for accepting unnecessary home-health services, and how much they would receive for referring new patients into the scheme, according to the indictment. Here is one alleged exchange in the indictment:

Beneficiary: "Each person I refer to you is $200 or $250?"

Ms. Futrell: "I'm going to be honest with you. I will give you $150. Alright $250, $200. [Expletive] I ain't goin fifty 'cause I got to have something now, come on."

The Dallas scheme billed Medicare a bit more than $1 million from November 2008 through November 2010, while the Miami ring billed Medicare almost $25 million and was paid more than $16 million from January 2006 through March

Associated Press

Valentina Kovalienko, a defendant in one of the cases involved in the fraud sweep, exiting Brooklyn federal court after posting bail Thursday.

Some Common Medicare Frauds

Pay kickbacks to patients to get their billing information and persuade them to say they receive services they don't need, or don't get.

Pay physicians to act as a clinic 'medical director' and sign off on care that isn't given, prescribe tests that aren't necessary, or order equipment such as wheelchairs that patients don't need.

Collude with shady ambulance or medical-transport companies to recruit patients. Such companies sometimes bribe patients and can have transportation costs covered by Medicaid.

Unbundling, a tactic whereby doctors break down what should be a single charge into many separate charges to increase total reimbursement.

2009, according to the indictments.

Ms. Futrell's lawyer, Lorenzo Brown, declined to comment but said his client had pleaded not guilty. Lawyers for the other defendants could not be reached.

A podiatrist in the Detroit area, Errol Sherman, is charged with billing for toenail removals that never happened—in one case allegedly billing for 18 of the painful procedures for a single patient, according to the indictment. At least three patients for whom Dr. Sherman allegedly billed for toenail removal, called avulsion, said they only received foot soakings and, in some cases, nail trimmings, according to a person familiar with the case.

Dr. Sherman's lawyer, Mark Kriger, said he didn't think it appropriate to comment on pending cases but said his client had entered a plea of not guilty, "which speaks for itself."

Brooklyn proctologist Boris Sachakov was indicted for what fraud experts call "unbundling," a term for breaking what should be a single group of charges into many single charges, which makes more money. Dr. Sachakov allegedly performed many hemorrhoid removals, billing office visits and subsequent hemorrhoid surgeries as if they were distinct conditions unrelated to the initial procedure. According to the indictment, from January 2008 through January 2010, Dr. Sachakov billed through his company more than $6.5 million to Medicare and more than $16 million to private insurers; Medicare paid out just less than $4.5 million and the private insurers about $5.8 million.

Calls to Mr. Sachakov's lawyers weren't immediately returned. In September 2010, a criminal complaint was issued against him on similar charges—including billing for 85 hemorrhoid removals on one patient—and in press accounts at the time his lawyers said he denied wrongdoing.

Brooklyn was home to the single largest alleged scheme, a physical-therapy ring that billed Medicare almost $57 million from February 2008 through the present, according to the indictment. A person familiar with the case said that Medicare paid more than $30 million during that time. Seven people were arrested in connection with that alleged fraud, which law-enforcement officials said was run mainly out three clinics and two medical-transport companies in Brooklyn. Lawyers for the defendants and the company couldn't be reached.

In Houston, chiropractor Justina Amuche Okehie was charged together with five others in another alleged physical-therapy scam, which billed Medicare and Medicaid in excess of $4.7 million from January 2007 through August 2010, according to the indictment. Ms. Okehie and some of her alleged conspirators paid patients cash for use of their Medicare and Medicaid numbers, which they then used to bill for physical therapy that wasn't actually provided, according to the charging document. Ms. Okehie's lawyer, James Alston, said his client had pleaded not guilty. "We believe the government is overreaching," he said.

The Journal has been mining Medicare claims data to expose waste, abuse and potential fraud. Together with the nonprofit Center for Public Integrity, the Journal obtained from the government a database that covered claims for a 5% sample of randomly selected beneficiaries.

In that database, proctologist Dr. Sachakov was by far the top earning colon and rectal surgeon in the country for

2008. Mr. Kharkover, the Brooklyn physical therapist arrested this morning, stood out as one of the highest-earning physical therapists in that year.

The Journal learned from a person familiar with his business that Mr. Kharkover had billed Medicare more than $2.5 million in 2008 and earned at least $1.8 million that year. In an interview in his Brooklyn bungalow last year, Mr. Kharkover was asked if billing $2.5 million in 2008 fit with his records. "I'd say that fits," he replied.

His attorney, Mr. Figgins, said at the time that Mr. Kharkover was a "successful businessman," adding that "there is no reason to believe my client was doing anything illegal." Today he said, "An indictment is nothing more than mere unproven allegations."

Mr. Kharkover came to the attention of law enforcement at least as early as mid-2009, and the investigation began in earnest in about August 2010, according to law-enforcement officials.

Despite the number of small rings in Thursday's sweep, FBI Executive Assistant Director Shawn Henry said the agency has increasingly seen organized-crime groups move into health-care fraud "because of its profitability." He said recruiters target low-income areas and soup kitchens to find new patients.

Corrections & Amplifications

Brooklyn physical therapist Aleksandr Kharkover was accused of being involved in one of at least three separate alleged physical-therapy rings broken up this morning. An earlier version of this article incorrectly said he was accused of being involved in at least three separate rings.

In Houston, chiropractor Justina Amuche Okehie was charged together with five others in another alleged physical-therapy scam. An earlier version of this article incorrectly referred to her as Justina Okehie Collins.

Write to Mark Schoofs at mark.schoofs@wsj.com, Maurice Tamman at maurice.tamman@wsj.com and Brent Kendall at brent.kendall@dowjones.com

THE WALL STREET JOURNAL.
WSJ.com

HEALTH INDUSTRY | MARCH 3, 2011

Bills Push Medicare Data Access

By MAURICE TAMMAN And MARK SCHOOFS

Two senators, a Republican and a Democrat, are pushing legislation to overturn a 1979 court injunction that bars the public from seeing what individual physicians earn from Medicare.

That data, commonly known as the Medicare claims database, is widely considered one of the best tools for identifying fraud and abuse in the $500 billion federal health-insurance program for the elderly and disabled.

Secrets of the System

Soaring Medicare costs threaten to overwhelm the federal budget, yet American taxpayers are blocked from seeing exactly where their money goes. Under a three-decade-old court order, Medicare can't publish the billings of individual physicians who participate in the program. In this series, The Wall Street Journal explores Medicare's vast databases and shows how they can be used to expose potential fraud and waste.

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(12/22/2010)

More

Using a Computer to Fight Medicare Fraud

Last year The Wall Street Journal, together with the nonprofit Center for Public Integrity, obtained from the government limited access to the database. Despite severe restrictions on the data, the paper was able to mine it and expose through a series of articles how doctors and other medical practitioners appear to be gaming Medicare to increase their profits. One physical therapist identified by the Journal as having suspicious billing patterns was indicted last month on charges of defrauding Medicare.

Through his lawyer, he maintained his innocence.

The judge who issued the injunction shielding the data ruled that physicians' privacy trumped the public's interest in knowing how tax dollars are spent.

Republican Sen. Chuck Grassley of Iowa said he was prompted in part by the Journal's stories to introduce legislation Wednesday. That legislation states that the government must "make available to the public" data on Medicare "payments made to any provider of services or supplier...." The bill also includes other provisions designed to fight Medicare and Medicaid fraud.

In an interview, Mr. Grassley said the intent of his legislation "is to change the court decision" that has barred public access to the claims data. "The intention is to make government transparent, because with transparency there comes accountability. And the fact of the matter is that there is billions of dollars of Medicare fraud, and we think it will help us get at the fraud," he said.

Sen. Ron Wyden, a Democrat from Oregon, said he had also drafted legislation "designed to make [the Medicare

claims] database public," an effort he described as "a taxpayer-rights issue." He said he planned to talk with Mr. Grassley to see if they could join forces, adding, "I believe we can have a bipartisan bill on this."

Both Mr. Grassley and Mr. Wyden said they weren't seeking the public release of data related to patients, and that they supported patient privacy protections.

In January, the publisher of The Wall Street Journal, Dow Jones & Co., filed legal papers to try to overturn the 1979 injunction in court and open the records fully to the public. The Journal didn't seek patient information.

Currently, the government is effectively barred from releasing how much money any individual doctor earns from Medicare by the 1979 injunction. That injunction stemmed from a lawsuit filed by the Florida Medical Association and the American Medical Association, the doctors' trade group.

The Carter administration had sought to publish a list of the annual Medicare reimbursements to all doctors. The AMA sued to block the move, and a Florida court ruled in favor of the physicians' privacy interest. That ruling remains in force.

Asociated Press

Iowa Sen. Charles Grassley, shown here in Washington last year, says public access to the Medicare database 'will help us get at the fraud.

In a written response to questions from the Journal, AMA President Cecil B. Wilson said, "The American Medical Association has zero tolerance for Medicare fraud, and studies have demonstrated that physicians are not a significant source of Medicare fraud." Noting that Medicare is policed by the Justice Department and others, he added, "Physicians, like all Americans, have the right to privacy regarding their personal financial information, and courts have repeatedly upheld this right."

A spokesman for the Centers for Medicare & Medicaid Services, which administers Medicare, also issued a written statement in response to questions from the Journal. In part, it said, "While the agency has not yet had an opportunity to review the legislation, CMS is committed to openness and transparency."

At a Senate Finance Committee Hearing Wednesday, Sens. Grassley and Wyden questioned officials from CMS and its parent, the Department of Health and Human Services, about opening Medicare billing data for public examination.

The officials declined to offer their support at the hearing.

Peter Budetti, who oversees the CMS's anti-fraud efforts, said, "The concept [of making the database public] has a lot of ramifications," and promised to report back on those ramifications.

HHS Inspector General Daniel Levinson said his "default position is transparency," but that it isn't always possible.

"I'll take that as a nonanswer," Mr. Grassley said.

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THE WALL STREET JOURNAL.
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U.S. NEWS | MARCH 29, 2011

SECRETS OF THE SYSTEM

Medicare Records Reveal Troubling Trail of Surgeries

By JOHN CARREYROU And TOM MCGINTY

PORTLAND, Ore.—Dr. Vishal James Makker had already operated on Ronald Johnson's spine six times in less than two years, but he had some grim news for the former machine-tool operator: X-rays showed Mr. Johnson needed a seventh surgery.

Mr. Johnson, 62 years old, says he had felt progressively worse after each operation. He told the doctor he was done with surgeries.

Limelight Video

Surgeon Vishal James Makker

The Medical Complaints

Read the Oregon Medical Board's complaint and corrective action order against Dr. Makker, and the malpractice suits filed against him.

- Oregon Medical Board's complaint and corrective action order
- Julie Ann Bailey v. V. James Makker 3/23/2011 (pending)
- Glenda Monroe v. V. James Makker 3/18/2011 (pending)
- Ronald Johnson v. V. James Makker 1/25/2011 (Case settled for $130,000)
- Dawn and Shane Johnson v. V. James Makker 1/15/2011 (Case settled for $500,000)
- Marsha Johnson v. James Makker 4/6/2010 (Dr. Makker prevailed when the case went to trial.)
- Jeriann Roberts v. V. James Makker 4/9/2009 (Case abandoned by plaintiff)

Dr. Makker took a second look at the X-rays and changed his tune, Mr. Johnson recalls. "Actually, you're going to be all right," he says Dr. Makker told him, adding that he had been looking at the films wrong.

At that moment, Mr. Johnson became the latest in a string of patients to grow suspicious about multiple surgeries performed on them by Dr. Makker, a handsome, 41-year-old neurosurgeon with a charming bedside manner. Mr. Johnson sued Dr. Makker for malpractice in August 2009, complaining that he performed "unnecessary surgeries," and reached a confidential settlement with him last month.

A Medicare database analyzed by The Wall Street Journal reveals that Dr. Makker has had an unusual propensity for performing such multiple surgeries on the spine. The data show that in 2008 and 2009, Dr. Makker performed spinal fusions on 61 Medicare patients. In 16 of those cases, he performed a total of 24 additional fusions. That gave him an overall rate of 39 additional fusions per 100 initial fusions, the highest rate in the nation among surgeons who performed spinal fusions on 20 or more Medicare patients during those two years.

For the past year, the Journal has been mining Medicare's claims databases to expose how some doctors potentially defraud the taxpayer-funded health program for the elderly and disabled and game its reimbursement system. The databases contain a computerized record of every bill submitted to, and paid out by, Medicare.

Jeanette Perley v. V. James Makker 9/21/2007 (Case settled for $275,000)

Rev. Edmond Bliven v. V. James Makker 10/11/2006 (Case settled for $300,000)

Related Article

How the Journal Crunched the Numbers

Analysis of the data suggests that it also could be used as a tool to help screen for potentially bad or negligent doctors by identifying suspicious patterns of care.

Dr. Makker declined to comment on the case involving Mr. Johnson, citing a confidentiality agreement in the legal settlement. But in a series of emails and text messages, he said all the spinal surgeries he performed were medically necessary.

"I NEVER try to persuade patients to have surgery," he wrote. "I always leave it up to the patient and family." He said his many patients wouldn't be returning to see him time and again if they weren't satisfied with his care. He cited a consumer website about doctors called vitals.com, which gives him a maximum four-star rating. His page on the site features seven glowing comments from patients.

Secrets of the System

Soaring Medicare costs threaten to overwhelm the federal budget, yet American taxpayers are blocked from seeing exactly where their money goes. Under a three-decade-old court order, Medicare can't publish the billings of individual physicians who participate in the program. In this series, The Wall Street Journal explores Medicare's vast databases and shows how they can be used to expose potential fraud and waste.

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Methodology for Cancer/IMRT Story: How the Journal Crunched the Medicare Numbers 12/8/2010

Top Spine Surgeons Reap Royalties, Medicare Bounty 12/20/2010

Confidentiality Cloaks Medicare Abuse 12/22/2010

Medicare-Fraud Crackdown Corrals 114 2/18/2011

Dr. Makker attributed his high rate of multiple fusions, in part, to referrals of difficult cases from other Portland-area spine surgeons who don't accept Medicare, and to failures of spinal implants from a supplier he has stopped doing business with.

In April 2006, the Oregon Medical Board issued a "complaint & notice of proposed disciplinary action" alleging that Dr. Makker performed "medically unnecessary" spinal fusions on several patients without obtaining their prior consent; didn't provide the patients with adequate follow-up care; and billed for some procedures he didn't do. Without admitting or denying wrongdoing, Dr. Makker agreed to complete a remedial training program and a billing course.

In less than nine years of practice, Dr. Makker has been sued by eight patients alleging medical malpractice, court records show, compared with an average for neurosurgeons nationwide of about one suit every two years, according to medical malpractice insurer The Doctors Company.

Dr. Makker says he hasn't been sued any more frequently than the average neurosurgeon, and that he has never been formally disciplined by the state's medical board. He says the board's corrective action order against him is "a less serious order and has been terminated."

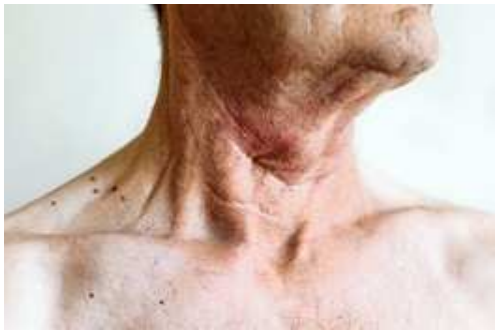
Charles Rosen, a spine surgeon at the University of California, Irvine School of Medicine, and president of the Association for Medical Ethics, says: "When you get to numbers like six and seven surgeries on someone's spine in a short period of time, that starts to be suspicious." The action against Dr. Makker by the Oregon medical board, he adds, "means it had to intervene to protect the public health. That's serious."

Controversial doctors are as old as medicine itself. Their identities are often known to their peers and even to the government, which compiles a confidential database of physician sanctions. But patients rarely know. Consumer-advocacy group Public Citizen reported this month that state medical boards didn't discipline 55% of doctors who either lost their hospital privileges or had them restricted between 1990 and 2009. Although some state medical boards have begun publicly releasing more information about problem doctors, much remains unavailable to the general public.

Information in Medicare databases about individual doctors is

Jake Stangel for The Wall Street Journal

Ronald Johnson of Vancouver, Wash., grew suspicious when Dr. Makker, after operating on his spine six times, said he needed a seventh surgery.



Jake Stangel for The Wall Street Journal

Surgical scars on Ron Johnson's neck.

kept strictly confidential and was obtained by the Journal only under significant restrictions. In January, the paper's publisher, Dow Jones & Co., filed legal papers to try to overturn a three-decade-old court ruling that bars the public release of this information. The case is pending.

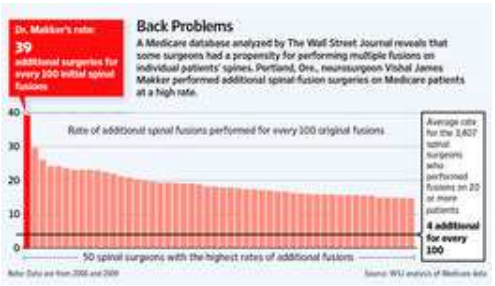
The American Medical Association opposes the release of any Medicare data that identifies individual doctors. "The release of Medicare claims data in the media or on the Internet, without the complete medical record and due process, would often be misleading, inaccurate and disruptive to patients' longstanding relationships with their physicians," said AMA President Cecil B. Wilson. "Medicare claims data alone cannot identify quality care."

The Journal used the data to pinpoint unusual patterns of care by some doctors. Restrictions imposed by the Department of Health and Human Services prohibit naming the doctors unless they agree to discuss their Medicare work, as Dr. Makker did.

For instance, the data reveal that a foreign-born surgeon currently operating in Texas has an unusual number of patient deaths associated with an elective procedure. The surgeon was excluded from both the Medicare and Medicaid programs for nine years in the 1990s after the Office of Inspector General of the Department of Health concluded that he had performed unnecessary and inappropriate procedures on seven patients while practicing in New Jersey. In two of the cases, the surgeon inappropriately operated on patients who were nearly dead, and he contributed to a third patient's death by misdiagnosing his condition, according to a letter the inspector general sent him when he was ousted from Medicare. He was temporarily barred from practicing in New Jersey.

The surgeon relocated to southern Texas in 2005. He currently operates at five hospitals there. In 2008 and 2009, nine of 49 Medicare patients on whom he performed an elective surgery died, three of them within days of the operation, according to the Medicare data. That equates to 18.4 deaths per 100 of the procedures, compared with a national average of 2.4 per 100 for the procedure.

Back pain is notoriously difficult to treat. Spinal fusions like the ones performed by Dr. Makker are expensive and controversial. They involve fusing two or more vertebrae, often by inserting thousands of dollars of hardware. Some spinal surgeons contend the procedure is used too much, to treat conditions for which it isn't effective, because it can be lucrative for surgeons and medical-device makers. While doing a second fusion surgery isn't uncommon, these surgeons say, conducting multiple fusions on the same patient in a short period of time, except in cases of a spinal infection or cancer, isn't good practice.



When the Medicare database was searched for surgeons who performed multiple spinal fusions on numerous patients, Dr. Makker's name popped up. (Data about Dr. Makker's non-Medicare cases, which represent a greater share of his practice, couldn't be obtained.)

Dr. Makker said the "main reason that I have had so many repeat surgeries" on patients is "honestly, I am the dumping ground for Medicare patients, especially the difficult ones that everyone knows are going to be difficult to fix with one or even

two surgeries." He added that in some cases, patients required separate surgeries to repair different parts of their spines.

Dr. Makker, who drives a sporty black Mercedes with "J MAK" vanity plates, attended medical school at the University of Texas Health Science Center in San Antonio and did his neurosurgery residency at Rhode Island Hospital in Providence. When he completed his training in 2002, he moved to Portland.

Dr. Makker quickly built a busy surgical practice. By July 2005, his net worth was $8.7 million, according to a document filed in court when he and his wife divorced in 2008. Dr. Makker estimated in a legal deposition in a separate proceeding that he performs between 300 and 500 spinal surgeries a year.

The Medicare data show that Dr. Makker performed seven separate spinal fusions on one patient in less than two years. Dr. Makker said the patient, who wasn't identified in the data, was "an extremely complicated and difficult" case, compounded by several device failures and by the fact that the patient was a heavy smoker, which he said impaired healing.

Five more Medicare patients had three separate spinal fusions performed by Dr. Makker, the data show.

Leo Hamilton, too, had his spine operated on by Dr. Makker seven times. Mr. Hamilton mentioned the surgeries in a lawsuit unrelated to his medical care—a suit against Gresham, a small city east of Portland, claiming that police officers injured his neck when they arrested him following a shooting in 2005.

Dr. Makker had operated on Mr. Hamilton's spine three times prior to the incident, and he did four more operations afterward. In a videotaped deposition for the lawsuit, Dr. Makker acknowledged that the seven surgeries, for which he personally billed about $175,000, did nothing to improve Mr. Hamilton's condition.

Dr. Makker faced his first malpractice suit in 2005. The plaintiff, an elderly Catholic priest named Edmond Bliven, was operated on in 2004 after injuring his back in a fall. Rev. Bliven alleged in the lawsuit that Dr. Makker missed one of his fractures during the surgery and then ignored his phone calls when his condition deteriorated. Rev. Bliven's lawyer says his client spent the next two years in a wheelchair before gradually recovering his ability to walk.

Records from the Oregon Medical Board show that Dr. Makker settled the case for $300,000. All told, Dr. Makker has settled four cases for a total of more than $1.2 million. He said he cannot comment about the settled cases because of confidentiality agreements. He prevailed at trial in a fifth case, and a sixth case was dropped by the plaintiff. Two more suits were filed recently by female patients and are pending. One of the women said she was operated on by Dr. Makker five times in less than 13 months, and the other said she had three operations in less than five months.

Dawn Johnson alleged in a 2009 suit that Dr. Makker operated on the wrong disk in her spine, then failed to adequately remove the correct disk in a second surgery. Ms. Johnson said she suffered numbness in her right leg and left foot and urinary incontinence, and had to have a third surgery, with a different doctor, to correct what she said were Dr. Makker's mistakes. Dr. Makker recently settled that case for $500,000.

Cathi Crandall, a 47-year-old photographer, said Dr. Makker could be very persuasive about having additional surgery. Ms. Crandall, who has not sued Dr. Makker, had three spinal surgeries with him in less than 18 months. She says she decided to halt treatment with him when he tried to persuade her to have a fourth. She likened him to "an Academy Award winning actor," adding: "It's as if he's charming you to go on a date, except the date is going to involve a surgery."

Mr. Johnson, the machine-tool operator, says he first consulted Dr. Makker in June 2006 after injuring his back lifting a five-gallon bucket at work. "At first, he makes everything sound so promising. He's pretty convincing," he says.

Mr. Johnson says that after six surgeries, he suffers from short-term memory loss that he blames on anesthesia,

and that he can no longer raise the front of his left foot, causing him to fall frequently.

Dr. Makker indicated that he settled the case for $130,000, which he says is less than what it would have cost him to defend himself at trial.

Several years ago, the Federal Bureau of Investigation began asking questions about Dr. Makker, according to two people interviewed by FBI agents. Dr. Makker says the FBI agents were part of an investigation related to billing issues by the U.S. attorney in Portland. He says his criminal defense attorney, Stephen Houze, was recently notified by the U.S. attorney in writing that the investigation had been abandoned for lack of evidence. The FBI declined to comment.

Over about three years, from early 2008 through early this year, he billed Medicare more than $5.4 million for all his work, but was paid only $597,510, for a payment rate of 11%, according to a person familiar with his billings. An analysis of a 5% sample of the Medicare billing of 3,247 spine surgeons in 2008 shows the average surgeon was paid 21% of the sums submitted. Law-enforcement officials who specialize in Medicare fraud say lower rates of payment can be red flags for fraud.

Dr. Makker said the difference between what he billed and what he was paid merely reflected the program's low reimbursement rates. "I have NEVER had one surgery, office visit, or any patient service rendered denied payment by Medicare," he said in an email.

Dr. Makker's billing led to disputes with two private health insurers. In a deposition in one of the malpractice suits, he acknowledged having to repay $150,000 he collected from the Providence Health Plan, the health-insurance arm of the Portland nonprofit hospital system Providence Health & Services. Dr. Makker is no longer part of the Providence Health Plan's network of doctors, but is allowed to continue to work out of an office at one of Providence's hospitals and to perform surgery there.

Another local insurer, Healthcare Resources NW, formerly known as UHN, also removed Dr. Makker from its physician network and asked him to repay some money he had collected, says one person familiar with the matter.

Dr. Makker declined to comment, citing confidentiality agreements reached with both health plans, but said he is still "allowed to see" patients with Providence Health Plan. A Providence spokesman declined to comment on Dr. Makker but explained that patients can choose to see doctors who aren't part of its network if they are willing to "pay a higher out-of-plan rate." A Healthcare Resources spokesman declined to comment, other than to acknowledge that Dr. Makker used to be in the health plan's physician network and isn't anymore.

In recent years, Dr. Makker appears to have been under some financial strain. In September 2008, he borrowed $3.75 million from KeyBank. He said he used part of the loan for his practice and for investments in a surgery center and three MRI centers, but also "lost some money in the stock market and in real estate investments." Court records show that Dr. Makker defaulted on the loan on Dec. 1, 2009.

Around that time, a judge in his divorce case ordered him to pay his ex-wife more than $1 million in accordance with a prenuptial agreement. KeyBank and Darlene Makker battled in court to obtain priority liens on Dr. Makker's Fidelity brokerage account. Ms. Makker had his earnings garnisheed.

Late last year, four neurosurgeons who covered for one another during off hours asked Dr. Makker to leave their call group. Two people familiar with the matter say the doctors tired of treating frequent complications of Dr. Makker's patients.

—Mark Schoofs and James Oberman contributed to this article.

Write to John Carreyrou at john.carreyrou@wsj.com and Tom McGinty at tom.mcginty@wsj.com

Secrets of the System

In Medicare's Data Trove, Clues to Curing Cost Crisis
10/25/2010

Physician Panel Prescribes the Fees Paid by Medicare
10/26/2010

Dividing the Medicare Pie Pits Doctor Against Doctor
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A Device to Kill Cancer, Lift Revenue 12/7/2010

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HEALTH INDUSTRY | APRIL 8, 2011

Senators Push to Open Database on Medicare

By MARK SCHOOFS and MAURICE TAMMAN

Two senators have introduced legislation to overturn a 1979 court injunction that bars the government from revealing what individual physicians earn from Medicare.

That information is stored in the Medicare-claims database, widely considered one of the best tools for finding fraud and abuse in the $500 billion federal health-insurance program for the elderly and disabled.

Secrets of the System Series

Soaring Medicare costs threaten to overwhelm the federal budget, yet American taxpayers are blocked from seeing exactly where their money goes. Under a three-decade-old court order, Medicare can't publish the billings of individual physicians who participate in the program. In this series, The Wall Street Journal explores Medicare's vast databases and shows how they can be used to expose potential fraud and waste.

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Journal Community

The Medicare Data Access for Transparency and Accountability Act, or DATA Act, was introduced Thursday by Sens. Ron Wyden (D., Ore.) and Charles Grassley (R., Iowa). They both serve on the Senate Finance Committee, which has jurisdiction over Medicare.

The Wall Street Journal, together with the nonprofit Center for Public Integrity, obtained from the government limited access to the database last year. Despite severe restrictions on using the data, the Journal was able to mine it and publish a series of articles exposing how doctors and other medical practitioners appear to be gaming Medicare to increase revenue.

One physical therapist identified by the Journal as having suspicious billing patterns, Aleksandr Kharkover, was indicted in February on charges of defrauding Medicare. He pleaded not guilty.

The judge who issued the 1979 injunction shielding the data ruled that physicians' privacy trumped the public's interest in knowing how tax dollars are spent. He relied on a privacy provision in the Freedom of Information Act, or FOIA. The new bill explicitly exempts physician Medicare billing data from that FOIA provision.

The legislation would also order the Department of Health and Human Services to make the data available at no cost. Patient identities would remain confidential.

Sen. Grassley, in prepared Senate floor remarks, cited articles in the Journal and said the bill "might deter some wasteful practices and overbilling."

Sen. Wyden, in prepared floor remarks, said "hiding" the data was "indefensible in a free society."

Limelight Video

Oregon neurosurgeon Vishal James Makker

Last month, the Journal used the data to detect potentially negligent or harmful care. It identified an Oregon neurosurgeon, Vishal James Makker, who had an unusual propensity for performing multiple spine surgeries—as many as seven—on the same patients. Dr. Makker denied wrongdoing and said he acted in the best interests of his patients.

The American Medical Association, which opposes releasing physician-specific Medicare billing records, has argued that such data could be misused to erroneously assess quality of care.

Asked to comment, the AMA provided statements by its immediate past president, J. James Rohack, M.D., who said in part: "Medicare claims data alone cannot identify quality care, and the public release of Medicare claims data, without the complete medical record and due process, would often be misleading, inaccurate and disruptive to patients' longstanding relationships with their physicians."

In January, the publisher of The Wall Street Journal, Dow Jones & Co., filed legal papers to try to overturn the 1979 injunction in court and open the records fully to the public.

A spokesman for the Centers for Medicare & Medicaid Services, which administers Medicare, said it couldn't comment because of Dow Jones's legal action and because it doesn't comment on pending legislation.

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HEALTH INDUSTRY | APRIL 13, 2011

Hospital Bars Surgeon From Operating Room

Medical Board in Oregon Separately Investigates Doctor Who Stood Out for High Rate of Multiple Spinal Procedures

By JOHN CARREYROU And TOM MCGINTY

A Portland, Ore., neurosurgeon who performed multiple spinal fusions on the same patients lost his operating privileges at the hospital where he did many of his surgeries and is under investigation by the Oregon Medical Board.

Read the WSJ's Previous Article About Dr. Makker

Medicare Records Reveal Troubling Trail of Surgeries

Providence Portland Medical Center revoked Vishal James Makker's surgical privileges last week following a March 29 article in The Wall Street Journal that identified Dr. Makker as having the highest rate of multiple spinal-fusion surgeries among 3,407 surgeons who performed the procedure on 20 or more Medicare patients in 2008 and 2009.

Dr. Makker's rate was nearly 10 times the national average, a Journal analysis of Medicare claims data showed. Dr. Makker, who operated on some of his patients' spines as many as seven times, last month denied wrongdoing and said he acted in the best interest of his patients.

Oregon's medical board has also opened an investigation into Dr. Makker, according to two people familiar with the matter. One of these people was recently interviewed by board representatives and Federal Bureau of Investigation agents as part of the probe. The FBI didn't return a call for comment. Dr. Makker's lawyer declined to comment.

The Oregon board forced Dr. Makker to undergo remedial training in 2006 for what it called unnecessary surgeries and for allegedly billing for procedures he didn't perform, but his status is listed as active on its website. A malpractice lawsuit—the ninth in less than seven years—was filed against Dr. Makker last week.

Limelight Video

Vishal James Makker

A spokesman for Providence Portland declined to say why it withdrew his privileges.

The latest developments came as new information emerged about the medical-device distributorship that supplies Dr. Makker with spinal implants. The distributor, Omega Solutions of Fresno, Calif., sometimes pays surgeons to use its products, according to a document reviewed by the Journal that Omega recently sent to surgeons it sought to recruit.

Omega Marketing Document

The document says that the


OMEGA SOLUTIONS

I am a representative for Spinal Elements, OS Spine, Alphatec and X-Spine. What sets me apart from other representatives is that I not only provide great FDA approved product, but I also guarantee to increase your patient load through my unique physician marketing program and my on going communication with over 200 primary care, chiropractor, urgent care and occupational medicine offices throughout the Coastal Valley.

Furthermore, a large portion of my referral base is generated through my relationship with the administrators at the American All-Risk Loss Administration (AARLA) Fresno, CA. Since I am not currently working with any spine surgeons in your area, I could direct workers compensation referrals for patients wanting to be seen in the area to you.

Choosing a doctor is not an easy task. I hope that I may be of help to you and people in need of back pain relief, by promoting your successful and uncompromising care.

I am confident that in a short amount of time, our team will be able to increase your patient load and in the process indirectly help those seeking back-pain relief.

company enters into partnerships with surgeons who agree to use its products and pays them "dividends" based on the number of surgeries they perform. Critics say such arrangements are controversial because they can skew medical decision-making.

The document details the cash payments made to one of Omega's partners, an unnamed spine surgeon in Los Angeles. From Jan. 1, 2009, to May 19, 2010, the surgeon received a total of $519,674.35 based on his use of Omega implants in two to three surgeries a week, the document says.

Dr. Makker told colleagues at Providence Portland Medical Center that he was a partner in Omega's business, according to a person familiar with the matter. Through his lawyer, Dr. Makker denied this.

Ted Switzer, the chief executive of Omega, said the company wasn't involved in a partnership with Dr. Makker that paid him to use its products, and declined to answer any other questions. Robert Zendejas, the Omega employee whose name is on the company's marketing document, hung up on a reporter when reached by phone.

Secrets of the System Series

Soaring Medicare costs threaten to overwhelm the federal budget, yet American taxpayers are blocked from seeing exactly where their money goes. Under a three-decade-old court order, Medicare can't publish the billings of individual physicians who participate in the program. In this series, The Wall Street Journal explores Medicare's vast databases and shows how they can be used to expose potential fraud and waste.

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Physician-owned distributorships, or PODs, such as the ones outlined in the Omega document have spread through spine-surgery circles. Distributorships act as middlemen between medical-device makers and the hospitals and surgery centers that buy their products. In exchange for marketing the devices and nurturing client relationships, they get a cut of each sale.

For a distributorship, winning the allegiance of surgeons is crucial because surgeons often dictate to their hospitals which devices to buy. By offering surgeons an ownership interest in their operations, distributorships can lock up a hospital's business while allowing the surgeon to profit from each device he uses, according to people familiar with how PODs function.

Critics say such deals have contributed to a jump in spine surgeries. Spinal fusion, which involves fusing together two or more vertebrae with the help of thousands of dollars of hardware, went from costing Medicare $343 million in 1997 to $2.24 billion in 2008, according to a Journal analysis of Medicare claims data.

The Office of Inspector General of the Department of Health and the Centers for Medicare and Medicaid Services have both warned that PODs may violate federal antikickback statutes and laws governing patient referrals.

Mr. Switzer, the Omega Solutions CEO, is listed in California corporate records as a partner in a half-dozen limited liability companies named after letters in the Greek alphabet. Asked whether they are PODs, Mr. Switzer declined to comment.

Dr. Makker's use of Omega implants raised eyebrows at Providence Portland Medical Center because Omega's product representative in Portland, Erin Martinson, is Dr. Makker's girlfriend, according to three people with knowledge of their relationship. Ms. Martinson was often present in the operating room with Dr. Makker to hand him the Omega implants during his surgeries there.

Ms. Martinson didn't return phone calls. In an email last month, Dr. Makker denied having a romantic

relationship with Ms. Martinson, saying she was merely a friend.

Write to John Carreyrou at john.carreyrou@wsj.com and Tom McGinty at tom.mcginty@wsj.com

EXHIBIT F OMITTED

(TEXT OF S. 756, 112th CONG., 1st SESSION)

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,

Plaintiffs,

v. Case No. 78-178-Civ-J-S

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,

Defendants,

DOW JONES & COMPANY, INC., *et al.*,

Intervenors.
_____/

DOW JONES & COMPANY, INC.'S MOTION TO VACATE PERMANENT INJUNCTION AND INCORPORATED MEMORANDUM OF POINTS AND AUTHORITIES

Dow Jones & Company, Inc. ("Dow Jones"), publisher of *The Wall Street Journal* (the "*Journal*"), respectfully moves, pursuant to Rule 60(b)(5) and (6) of the Federal Rules of Civil Procedure, to vacate the Final Declaratory Judgment and Permanent Injunction entered in this case on October 22, 1979 ("1979 Injunction"). This Motion is based on the following Memorandum, the Declarations and Exhibits filed herewith, and the Declarations and Exhibits filed with Dow Jones's Motion to Intervene.[1]

A permanent injunction should be vacated whenever "changes in the nature of the underlying problem, changes in governing laws or its interpretation by the courts, and new

[1]This Motion and the Motion to Vacate Permanent Injunction filed by Jennifer Alley [dkt 55] are, combined, permitted to be 50 pages in length pursuant to the Court's Case Management and Scheduling Order dated January 23, 2012 [dkt 51]. The Order also permitted intervenors' memoranda to be combined with their motions.

policy insights . . . render[] continued enforcement . . . 'detrimental to the public interest."' *Horne v. Flores*, 129 S. Ct. 2579, 2593, 2596-97 (2009) (citation omitted). After 33 years, Medicare and the laws governing when the government can withhold public information under Exemption 6 to the Freedom of Information Act ("FOIA") have so evolved that continued application of the Injunction in this case is far from the public interest. Instead, this secrecy is serving merely to facilitate fraudsters in spoiling one of our nation's largest taxpayer expenses, frustrate the government's efforts to stamp out Medicare abuse, and withhold from public view what the government is doing to police the system. The power of this Court to modify a decree of injunctive relief is "long-established, broad, and flexible." *Brown v. Plata*, 131 S. Ct. 1910, 1946 (2011). With that power comes the "continuing duty and responsibility to assess the efficacy and consequences of its order." *Id*. The Court should do so here, because the facts and law have changed fundamentally.

In 1979 – when Medicare, FOIA, and the Privacy Act were all in their infancy – the American Medical Association ("AMA") and others successfully petitioned this Court to prohibit the government from disclosing how much taxpayer money was paid to individual Medicare providers. Their concern was never the privacy of patients – all parties agreed their identities should be protected – but the interest of Medicare providers in keeping the public from knowing how much taxpayer money they received. The Court held that the payment data was "exempt from . . . disclosure under the FOIA because it would 'constitute a clearly unwarranted invasion of personal privacy'" and that the data "is prohibited by the Privacy Act from disclosure." *FMA v. HEW*, 2011 WL 4459387, at *2 (M.D. Fla. Sept. 26, 2011) (citation omitted). It issued an equally sweeping order that "permanently enjoined [HEW]

from disclosing any list of annual Medicare reimbursement amounts, for any years, which would personally and individually identify those providers of services under the Medicare program" and, further, that "[a]ny such disclosure . . . [was] declared to be contrary to federal law." *Id.* at *3 (citation omitted).

Behind this curtain, in the three decades since the 1979 Injunction, Medicare fraud has mushroomed into what former Attorney General Janet Reno declared the nation's second leading crime problem. The Department of Health and Human Services ("HHS") estimates that 8.6% of all Medicare spending is illegitimate, including millions for services purportedly rendered by long-dead doctors, or to long-dead patients. Other studies show far *more* fraud.

In 2010, HHS agreed to sell the *Journal* a fraction of the Medicare payment data, but on condition that it not use the data to reveal the names of individual providers, consistent with the dictates of the 1979 Injunction. Even with these limitations, the *Journal* was able to analyze the data to uncover evidence of waste, fraud, and abuse in the system. Its *Secrets of the System* series, a finalist for the 2011 Pulitzer Prize, used the data to expose suspicious billing activity by Medicare providers, some of whom were later indicted, suspended, or had their licenses revoked. It also raised questions as to whether the government is effectively mining the data at its disposal to prevent improper Medicare billing, and whether regulatory loopholes and other economic incentives encourage some doctors to disregard their patient's best interests and instead pursue unnecessary or high-cost procedures.

In September, recognizing that the 1979 Injunction "impairs their interests," this Court permitted Dow Jones, Jennifer D. Alley ("Alley"), and Real Time Medical Data, L.L.C. ("RTMD") to intervene as of right and move to vacate or modify the 1979 Injunction

pursuant to Rule 60(b) of the Federal Rules of Civil Procedure. *Id.* at *10. In granting intervention, the Court identified "the important questions raised by the proposed intervenors – whether Medicare records which identify Medicare providers' income should remain protected by the 1979 FMA Injunction and its application of the Privacy Act and the privacy exemption to FOIA, given the alleged change in circumstances underpinning that injunction." *Id.* at *9.

The law has evolved since 1979. This Circuit has clarified that "those who receive a governmental benefit" cannot expect to keep those government payments secret, in light of the "enormous" public interest in knowing whether an agency "is a good steward of (sometimes several billions of) taxpayer dollars." *News-Press v. DHS*, 489 F.3d 1173, 1192, 1202, 1206 (11th Cir. 2007). The facts have also changed, as Medicare has grown *twenty-fold* in nominal dollars since 1979, to more than half a *trillion* dollars a year. New electronic payment systems have been put in place since the 1979 Injunction, and huge "hit and run" fraud schemes have sprouted up to exploit them. At the same time, electronic records have made Medicare payment data far more valuable for those working to unmask such schemes.

Meanwhile, the privacy interest of the providers in what they receive from taxpayers has significantly diminished as this same information has been released to the public. Indeed, HHS regularly released this same Medicare claims data to RTMD as matter of course, pursuant to FOIA requests, from 2001 to 2007 without a single complaint from a provider. The Affordable Care Act of 2010 *requires* HHS to release this data to "qualified entities," who are then *required* to publish that data and are free to identify payments to individual providers. 42 C.F.R. § 401.701 et seq. Congress has so roundly repudiated the

notion that Medicare payment data should be secret that it *mandated* the publication of this information. *See Sorrell v. IMS Health Inc.*, 131 S. Ct. 2653, 2658 (2011) (rejecting an "asserted interest in physician confidentiality" in prescription data "[g]iven the information's widespread availability and many permissible uses").

A fundamental change in the way providers are paid also minimizes any privacy interest. In 1979, Medicare reimbursements were based on how much individual providers chose to charge for procedures, so release of Medicare payment data provided information about a provider's customary rates. *See* RTMD Motion to Vacate ("RTMD Mot.") 1-3. But the Omnibus Budget Reconciliation Act of 1989 introduced standardized payment schedules for all providers, meaning that payment data no longer sheds light on what a provider charges non-Medicare patients. *Id.* at 3-4

Dow Jones respectfully moves for an order vacating the Final Declaratory Judgment and Permanent Injunction entered in this case on October 22, 1979, because the facts and law underlying it have changed so fundamentally in the past 33 years.[2]

I. BACKGROUND

A. This Court's 1979 Injunction was based on a factual and legal landscape that is unrecognizable today.

In the early days of Medicare, the U.S. Department of Health, Education, and Welfare ("HEW"), which later became HHS, released a list of Medicare providers or groups of

[2] As the public debate over the role of waste, fraud and abuse in Medicaid and Medicare grows in this election year, Dow Jones's interest in *obtaining* Medicare payment data – and freely disseminating data already in its possession but subject to restraints on dissemination – has never been greater or more urgent. *See Bernard v. Gulf Oil Co.*, 619 F.2d 459, 470 (5th Cir. 1980) (collecting cases and noting that because "fragile First Amendment rights are often lost or prejudiced by delay," courts "have therefore been commendably willing to expedite proceedings involving First Amendment rights"), *aff'd*, 452 U.S. 89 (1981).

providers whose Medicare reimbursements totaled $100,000 or more during 1975. HEW also announced plans to release 1977 reimbursement data for all Medicare providers, in order to serve the interest in open government recognized by the nascent FOIA. *See FMA v. HEW*, 479 F. Supp. 1291, 1297 (M.D. Fla. 1979). In 1979, however, the plaintiffs in this action successfully petitioned this Court for an order enjoining HEW from disclosing annual Medicare payments to individually identified medical providers. *Id.* at 1311. The issue was never the privacy of *patients*, whose identities were (and are) closely guarded by the government. Rather, the providers receiving government payments complained that releasing Medicare payment data invaded their privacy by providing "information about at least part of [their] gross incomes." *Id.* at 1304. Their concern was due in part to the fact that, at the time, Medicare reimbursements were based on how much individual providers chose to charge for procedures, and release of Medicare payment data therefore provided information about how much individual providers chose to charge all their patients for procedures, as well as their annual incomes. *Id.* at 1296 (reimbursement of up to 80% of reasonable costs); RTMD Mot. 1-3.

This Court, Senior District Judge Charles R. Scott, presiding, issued an injunction and declaratory judgment, holding such information was "exempt from required disclosure under the FOIA because it would 'constitute a clearly unwarranted invasion of personal privacy'" under 5 U.S.C. § 552(b)(6), and that HEW was "prohibited by the Privacy Act from disclosure, without the prior written consent of each affected [provider]." *Id.* at 1311. This Court also enjoined HEW "from disclosing *any list* of annual Medicare reimbursement[] amounts, for *any years*, which would personally and individually identify those providers of

services under the Medicare program who are members of the recertified class in this case." *Alley v. HHS*, 590 F.3d 1195, 1199-1200 (11th Cir. 2009) (citation omitted). Considering only the information before it, which included only a vaguely-defined and ill-supported interest in informing the public debate over Medicare generally, it concluded that "the national debate over putative legislative activity involving national health insurance may well be served by disclosing the annual amounts of public funds expended for reimbursement of providers of services under the Medicare Act. But that public concern is no further advanced by revealing the identity of individual providers and their annual reimbursement amounts." *FMA*, 479 F. Supp. at 1305.

The class includes all physicians licensed to practice in Florida and all AMA members who are not Florida physicians but are providers of Medicare services. Because HHS has successfully argued that data on class members cannot be segregated from data pertaining to non-members, *see Alley v. HHS*, No. CV-07-BE-0096-E (N.D. Ala. Mar. 30, 2011) [dkt 139; Mem. Op. 9], the 1979 Injunction has been tantamount to a permanent, blanket, nationwide ban on the release of data for *any* year on payments to *all* individual Medicare doctors. This injunction continues to bind HHS. *Alley*, 590 F.3d at 1210. It was never reviewed by any court, because the government declined to appeal Judge Scott's order.

Subsequent decisions suggested that the 1979 Injunction has become outdated, but found no way to collaterally revisit the order. As discussed in the Motion to Vacate filed by Alley RTMD, in 2003, Alley filed a FOIA request for data on all Medicare claims paid in 2002 for procedures performed in Florida, Georgia, Mississippi, and Tennessee. *Id.* The Alabama district court "dust[ed] off the 1979 injunction," "construed it narrowly and decided

that it does not cover the information the plaintiffs [sought]." *Id*. at 1198. The Eleventh Circuit reversed, in an order that strongly suggested it was uncomfortable with the scope of the Injunction, but concluded that it had no power to revisit it:

> Perhaps, as Alley also contends, a "fundamental shift in Medicare's purpose, as well as dramatic increases in the number of Medicare participants," have bolstered the public interests favoring disclosure. Perhaps not. If Alley wants to raise those issues, she can do so . . . in a proceeding to alter or vacate the injunction.

Id. at 1209-10.

Another district court in 2007 ordered HHS to produce information on the number of procedures performed by individual providers in response to a FOIA request, finding that the interest in disclosure overwhelmed any privacy interests under FOIA Exemption 6 and the Privacy Act. *Consumers' Checkbook v. HHS*, 502 F. Supp. 2d 79, 85-86 (D.D.C. 2007). It found the privacy interest to be "minimal," noting that the information requested "related to the physicians' participation in and compensation from a government program" rather than "intimate facts about their personal lives." *Id.* On the other hand, the court found a strong public interest in disclosure because the requested physician-identifying information would shed light on the quality of services provided by the Medicare program and generally on "how government funds are spent." *Id.* at 84.

The D.C. Circuit reversed, 2-1, based in large part on the conclusion that the respondents had "not provided any evidence of alleged fraud the requested data would reveal" as to outweigh any alleged privacy interests. *Consumers*' *Checkbook v. HHS*, 554 F.3d 1046, 1049, 1054 (D.C. Cir. 2009). Yet one judge strongly disagreed, noting that the information should be released even in the absence of direct evidence of fraud:

> [T]he requested data would shed light on HHS's fraud-detection and fraud-prevention efforts. For instance, the data could identify providers who perform a suspiciously large number of procedures in a given time period or submit[ ] claims for procedures that are outside [their] own practice areas. The data could therefore facilitate public monitoring of HHS detection and prevention of fraud. Additionally, to the extent that consumer choice could be enhanced by knowing which physicians are potentially responsible for wasteful or even fraudulent claims, release of physician-identifying data is consistent with HHS's goal of improving consumers' decisions about which medical providers to patronize. The public could utilize the requested information in determining whether HHS is fulfilling this stated goal.

Id. at 1062 (Rogers, J., concurring in part and dissenting in part) (internal citations and quotation marks omitted). Still, Judge Rodgers would have remanded the case for further proceedings as to whether the 1979 Injunction barred release of the data in spite of the overwhelming public interest in its disclosure. *Id.* at 1065.

B. As Medicare – and Medicare fraud – have grown exponentially over the past 33 years, so too has the public interest in monitoring the system.

In 1979, when Judge Scott issued the Injunction, Medicare was just fourteen years old. It cost $26.5 billion – just over 5% of total federal outlays – in 1979. As discussed in detail in the attached Declaration of Malcolm Sparrow, Professor at Harvard's Kennedy School of Government and a leading expert on Medicare fraud ("Sparrow Decl."), the program has grown *twenty-fold* in nominal dollars, and nearly three-fold as a percentage of the total federal budget. Sparrow Decl. ¶ 20. Medicare's fee-for-service program now pays more than $1 billion on 4.5 million claims *every single work day*, and it must pay them all within 30 days of receipt. *Id.* Meanwhile Medicare fraud has become a problem of breathtaking scope – so large that Attorney General Janet Reno declared health care fraud the "number two crime problem in America" after violent crime. Since 1990, the General Accounting

Office (GAO) has considered Medicare at "high risk for fraud, waste, abuse, and mismanagement." GAO, *High Risk Series*, available at www.gao.gov/new.items/d09271.pdf.

There are countless examples in Florida alone. In 2008, a couple in Miami Lakes pleaded guilty to submitting nearly half a *billion* dollars in false Medicare claims for medical equipment. In 2011, 91 defendants – most based in Florida – were charged in Medicare fraud schemes worth approximately $295 million. Two weeks later, the owner of a Miami-area company was sentenced to 50 years in prison for orchestrating a $205 million Medicare fraud scheme. *Id.* ¶ 12. In 1999, the chair of the Florida Senate Health Care Committee pleaded guilty to using voter lists from his district to concoct a fraudulent Medicare scheme that netted nearly $2 million. And in 1993, Blue Cross/Blue Shield of Florida, a nominal party in this case, paid $10 million to settle Medicare fraud claims. *Id.* ¶ 13.

These are not isolated incidents. In 2000, the Office of Inspector General at HHS ("OIG"), which oversees the integrity of the Medicare program, identified $20.6 million in Medicare claims for services to patients who were dead at the time of the purported treatment. In 2002, it found Medicare beneficiaries for whom claims had been received and paid after the recorded date of deportation, and additional payments for patients in prison healthcare systems. *Id.* ¶ 15. And in 2008, a Senate subcommittee identified tens of millions of dollars paid for services or equipment prescribed by long-dead doctors. *Id.* ¶ 16. At the same time, few attempts have been made to generate any reliable estimates of fraud-loss rates. OIG studies between 1997 and 2002 showed overpayment rates between 6.3% and 14%. But the GAO found that even these estimates "did not take into consideration

numerous kinds of outright fraud" because it "assumes that all medical records received for review represent actual services provided." *Id.* ¶¶ 17-19.[3]

One key reason for this surge in fraud is a change in the way claims are processed. In 1979, claims were submitted on paper and reviewed by claims processing clerks. Now, the bulk of Medicare claims are submitted electronically and processed without *any* human scrutiny. OIG's chief counsel testified in 2011 that "[t]he very aspects of [electronic records] that make a physician's job easier . . . can also be used to fabricate information that results in improper payments." *Id.* ¶ 21. And fraud happens fast, one investigator said. "By the time [HHS] becomes aware of the scam, the company and John Doe have vanished." These "hit and run" schemes exploit the automation of modern claims processing systems. *Id.* ¶ 23.

Meanwhile, the resources available for fraud detection and control in Medicare are grossly inadequate. Fraud losses in Medicare range from scores to hundreds of times the "acceptable business risk" benchmarks used by the credit card industry, while Medicare spends just 0.2% of funds to police program integrity. *Id.* ¶ 26.

C. *The Wall Street Journal* and others have shown how the timely, granular Medicare payment data now kept by CMS can be used to uncover evidence of waste, fraud, and abuse in the Medicare system.

Even with the 1979 Injunction's limits on Medicare claims data, the *Journal* and others have uncovered ample evidence of fraud, waste, and abuse in the system.

The factual and procedural background of this case is set out in detail in Dow Jones's Motion to Intervene [dkt 1]. Briefly, the *Journal* embarked on a landmark project in 2010 to

[3] For example, just weeks ago, a Texas doctor and six others were arrested for a scheme that allegedly billed more than $350 million to Medicare for home health services. The operation, called "the largest alleged home health fraud scheme ever committed," was uncovered "[u]sing sophisticated data analysis [to] target suspicious billing spikes." *Id.* ¶ 40.

investigate Medicare fraud based on a set of databases known as the Limited Data Set Files (the "LDS Files"), which are maintained by CMS. Declaration of Michael Allen [dkt 1-2] ¶ 2. In particular, the *Journal* sought access to the Carrier Standard Analytic File (the "Carrier File"), an enormous database of all fee-for-service Medicare Part B claims in the United States. The Carrier File is unique because it contains information about the direct billings of and reimbursements to individual providers. Although long sought by journalists because of its potential to help expose fraud, waste, and abuse in the Medicare system, no news organization has been permitted access to the entire Carrier File. *Id.* ¶¶ 3-4.

HHS denied a FOIA request for the data, citing the Injunction. Declaration of Maurice Tamman [dkt 1-3] ¶ 5. As part of the settlement of the subsequent FOIA lawsuit brought by a partner organization, Dow Jones negotiated to purchase from HHS a portion of the Carrier File which contained all billings for a randomly selected 5% of Medicare recipients, as well as 5% samples of other Standard Analytic Files, such as those covering inpatient hospital stays and the purchase of durable medical equipment. In addition, Dow Jones received 100% of other specific LDS files, including a summary file of hospital billings called MEDPAR. *Id.* ¶¶ 6-9. Patients are anonymized in the LDS Files Dow Jones acquired. *Id.* ¶ 17. CMS restricted Dow Jones's use of the data, citing the Injunction. *Id.* ¶¶ 12-16. CMS agreed to disclose the LDS Files only on the condition that Dow Jones sign a standardized Data Use Agreement ("Agreement") providing that it would not disseminate information derived from the LDS Files if the information could be reasonably used to deduce an individual doctor's identity. *Id.*, Ex. A. Individual doctors could only be identified if their identities could be independently confirmed by Dow Jones.

That data, along with months of intensive investigative reporting and several additional requests for information, resulted in the groundbreaking series, *Secrets of the System* (the "Series"), a finalist for the 2011 Pulitzer Prize. Sparrow Decl., Ex. 23; Mot. to Intervene 9-16. To pick just a few examples – many more are included in the declarations of Michael Allen, Maurice Tamman, and Mark Schoofs – the Series introduced *Journal* readers to a Brooklyn physical therapist, Aleksandr Kharkover, who apparently billed Medicare for more than $2.5 million in 2008. Two months after the story ran, Kharkover was indicted on five counts of health care fraud. It reported on a New York doctor who allegedly pocketed more than $2 million in 2008 from Medicare with a pattern of billing that strongly suggested abuse or even outright fraud, but could not name the doctor due to the 1979 Injunction. More than a year after the story, she was publicly identified as Emma Poroger and indicted for her role in a massive fraud scheme. The Series reported on Dr. Theresa Rice, noting that Medicare received claims totaling over $11.6 million and paid out more than $7.1 million under her provider number in 2007. Rice was later suspended by the Texas medical board. And the Series reported on a spine surgeon who received large sums of money from medical device makers and performed seven fusions on the same patient in two years. His hospital privileges were suspended following the *Journal*'s story, and the state medical board was investigating. *Id.* at 9-15; Sparrow Decl., Ex. 23 at 25, 38, 43, 44. In sum, the *Consumers' Checkbook* decision was based on the lack of "any evidence of alleged fraud" that could be uncovered using the data. 554 F.3d at 1049, 1054. But the *Journal* used this data to uncover ample "evidence of alleged fraud" in the system. Even with only 5% of the Carrier File, and onerous restrictions on the use of the data, the *Journal* exposed suspicious billing patterns by

several providers who were later indicted, suspended, or had their licenses revoked. At the same time, it went beyond exposing individuals and investigated whether the government is effectively policing Medicare.

Other journalism organizations likewise have used Medicare claims data to uncover waste, fraud, and abuse. For example, PBS NewsHour and the Center for Investigative Reporting analyzed Medicare data and uncovered a pattern of suspicious diagnoses suggesting that California-based Prime Healthcare Services "encouraged [its] physicians to stop documenting syncope, which is fainting or dizzy spell, and instead use the term autonomic nerve dysfunction, which reimburses at a higher rate." After "a yearlong investigation of millions of patient records," they reported that Prime hospitals recorded this diagnosis "90 times more often than the average California hospital." Sparrow Decl. ¶ 36. Investigating – and reporting on – this story was possible only because records of Medicare payments to hospitals, rather than individuals, are beyond the scope of the 1979 Injunction.[4] Similarly, the *New York Times* in 2011 analyzed Medicare outpatient claims from 2008 and found that "hundreds of hospitals across the country needlessly exposed patients to radiation by scanning their chests twice on the same day." *Id.* ¶ 47. The *Times* had access to the data because it dealt with hospitals, but similar data on individual providers would be kept secret due to the 1979 Injunction.

[4] Whistleblowers likewise have frequently used data and data analyses in qui tam cases, 65% of which now involve Medicare or Medicaid. *Id.* ¶ 37. In 2003, for example Tenet HealthCare paid the United States $4.3 million to settle allegations that several of its Florida hospitals submitted fraudulent claims to Medicare by "upcoding" diagnoses by assigning a billing code that is paid at a higher rate than the right one. This followed a whistleblower suit filed by a company that analyzed publicly available Medicare claims data. *Id.*

The government has embraced the value of "crowdsourcing" accountability by making payment data public. For example, the salaries of nearly all federal *employees*, including doctors, have been public pursuant to federal regulations issued in 1985. *See* 5 C.F.R. § 293.311. Payments to lawyers appointed by the courts to represent indigent defendants are public as well.[5] Indeed, even the same Medicare payment data sought by Dow Jones may be published by qualified entities – with providers identified – pursuant to the recently enacted Affordable Care Act ("ACA"). The regulations that implement parts of the ACA require Medicare claims data to be made available to "qualified entities," primarily non-profit, region based entities, for the evaluation of the performance of providers. Qualified entities that use the information are then required to generate public reports using the claims data, which may provide payment data on named providers. *See* 42 C.F.R. § 401.717; RTMD Mot. 9-11.

More generally, the American Recovery and Reinvestment Act of 2009 required the creation of "recovery.gov," which shows the distribution of all Recovery funds by federal agencies and how the recipients are spending those funds. Some government officials have described this effect as akin to creating "a million Inspectors General" to monitor government spending. Sparrow Decl. ¶ 44. Similarly, the Federal Funding Accountability and Transparency Act (FFATA) of 2006 created "USAspending.gov," a website that includes the recipient, amount, and funding agency of nearly every federal grant, contract, loan, or other award of financial assistance. Currently, Medicare providers are left off these websites,

[5] *See* Administrative Office of the U.S. Courts, *Guidelines for the Administration of the CJA*, available at www.uscourts.gov/FederalCourts/AppointmentOfCounsel/CJAGuidelines Forms/vol7PartA/vol7PartAChapter5.aspx (noting that "[t]he CJA, as amended in 1998, mandates disclosure of amounts paid to court appointed attorneys upon the court's approval of the payment," and providing procedures for expeditiously releasing this information).

even though they act in effect as contractors to the government, are paid with public funds, and serve the clients (beneficiaries) of public programs. Senators Grassley and Wyden – recognizing the anomalous exclusion of medical providers and citing the fraud identified by the *Journal*'s series – introduced the Medicare Data Access for Transparency and Accountability Act (S.756). This bipartisan bill was introduced *specifically* to override the 1979 Injunction and require that Medicare claims data be posted on "USAspending.gov." Introducing the bill, Grassley lamented that "virtually every other government program . . . is more transparent than spending by the Medicare program." *Id.* ¶ 43.

D. Since 1979, the Injunction's restrictions have increasingly hampered the public's ability to supervise Medicare.

Despite the recognized value of the data, the limits CMS imposed on the LDS Files prevented the *Journal* from fully reporting what its investigations uncovered, and from uncovering much more. As this Court recognized, "the Injunction, as a practical matter, impairs [Dow Jones's] interests." *FMA*, 2011 WL 4459387, at *10. These restrictions, reported in detail in Dow Jones's Motion to Intervene [dkt 1], have three effects.

First, the 1979 Injunction limits the *Journal*'s ability to access the LDS Files. CMS provided the *Journal* with only a 5% sample of beneficiaries in the Carrier File and other files because the agency fears that providing all the data would violate the 1979 Injunction against disclosing the annual Medicare earnings of individual physicians. Mot. to Intervene 17. It is rarely, if ever, possible to compare a slice of a physicians' activities – such as how often he or she gave treatment A versus treatment B for a given diagnosis – against the norm for all physicians. As a result, many investigations of potential waste, fraud, and abuse are impeded because the *Journal* has been limited to a 5% sample of beneficiaries. *Id.*

Second, the 1979 Injunction limits the *Journal*'s ability to fully use the information in its reporting. In order to obtain the LDS Files, CMS required Dow Jones sign a Data Use Agreement providing that it would not disseminate information derived from the LDS Files that would identify an individual provider and the provider's reimbursements from Medicare. Indeed, under the CMS "cell-size suppression policy," no data may be disclosed even for small practice groups of fewer than 11 providers. Thus, *Journal* reporters are not permitted to disclose information about particular providers from the LDS Files when interviewing those who do not have access to the files – such as state medical boards, most current or former staff, or referring doctors. They are not even able to disclose information about corporate medical practices, even if the data is otherwise anonymized, unless that practice happens to have 11 or more providers. Mot. to Intervene 17-18; *cf. FCC v. AT&T Inc.*, 131 S. Ct. 1177, 1184-85 (2011) (FOIA Exemption 6 does not protect corporations). In addition, reporters generally find it necessary to consult others, ranging from expert statisticians to medical billing professionals to help understand the data. But further newsgathering often is prevented by the contractual duty not to disseminate information derived from the Carrier File and other LDS Files. The *Journal* often would be interested in conducting further newsgathering on certain providers based on information in the LDS Files, only to be forced to "triage out" these providers and not investigate them further. Mot. to Intervene 17-18.

Third, the 1979 Injunction limits the *Journal*'s ability to report on what its reporters have found. Many patients would want to know whether their doctor performs an inordinate number of risky surgeries in cases where other doctors generally recommend less drastic options. Many medical boards would want to examine such practices among their licensed

physicians, as well as billing patterns that suggest financial abuse or fraud. And many referring doctors would want the best information about those physicians to whom they are entrusting their patients. But none of these groups can learn this information because this Court's 1979 Injunction prevents the naming of individual doctors. *Id.* 18.

Even those working with the government have been hampered by CMS's tight controls on Medicare claims data, due at least in part to the 1979 Injunction. OIG recently reported that Medicare contractors, paid tens of millions to detect fraudulent claims, were forced to use inaccurate and inconsistent data that made it difficult to detect fraud. The naming of individual doctors suspected of fraud in a series like *Secrets of the System* assists law enforcement and deters wrongdoers. Sparrow Decl. ¶ 46.

II. ARGUMENT

A. The Court has a "duty and responsibility" to revisit the Injunction because its continued enforcement would be detrimental to the public interest in light of changes to Medicare and privacy law.

Rule 60(b)(5) expressly authorizes a district court to relieve a party from a final judgment if "applying it prospectively is no longer equitable." Relief is appropriate if "changes in the nature of the underlying problem, changes in governing laws or its interpretation by the courts, and new policy insights . . . render[] continued enforcement . . . 'detrimental to the public interest."' *Horne*, 129 S. Ct. at 2593, 2596-97 (quoting *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 384 (1992)). In addition, Rule 60(b)(6) authorizes relief for "any other reason that justifies relief."

Rule 60(b) is, in turn, a recognition of an inherent power of the court to modify its own orders. *Hodge v. Dep't of Housing & Urban Dev.*, 862 F.2d 859, 861-62 (11th Cir.

1989). This Court recognized as much when it issued an order in 1982 clarifying that its 1979 Injunction "is construed not to prohibit disclosure" of Medicare payment information that is authorized under FOIA's Law Enforcement Exemption. Order at 2, 3 (Dec. 2, 1982). Once a party shows that changed circumstances warrant relief, "a court abuses its discretion when it refuses to modify an injunction or consent decree in light of such changes." *Horne*, 129 S. Ct. at 2593 (quotation marks omitted).

Even a permanent injunction "is 'permanent' only for the temporary period for which it may last," Justice Frankfurter noted, because "[f]amiliar equity procedure assures opportunity for modifying or vacating an injunction when its continuance is no longer warranted." *Milk Wagon Drivers Union v. Meadowmoor Dairies*, 312 U.S. 287, 298 (1941) (Frankfurter, J.). Justice Cardozo agreed, noting that, "[a] continuing decree of injunction directed to events to come is subject always to adaptation as events may shape the need." *United States v. Swift & Co.*, 286 U.S. 106, 114 (1932). More recently, the Supreme Court noted that injunctions "often remain in force for many years, and the passage of time frequently brings about changed circumstances—changes in the nature of the underlying problem, changes in governing law or its interpretation by the courts, and new policy insights—that warrant reexamination of the original judgment." *Horne*, 129 S. Ct. at 2593 (discussing institutional reform litigation).

The time has now come to decide what this Court called the "important questions;" "whether Medicare records which identify Medicare providers' income, should remain protected by the 1979 *FMA* Injunction and its application of the Privacy Act and the privacy exemption to FOIA, given the alleged change in circumstances underpinning that

injunction." *FMA*, 2011 WL 4459387, at *9. In resolving these "important questions," the Court need only conclude that its decades-old injunction should not preclude agencies and other courts nationwide from releasing these records in the future, given that the Medicare system, the law on access to the records of government payments, and privacy law under FOIA have changed dramatically.

B. Since 1979, this Circuit clarified that FOIA "disfavors privacy claims by those who receive a governmental benefit," and Medicare payment data has been routinely released to the public without complaint.

FOIA was in its infancy when the 1979 Injunction issued, having been created in 1966 and drastically overhauled in the wake of Watergate in 1974. Over the past 33 years, FOIA has been firmly established as "a broad disclosure statute which evidences a strong public policy in favor of public access to information in the possession of federal agencies." *News-Press*, 489 F.3d at 1190. Thus, a FOIA request which includes names or other individual identifying information "does not inherently and always constitute a 'clearly unwarranted' invasion of personal privacy" that will invoke the protection of Exemption 6. *Id.* at 1199 (citation omitted). Instead, "whether disclosure of a list of names is a significant or a de minimis threat depends upon the characteristic(s) revealed by virtue of being on the particular list, and the consequences likely to ensue." *Id.* Exemption 6 was intended to protect "intimate details" such as "marital status, legitimacy of children, identity of fathers of children, medical condition, welfare payments, alcoholic consumption, family fights, and reputation." *Washington Post Co. v. DOJ*, 863 F.2d 96, 100 (D.C. Cir. 1988). This is a far cry from physicians "who contract with the government to provide medical services in exchange for federal payments" and thus "perform a quasi-public function." *Public Citizen*

Health Research Group v. HEW, 477 F. Supp. 595, 604-05 (D.D.C. 1979), *rev'd on other grounds*, 668 F.2d 537 (D.C. Cir. 1981).

No patient information is at issue in this case. The only "characteristics" revealed by the data are details related to the provider's professional services, all of which are paid for (to the tune of hundreds of billions of dollars a year) by taxpayers. This is not the kind of intimate personal information that the Privacy Act is intended to shield. Indeed, decades after the 1979 Injunction was issued, the Eleventh Circuit rejected the claim that information about those receiving FEMA payments should be shielded because they might indicate that a recipient lacked insurance or rented rather than owned their homes, essentially incorporating the legislative history of FOIA into the law of the circuit:

> [T]he "[l]egislative history of [Exemption 6] disfavors privacy claims by those who receive a governmental benefit." The Senate Report accompanying the FOIA expressly stated that "health, welfare, and selective service records are highly personal to the person involved, *yet facts concerning the award of a pension or benefit should be disclosed to the public*." The House Report similarly observed that Exemption 6 was "intended to cover detailed Government records on an individual which can be identified as applying to that individual and *not the facts concerning the award of a pension or benefit* or the compilation of unidentified statistical information from personal records."

News-Press, 489 F.3d at 1202 (citations omitted; emphasis added by court). *News-Press* considered whether records shedding light on FEMA's disbursement of disaster assistance funds – and the fraud, waste, and abuse that took place in in the course of that disbursement – could be withheld under Exemption 6. A judge in the Middle District of Florida found that the information was covered by Exemption 6, but the Eleventh Circuit reversed. Characterizing the public interest in monitoring fraud, waste, and abuse in FEMA's

operations as "undeniable," "powerful," "substantial," and "enormous," the court "easily conclude[d] … that the asserted interest in learning whether FEMA is a good steward of (sometimes billions of) taxpayer dollars … is one which goes to 'the core purpose of the FOIA, which is contributing significantly to public understanding of the operations or activities of the government.'" *Id.* at 1191-92, 1196, 1206. The court reasoned that the "critical nature" of the program "makes reports of waste, mismanagement and outright fraud particularly disturbing." *Id.* at 1206 (citation omitted). It thus ordered the addresses of FEMA recipients released, along with the amount of assistance provided and other information. The court ordered the addresses released, but not the names of the disaster victims themselves, in part because "it is possible to derive names from addresses through public records." *Id.* at 1205.

Other cases decided since 1979 have likewise clarified that, even where there may be some minimal privacy interests in information that pertains to business activities, any such privacy interest shrinks considerably when the business is funded by the federal government. *Washington Post Co. v. HHS*, 690 F.2d 252, 261 (D.C. Cir. 1982) (disclosure of agency consultants' non-federal employment would be only a minimal invasion of privacy); *Washington Post Co. v. DOJ*, 863 F.2d at 100 (Exemption 6 applies to disclosures of "an intimate personal nature," thus "information relating to business judgments and relationships does not qualify for exemption. This is so even if disclosure might tarnish someone's professional reputation."); *Sims v. CIA*, 642 F.2d 562, 575 (D.D.C. 1980). Thus, in *Washington Post Co. v. Department of Agriculture*, 943 F. Supp. 31, 35-36 (D.D.C. 1996), the court held that cotton farmers who received government subsidies had no substantial

privacy interests in data requested under FOIA, even though such data would reveal their names, addresses and specific amounts of money they received from the government. As the court stated, "[t]he individuals on this particular list are there because they . . . sought and received government subsidies in their business capacities." *Id.* at 35.

Similarly, in *Multi Ag Media LLC v. Department of Agriculture*, 515 F.3d 1224 (D.C. Cir. 2008), the government objected to disclosure of a farm's acreage and related data on the ground that it "'may provide a snapshot' of a farm's financial circumstances and 'shed[ ] light on the financial condition of the farmer.'" *Id.* at 1230 (citation omitted; alteration in original). The D.C. Circuit agreed, but found that any privacy interest was trumped by the "significant public interest in disclosure of the GIS database."[6] It found a "particular and significant interest" in the information because "USDA uses this information in the administration of its subsidy and benefit programs, and there is a special need for public scrutiny of agency action that distributes extensive amounts of public funds in the form of subsidies and other financial benefits." *Id.* at 1232.

Of course, the same is true here. The "characteristics" of providers revealed in these records are nothing on the order of legitimacy of children or medical conditions – indeed, the data is anonymized as to patients' identities. Rather, it is the fact that they are, in effect, government contractors being paid for their services – hardly an intimate fact, or one that

[6] It rejected the claim that, "although the information it withheld from the database may say much about the farm, it says nothing about how the agency administers its programs," reasoning that the database allowed the public to "more easily determine whether USDA is catching cheaters and lawfully administering its subsidy and benefit programs." *Id.* at 1232.

deserves to be shielded from public scrutiny. *See Public Citizen Health Research Group*, 477 F. Supp. at 604-05 (Medicare providers "perform a quasi-public function").[7]

In addition, it has become clear over the last 33 years that the only "consequence[] likely to ensue" from public access to this payment data, *News-Press*, 489 F.3d at 1199, is better oversight of the Medicare system. *First*, as Alley and RTMD discuss in detail in their Motion to Vacate, HHS routinely released Medicare claims data to RTMD for nearly six years until 2007. During those nearly six years, HHS disclosed millions of Medicare records that included this physician identifying data, yet neither the *Alley* litigation nor discovery in this case turned up a single physician who ever complained about the disclosure. *See* Declaration of Jennifer Alley ¶ 24. AMA itself sells detailed demographic data and contact information it collects on all doctors – members and non-members – to telemarketers and others for marketing purposes. *See* RTMD Mot. 14.

Second, Medicare payment data may be published by qualified entities – *with providers identified* – pursuant to the recently enacted Affordable Care Act ("ACA"). The regulations that implement parts of the ACA require Medicare claims data to be made available to "qualified entities," primarily non-profit regional entities, for the evaluation of the performance of providers. *See id.* at 9-11. Qualified entities that use the information

[7] Even where disclosure may allow "commercial advertisers or solicitors" to approach individuals with offers of "special goods, services, and causes likely to appeal to" them, this "modest intrusion" is "simply the price we pay for living in a society marked by freedom of information laws, freedom of the press, and publicly-funded disaster assistance." *News-Press*, 489 F.3d at 1203. "Many are those who must endure speech they do not like, but that is a necessary cost of freedom." *Sorrell*, 131 S. Ct. at 2669 (rejecting interest in protecting doctors who "felt coerced and harassed" by pharmaceutical marketers).

must generate public reports using the claims data. 42 C.F.R. § 401.717.[8] This means that the claims data of individual providers will be publicly disclosed at least by *some* entities. The ACA underscores the public interest that the government and Congress clearly believe disclosure of this data serves.[9]

Third, Medicare payment data no longer offers any insight into the rates that individual providers charge. In 1979, Medicare reimbursements were not set, as they are today, by a statutory, publicly-disclosed fee schedule that paid every physician the same amount for the same procedure performed. Instead, individual physicians were given considerable discretion in determining for themselves how much to charge the Medicare program for any given procedure, and the amount of fees charged were not disclosed to the public. This dramatically changed with the Omnibus Budget Reconciliation Act of 1989, and Medicare now pays all providers according to a published rate schedule set by HHS. *See* www.cms.gov/apps/physician-fee-schedule/.

Fourth, in issuing the 1979 Injunction, Judge Scott found that the government's data releases in 1975 were riddled with errors. *FMA*, 479 F. Supp. at 1297. But electronic billing offers far less opportunity for introduced error. While there may be errors in bills *submitted* to Medicare, those generally are errors of the providers rather than the government. *See* OIG Report OEI-05-99-00100, available at http://oig.hhs.gov/oei/reports/oei-05-99-00100.pdf

[8] Because the release of the information is specifically authorized by the ACA, this release will be beyond the scope of the Privacy Act and thus the scope of the 1979 Injunction.

[9] The ACA also requires manufacturers of drugs, devices, biologicals, or medical supplies to report to CMS any payments or other transfers of value to physicians and teaching hospitals. 42 U.S.C. § 1320a–7h. CMS must then publish this payment data – including the doctor's identity – in searchable form on the Internet. *Id.*

("As with paper claims, humans (and not software) may be the greatest cause of claim error."). To the extent that the bills submitted to CMS do contain erroneous information, there is a public interest in knowing this as well since this is the data used to pay claims.

Fifth, the notion that providers will stop accepting Medicare were the public to gain access to information on how much of its money physicians receive from the system is even more fanciful than in 1979. In 1979, AMA argued that the public interest in disclosure is undermined by the risk that providers will stop accepting Medicare rather than have their payments subject to FOIA. This assertion played no role in granting the 1979 Injunction. Any notion that providers will stop accepting Medicare in large numbers is based purely on conjecture. The AMA has not produced *any* evidence to support its previously unsubstantiated argument. When asked in discovery in the last few months for *any* surveys or other evidence in their possession suggesting that doctors might exit Medicare were the public to gain access to payment information, neither AMA, FMA nor HHS could provide any. To the contrary, the evidence suggests that a mass provider exodus is an extremely unlikely outgrowth of lifting the Injunction. Medicare now accounts for 21% of total national health care spending in 2011, and 23% of total spending on physician services. Kaiser Family Foundation, *Medicare Spending and Financing*, available at http://www.kff.org/medicare/upload/7305-06.pdf. Indeed, over the last decade, a formula established in the Balanced Budget Act of 1997 has repeatedly threatened to reduce Medicare payments by over 20%, but *even this* has not led to significant defections from the system. *See, e.g.*, Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy*, available at http://medpac.gov/documents/Mar11_EntireReport.pdf. Participation

among providers has steadily *climbed* – for example, from 80.2% in 2000 to 99.2% in 2011 for general practice doctors. CMS Data Compendium, Table VI.8, available at www.cms.gov/DataCompendium/13_2011_Data_ Compendium. asp#TopOfPage.

C. Public policy has shifted in favor of "disclosure, not secrecy" since 1979, in light of the "undeniable" interest in monitoring public spending.

Even if the privacy interest were more than de minimis, it must be balanced against the interest in openness. The last 33 years have seen a public policy shift in favor of access, as courts and President Obama have made clear that FOIA "should be administered with a clear presumption: In the face of doubt, openness prevails." *Freedom of Information Act*, Memorandum for the Heads of Executive Departments and Agencies, 74 Fed. Reg. 4683 (2009). Consistent with "the basic policy that disclosure, not secrecy, is the dominant objective of the Act," the Supreme Court has "repeatedly stated that the policy of the Act requires that the disclosure requirements be construed broadly, the exemptions narrowly." *News-Press*, 489 F.3d at 1191 (citations omitted). This is especially true of Exemption 6, which was drafted to allow the withholding of information only under the most exceptional circumstances, that is, where "a balancing of individual privacy interests against the public interest in disclosure reveals that disclosure of the information would constitute a clearly unwarranted invasion of personal privacy." *Id.* at 1196-97 (citation and internal quotation marks omitted). Indeed, "under Exemption 6, the presumption in favor of disclosure is as strong as can be found anywhere in the Act." *Washington Post Co. v. HHS*, 690 F.2d at 261-62. This Circuit, in particular, has been especially protective of the public right to documents under FOIA, noting that, "[i]f the balance . . . is equal the court should tilt the balance in

favor of disclosure." *News-Press*, 489 F.3d at 1205 (citation omitted).[10] This is doubly true as to "privacy claims by those who receive a governmental benefit." *Id.* at 1202 (citation omitted). This interest in public oversight exists even when government is making efforts to control abuses. In *HHS*, 690 F.2d at 261-62, the court noted that "[o]ne hopes, of course, that HHS's in-house review is rigorous enough to catch any abuses. But the purpose of FOIA is to permit the public to decide *for itself* whether government action is proper. . . . In light of that purpose, the public interest in disclosure is not diminished by the possibility or even the probability that HHS is doing its reviewing job right." *Id.* at 264. In a democracy, "the protection of the public fisc is a matter that is of interest to every citizen." *Brock v. Pierce County*, 476 U.S. 253, 262 (1986). As courts have made clear since 1979, this presumptive public interest in government spending tips the Exemption 6 balance decidedly in favor of disclosing government payment data. *See supra,* Section II.B.

Recognizing what the Eleventh Circuit in *News-Press* called this "undeniable" interest in monitoring how public funds are used, the government has released similar financial information for any number of individuals and organizations that receive public money. This is true whether the public money comes in the form of disaster relief as in *News-Press*, or subsidies, as in *Multi Ag Media*. And it is doubly true when payment comes

[10] The *Checkbook* decision "rests on its fact-bound conclusion that the particular data petitioner seeks – the identification of the specific physicians who performed, and were reimbursed for, particular medical procedures – would not in fact be useful for any of the public-interest purposes petitioner posits." Br. for Fed'l Resp'ts in Opp'n to Cert., *Consumers' Checkbook v. HHS*, No. 09-538, 2010 WL 942805. In this case, Dow Jones and others have provided ample evidence of the compelling interest in public oversight of Medicare and the fact that access to claims data – not just the medical procedure data sought in *Checkbook* – is essential to this oversight.

in the form of salaries, or other payment for services rendered.[11] The modern emphasis on *transparency* of government spending, as typified by the appearance of government websites such as "recovery.gov," "USAspending.gov," and "paymentaccuracy.gov," also allows the public more readily to monitor the use and abuse of taxpayer dollars given to private entities.

Modern Medicare has become the poster child for the compelling interest in public oversight, since even HHS estimates that 8.6% of all Medicare spending – $28.8 billion – is illegitimate. Medicare's automated claims system – established long after the 1979 Injunction – enables large-scale "hit and run" fake billing schemes in which millions disappear before HHS even notices it is gone. And once gone, the money is extremely unlikely to be recovered – an OIG report found that just 7% of Medicare payments identified as problematic were recovered. *See* OIG Report No. OEI-03-08-00030, available at http://oig.hhs.gov/oei/reports/oei-03-08-00030.pdf. At the same time, automation of the Medicare claims procedure means that current, high-quality data is now available for use in monitoring waste, fraud, and abuse. Sparrow Decl. ¶ 33.

These changes make public oversight of Medicare claims more vital – *and more feasible* – than ever. The timely, granular data now available allows the public and press to see more clearly how Medicare allocates its resources and how effectively it polices waste, fraud, and abuse – an increasingly important public policy question since Medicare fraud has been declared a leading crime problem. The public should not be required to accept at face

[11] This is true whether they are government employees or court-approved private lawyers serving indigent clients. In 1989, the Second Circuit decided, as a matter of first impression, that the public has a qualified First Amendment right of access to records of payments to court-appointed counsel and for experts and other services. *United States v. Suarez*, 880 F.2d 626, 630 (2d Cir. 1989) (reasoning that "there is an obvious legitimate public interest in how taxpayers' money is being spent, particularly when the amount is large").

value government pronouncements on how it is doing, *particularly* where the government admits that it cannot even accurately measure how it is doing. *Id.* ¶¶ 42-44, 49. Public access also allows the public to supplement the fraud detection efforts of CMS, DOJ, and related agencies. When an outside watchdog like the *Journal* decides to look at a particular segment or receives and explores information about a particular provider, it utilizes a different set of methods and can devote considerable attention to non-traditional areas of inquiry. And many sources who may come to a reporter or other independent watchdog, may not – for a wide variety of reasons – want to speak to law enforcement. *Id.* ¶ 25.

Public access to the data also allows the government to crowdsource accountability and thus deter fraud. If the data were public, fraudsters would face the added deterrent of knowing that their billings were publicly available and that they might be called out by name. It would be that much harder for them to predict the types or level of scrutiny that might be applied. *Id.* ¶ 46. Dr. Donald M. Berwick, who led CMS until recently, estimated that 20-30% of health spending is "waste" that yields no benefit to patients. *Id.* ¶¶ 46-47. By all accounts, the data is invaluable to monitoring waste and government efforts to combat it.

CONCLUSION

Dow Jones respectfully moves for an order vacating the Final Declaratory Judgment and Permanent Injunction entered in this case on October 22, 1979. The explosive growth of Medicare and Medicare fraud, the increased public disclosure of government payment data in general and Medicare payment data in particular, and changes in the law on privacy under FOIA have undermined its legal and factual basis. The order should be vacated in its entirety because "changes in the nature of the underlying problem, changes in governing laws or its

interpretation by the courts, and new policy insights" have "render[ed] continued enforcement 'detrimental to the public interest."' *Horne*, 129 S. Ct. at 2593, 2596-97.

LOCAL RULE 3.01(g) CERTIFICATION

The undersigned counsel for Intervening Defendant Dow Jones & Company, Inc., pursuant to Local Rule 3.01(g), represents that counsel has conferred with counsel for the parties in regard to the foregoing motion. Plaintiffs AMA and FMA oppose the relief requested, defendant HHS takes no position at this time, and intervenors Jennifer D. Alley and Real Time Medical Data, L.L.C. support the relief requested.

Dated: March 19, 2012

Respectfully submitted,

By: /s/ Laura R. Handman

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CERTIFICATE OF SERVICE

I hereby certify that, on March 19, 2012, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system which will send a notice of electronic filing to the following:

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,

Plaintiffs,

v. Case No. 78-178-Civ-J-S

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,

Defendants,

DOW JONES & COMPANY, INC., *et al.*,

Intervenors.
_____/

DECLARATION OF PROFESSOR MALCOLM K. SPARROW

I, Malcolm K. Sparrow, pursuant to 28 U.S.C. § 1746, declare as follows:

1. I have been retained by intervenor Dow Jones & Company, Inc. ("Dow Jones") in this action. I make this declaration in support of Dow Jones's motion to vacate the permanent injunction issued by this Court in 1979. I have personal knowledge of the facts contained herein.

2. I have studied health care fraud, Medicare fraud in particular, since 1993. From its relatively modest beginnings in 1965, the Medicare program has grown into a complex, automated system that now consumes roughly one-eighth of the entire federal budget. Since the early 1990's Medicare fraud has been recognized as one of the nation's most severe crime problems, as program vulnerabilities have attracted an extraordinary range of fraud perpetrators, from small-time criminals who can steal millions acting alone, to organized crime syndicates whose scams often net hundreds of millions of dollars. Massive "hit-and-run" fake billing schemes are facilitated by extensive automation of the payment systems – systems that were not in place in 1979 – which process the vast majority of claims with no human intervention. The

controls in health care payment systems focus primarily on whether claims are correctly submitted and accurately paid, rather than on whether claims are fraudulent; and fraud prevention programs remain woefully underfunded.

3. This vulnerability of public funds disbursed through the Medicare program makes broader public access to Medicare claims data even more imperative than in the early years of Medicare. The quality of the data collected and the more sophisticated data analysis makes access to data critical to any effective fraud detection and control operation. Public access to government expenditure data also constitutes the cornerstone for public accountability of the program administration itself. Skilled reporting teams can analyze the data, follow leads, and interview sources. Such scrutiny quickly brings questionable practices to public attention, and mobilizes increased official scrutiny before more taxpayer money is wasted. These efforts of Dow Jones and others can significantly enhance government efforts at deterring and uncovering waste, fraud and abuse. More important, it can pinpoint where government is lagging in its own efforts. This has now become accepted as conventional wisdom for those working across a vast range of governmental programs, particularly in programs that involve contracting with private companies for the delivery of public services. I believe the same fundamental logic applies when the contractors are medical providers servicing the clients (patients) of public health programs such as Medicare and Medicaid.

A. Background and qualifications

4. I am Professor of the Practice of Public Management at the John F. Kennedy School of Government, Harvard University. I am Faculty Chair of its Executive Programs on regulation and enforcement, and have chaired Executive-level programs on corruption control, policing, and counter-terrorism. My research focuses on risk control generally, but I have paid special and detailed attention to the challenge of fraud control in Medicare and other government

programs. In 2010, I was appointed by President Obama as one of four members of the Recovery Independent Advisory Panel, which advises the Recovery Board on protecting the integrity of the economic stimulus package created by the American Recovery and Reinvestment Act of 2009. Attached as Exhibit 1 is a copy of my curriculum vitae.

5. My formal training is in mathematics and public policy. I hold an M.A. in Mathematics from Cambridge University (England); an M.P.A. from the Kennedy School of Government at Harvard; and a Ph.D. in Applied Mathematics from the University of Kent at Canterbury (England).

6. I am also a former police detective with expertise in fraud investigations. I joined the British Police Service in 1977, serving for ten years and rising to the rank of Detective Chief Inspector. At that rank, I headed the Kent County Constabulary Fraud Squad. I hold six U.S. and foreign patents covering systems for the computerized identification of fingerprints.

7. I am the author or co-author of seven books, including *License to Steal: How Fraud Bleeds America's Health Care System* (1st ed. 1996; 2d ed. 2000); *Imposing Duties: Government's Changing Approach to Compliance* (1994); *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance* (2000); and *The Character of Harms: Operational Challenges in Control* (2008).

8. I am the author of a paper entitled "Fraud in the U.S. Health Care System: Exposing the Vulnerabilities of Automated Payment Systems," published in *Social Research: An International Quarterly of the Social Sciences* (2008). My declaration is based in large part on this article, a copy of which is attached as Exhibit 2. I have also written many other articles, book chapters, and reports, many of which are focused on Medicare, Medicaid, and health care fraud. These include: "Fraud and Abuse Detection and Control in the Florida Medicaid

Program: A Strategic Review of AHCA's Program Integrity Operations," prepared for Florida's Agency for Health Care Administration (2001); "Corruption in Health Care Systems: The American Experience," in *Global Corruption Report 2006: Special Focus – Corruption & Health* (2006); "Fraud Control in the Health Care Industry: Assessing the State of the Art," in *Research in Brief*, National Institute of Justice (1999); "Health Care Fraud Control: Understanding the Challenge," in the *Journal of Insurance Medicine* (1996); "The State of the Fraud Control Game; and the Impact of Electronic Claims Processing on Fraud and Fraud Control," in the *International Symposium on Criminal Justice Information Systems and Technology* (1994); "Fraud Control Redesign Analysis," a confidential review prepared for Kaiser Permanente (2002); "Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles," a report published by the Health Care Financing Administration (1999); "Health Care Fraud: Towards Effective Control," a report for National Institute of Justice (1997); and "Health Care Fraud Control: The State of the Art," prepared for the Kennedy School's Program on Strategic Computing and Telecommunications in the Public Sector (1995).

9. I have testified before the United States Congress on several occasions. Most recently, on May 20, 2009, I testified before the Senate Committee on the Judiciary, Subcommittee on Crime & Drugs on the subject of Health Care Fraud Control. Attached as Exhibit 3 is a copy of the transcript of this testimony. I have also testified to state legislatures on health care fraud, both in California and in Florida.

10. I have served as a consultant for more than a dozen governmental and non-governmental organizations on issues related to health care fraud control, including the Federal Bureau of Investigation, the Health Care Financing Administration, the Canadian Health Care

Anti-Fraud Association, the Florida Agency for Health Care Administration, Florida Blue Cross/ Blue Shield, and Kaiser Permanente.

B. Medicare fraud has grown exponentially since 1979

11. In the 33 years since the permanent injunction was entered in this case, Medicare fraud has become a problem of breathtaking scope. In 1993, Attorney General Janet Reno declared health care fraud the "number two crime problem in America" after violent crime – a remarkable status for a category of white-collar crime. In 1995, FBI Director Louis J. Freeh testified that cocaine-traffickers in Florida and California were switching from drug dealing to health care fraud. The traffickers had discovered that health care fraud was safer, easier, and more lucrative than the drug trade, and carried a smaller risk of detection. *See* Exhibit 4, attached. In 1997, the *New York Times* reported that mafia families in New York City and New Jersey were abandoning their traditional lines of business (extortion and bid-rigging rackets) in favor of new criminal enterprises, including health insurance. *See* Exhibit 5, attached. Meanwhile, in 2003, Columbia HCA, America's largest hospital chain, finalized a $1.7 billion settlement with the U.S. Department of Justice, the largest in history, following 10 years of investigation into an array of whistleblower allegations. *See* Exhibit 6, attached.

12. Some local examples illustrate just how much money can be stolen from the system. In July 2008, a couple in Miami Lakes, Florida, pleaded guilty to fraud, admitting they had submitted to Medicare $420 million – nearly *half a billion dollars* – in false claims for medical equipment. *See* Exhibit 7, attached. On September 7, 2011, Attorney General Eric Holder and HHS Secretary Kathleen Sebelius announced that a nationwide takedown by Medicare Fraud Strike Force operations resulted in charges against 91 defendants – most based in Florida – for their alleged participation in Medicare fraud schemes involving approximately $295 million in false billing. *See* Exhibit 8, attached. And on September 16, 2011, HHS

announced that the owner of a Miami-area mental health company was sentenced to 50 years in prison for orchestrating a $205 million Medicare fraud scheme. According to HHS, the fraudsters "paid bribes and kickbacks to recruit Medicare beneficiaries" and billed Medicare for treatments that were medically unnecessary or never provided. They also "used sophisticated measures to conceal their fraudulent activities from Medicare and from law enforcement." *See* Exhibit 9, attached.

13. The range of perpetrators participating in Medicare fraud is often surprising. In 1999, Florida State Senator Alberto Gutman, the chair of the Florida Senate Health Care Committee, resigned and pleaded guilty to using voter lists from his district to concoct a fraudulent Medicare scheme that netted nearly $2 million. And in 1993, Blue Cross/Blue Shield of Florida, a nominal party in this case because it is Medicare's fiscal intermediary in Florida, paid $10 million to settle allegations that it paid claims without performing required audits in order to report reductions in its claims backlog. *See* Exhibit 10, attached.

14. The Office of Inspector General at the Department of Health and Human Services (OIG), which is the primary agency responsible for overseeing the integrity of the Medicare program, has produced an extraordinary series of reports on Medicare and Medicaid fraud beginning in 2000. While the databases at issue in this case do not identify patients and Dow Jones does not seek any information that would identify patients, OIG was able to review patient information and found that several different categories of patients, none of whom should be getting treatment under these programs, have been showing up in significant numbers within paid Medicare claims.

15. The most obvious embarrassment involves treatments apparently rendered to patients who were already dead on the purported date of treatment. In March 2000, OIG

identified $20.6 million in such claims paid in 1997. *See* Exhibit 11, attached. For a small minority of these claims, there was a plausible "administrative error" story, but a significant volume of the claims showed *new* treatments beginning for a patient, more than a month after they had died. In March 2002, OIG reported finding deported Medicare beneficiaries for whom fee-for-service claims had been received and paid after the recorded date of deportation. *See* Exhibit 12, attached. Similarly, patients who are incarcerated generally ought not to show up in Medicare paid claims, as the majority of health care for prisoners is provided through prison systems, not through the Medicare program. There are a few specific exceptions to this general rule, relating to hospital and other treatments delivered outside the prisons. The OIG has uncovered millions in Medicare payments apparently made for patients in prison. *See* Exhibit 13, attached.

16. In July 2008, another category of obviously implausible claims came to light. The Senate Permanent Subcommittee on Investigations revealed the presence of dead *doctors* (as prescribing or referring physicians) within Medicare's paid claims. The Subcommittee's investigation revealed that, from 2000 to 2007, between $60 million and $92 million was paid for medical services or equipment that had been ordered or prescribed by dead doctors. In many cases, the doctors had been dead for more than 10 years on the date they supposedly ordered or authorized treatments. *See* Exhibit 14, attached.

17. The Fee-For-Service component of the Medicare program has always been vulnerable to fraud, but recent years have seen qualitative changes in the scope and organized nature of many fraud scams. In the last year alone, multiple fake-billing scams exceeding $100 million in volume have been uncovered within the Medicare program. At the same time, few attempts have been made to generate any reliable estimates of fraud-loss rates. The best known

approximations, perhaps, have been OIG's "Medicare Overpayment Rate" studies. The first of these OIG studies, reported in 1997, showed an overpayment rate of 14%, equivalent to $23 billion in annual losses from the Medicare program. The measured overpayment rates came down in subsequent years, reaching 6.3% in 2002.

18. But these statistics fail to accurately capture fraud rates in the Medicare system. Early in 2000, the General Accounting Office (GAO) examined the methodology the OIG had been using to estimate Medicare overpayment rates. The GAO reported that it "did not take into consideration numerous kinds of outright fraud such as 'phony records' or kickback schemes" because it "assumes that all medical records received for review represent actual services provided." *See* Exhibit 15, attached. More rigorous "fraud audit" protocols are available, which include direct contact with patients and on-site audits, but OIG did not use them. Thus, the overpayments detected by such studies would not have included the majority of fraud losses.

19. Responsibility for measuring "Improper Payment" rates was passed to the Center for Medicare and Medicaid Services (CMS) in 2002. Currently, CMS estimates the "Improper Payment Rate" for the Medicare program to be 8.6% (for 2011). *See* Exhibit 16, attached. However, CMS has perpetuated the use of weak audit protocols similar to those previously used by the OIG. Therefore, the majority of fraud losses would be *in addition* to the errors and overpayments captured in its studies. In August, 2008, OIG reported that some additional audit steps such as interviewing patients and providers face-to-face revealed an *additional 11%* of claims that contained errors. *See* Exhibit 17, attached. Such findings suggest that the actual overall level of financial losses due to fraud, waste and abuse likely is substantially higher than the currently reported rate of 8.6%.

C. Medicare's highly automated claims-processing systems enables fraud on a scale unfathomable 33 years ago

20. In 1979, Medicare was just fourteen years old. It cost $26.5 billion – 5.26% of total federal outlays in 1979. The program has mushroomed in the last three decades to an estimated 2013 cost of over $530 billion, nearly 14% of 2013 estimated outlays. *See* Exhibit 18, attached. In the fee-for-service parts of the program alone, Medicare now pays more than $1 billion on 4.5 million claims *every single work day*, and it is legally obligated to pay claims within 30 days of receipt.

21. During this same time period, the fraud problem has escalated rapidly. One key reason is the way claims are processed. In 1979, claims were submitted on paper and reviewed and paid by claims processing clerks. Now, the bulk of Medicare claims are submitted electronically and processed automatically by computerized, rule-based systems. If the claims satisfy the criteria built into the system, then automatic payment follows, generally without any human involvement. As OIG Chief Counsel Lewis Morris told a Senate subcommittee in July 2011, "electronic health records (EHR) may not only facilitate more accurate billing and increased quality of care, but also fraudulent billing. The very aspects of EHRs that make a physician's job easier – cut-and-paste features and templates – can also be used to fabricate information that results in improper payments and leaves inaccurate, and therefore potentially dangerous, information in the patient record." *See* Exhibit 19, attached.

22. Medicare's modern automated claims-payment systems, by design, are utterly predictable and transparent. If a claim for payment is denied, helpful computer-generated explanatory notices explain the reasons for the denial so that the claim submitter can get it right next time. Everything is geared toward the honest physician, possibly error prone, but basically well intentioned. The result, from the perspective of fraud perpetrators, is a target that exhibits

all of their favorite qualities: it pays fast, because it is required to do so by law. It is also perfectly predictable (so if it pays one claim without a hiccup, then it will reliably pay 10,000 similar claims for other patients exactly the same way, without any human intervention). If all the claims submitted are fashioned to reflect medical orthodoxy (even if they are all *false*), then there is very little risk of encountering a human being at all, let alone a criminal investigator.

23. And fraud happens fast. One OIG investigator told the *Miami Herald* that, by the mid-90s, "a series of health care providers [came] into existence solely on paper. A company is incorporated using a fictitious name. The company submits a series of claims, usually between $200,000 and $1 million. By the time [HHS] becomes aware of the scam, the company and John Doe have vanished." *See* Exhibit 20, attached.

24. Similarly, the machinery trusted by Medicare to control fraud is profoundly inadequate for the task. Claims-processing systems incorporate extensive suites of rule-based checks (edits and audits) to make sure services have been billed correctly and fall within the bounds of medical orthodoxy and coverage; but these systems do nothing to verify the *truthfulness* of either the diagnosis, the accompanying medical evidence, or the procedures claimed. What this set of functions manages to accomplish, given typical resource levels and configurations, is to provide relatively good protection against anomalous medical practices and against patterns of administrative error. But these are not *fraud* controls. They were not designed to control criminal conduct, and they are generally ineffective in doing so.

25. In my opinion, this is an area where public access to claims data would help a great deal. While Medicare's resources for analysis remain very limited when compared to the scale of the program, and somewhat predictable in nature, the press and the public are not so constrained. If the *Wall Street Journal* decides to look at a particular segment or receives and

explores information about a particular provider, it will tend quite naturally to utilize a different set of methods and might more readily devote considerable attention to non-traditional areas of inquiry. Involving non-governmental institutions in fraud control has other advantages too. Many sources who may come to a reporter or other independent watchdog, would not – for a wide variety of reasons – want to speak to law enforcement.

D. As Medicare claims have exploded over the past 33 years, resources for investigation and enforcement have failed to keep pace

26. The resources available for fraud detection and control in modern Medicare are not only inadequate, they are of the wrong scale. The credit card industry has established benchmarks for "acceptable business risk" with respect to fraud losses. Their threshold for "confirmed fraud losses" is typically one-tenth of one percent. By contrast, estimates of fraud losses in Medicare range from 3% to 10% to 14%, depending on the source. If the real loss rate were 10%, it would be one hundred times the acceptable business risk threshold set by the credit card industry.

27. Meanwhile, spending on program integrity functions tends to run at roughly 0.2% of overall Medicare payouts. These investments in control, while minimal, pay off handsomely. From year to year, OIG reports that their return ratios (dollars saved per dollar spent) are in the region of 17 to 1, sometimes higher. One interpretation is that these handsome returns reveal a highly efficient operation. But this also shows the levels of investments in control are nowhere near an optimal level, which should be closer to 1 to 1. Returns of the order of 20 to1 indicate a reservoir of fraud available, largely untapped, and a control operation that appears to be skimming off the easier and more obvious cases. By focusing on the fraud and abuse problem more intensively, the government might be able to save 10% or even 20% from the Medicare budgets. But to do that, one would have to spend 2% or maybe 3% (as opposed to the prevailing

0.2%) in order to check that the remaining 97% or 98% of the funds were well spent. But this would be a massive departure from the status quo.

28. In March 2011, OIG published a study of CMS's processing of complaints received through the 1-800-HHS-TIPS hotline. It found that "[l]ong timeframes and inefficient processes delay starting work on complaints." Investigation on 29% of complaints had not even *begun* 4 months after the call, including "complaints that contractors were unaware had been assigned to them (22 percent of all complaints)." Delays like this are all a fraudster needs to run a massive "hit and run" scam. The study is attached as Exhibit 21.

29. This is not to say that the government does not attempt to deal with the onslaught of fraud in its vital health care programs. Two Clinton-era laws were instrumental in beefing up Medicare's anti-fraud capabilities. First, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 increased funding for enforcement, created several new crimes related to health care and required HHS to exclude providers with felony fraud convictions from Medicare. Second, the Balanced Budget Act of 1997 authorized the Health Care Finance Administration to require certain providers to post $50,000 surety bonds before receiving certification for Medicare.

30. More recently, the Affordable Care Act (ACA) provided $350 million in new program integrity resources for anti-fraud efforts. This funding supports new Medicare Strike Forces, currently active in nine cities, which investigate and track down individuals and entities defrauding Medicare and other government health care programs. The ACA also required CMS to permit select organizations to access – and make public – claims data on individual physicians. Both these developments underscore the value of scrutiny through enhanced data

access and analysis to uncover waste, fraud and abuse, whether that scrutiny is carried out by federal prosecutors, a qualified non-profit research group, or a team of investigative reporters.

31. Each of these recent legislative and policy enhancements will help to some degree, just as Clinton-era fixes helped to some degree. But they are not sufficient to solve the problem, or to alter the reality that the Medicare program remains overwhelmed by fraud. It takes committed fraud perpetrators, at most, a few weeks to fathom the nature of new controls, and to redesign their scams accordingly. It takes, at most, a few months for these newly adapted fraud methods to spread across the country. But it can take authorities *years* to make the legislative, policy, or system changes necessary to catch specific fraud threats or for law enforcement to build their cases. Even with the advent of the additional Health Care Fraud Prevention and Enforcement Action Team (HEAT) forces, the investigative resources available are nowhere near sufficient to deal even with the volumes of scams that do surface.

32. These structural challenges to effective fraud control for the Medicare program help explain why enhanced public oversight of Medicare claims represents pure value added. Unlike new *government* investigators, investigations like the series in the *Journal* cost the government nothing. Fraudsters are caught, potential fraudsters are deterred, and public money is conserved, all at little or no cost to the taxpayer. Equally important, the public and press can see and assess how Medicare allocates its resources and how effectively it polices waste, fraud, and abuse.

E. If the injunction's cloak of secrecy is lifted, the granular, real-time claims data now collected could facilitate efforts to combat fraud

33. Modern electronic billing enables fraud on a scale much larger than paper billing. But it has some potential benefits, also, for fraud detection. Billing data is easier (in electronic form) to aggregate, transmit, and analyze. It is, therefore, technically feasible to allow "more

eyes" on the problem than would ever have been possible in the era of manual claims processing. Technology therefore provides some new opportunities for fraud controllers, as well as for fraud perpetrators. Permitting, supporting, and facilitating broader data access, and thereby mobilizing a wider variety of claims analyses is one such important opportunity.

34. Restricting data production to groups of 11 or more individuals, as CMS sometimes does under its cell size suppression policy, constitutes a regrettable constraint. First, with electronic claims processing, one person acting alone can now defraud Medicare out of millions. My book *License to Steal* quotes the director of monitoring and analysis at one of the four Durable Medical Equipment (DME) regional processing sites for Medicare: "If I wanted to do fraud I'd … get a [supplier] number, pay a $75 fee, set up in some office across the street and start billing. I'd bill $5 million in thirty days and walk away." *See* Exhibit 22, attached. Second, individual scams may be less apparent or visible in a neighborhood than clinics, as individual scam artists may work out of their homes rather than setting up sham medical offices. Third, it is important to have individualized information even when evaluating larger groups, because aggregating claims data across several individuals may obscure patterns (such as performing an improbable number of procedures in a single day) that are indicative of fraud. Fourth, it is important to be able to pin criminal responsibility for fraudulent actions on specific individuals – particularly because of the potency of the resulting deterrent effects – rather than allowing fraudsters to hide their behavior under the cloak of some broader "corporate policy."

35. Dow Jones has made the value of claims data access clear, in that it used a small slice of Medicare data to uncover suspicious billing practices. Indictments, license suspensions, and Congressional action soon followed. Its *Secrets of the System* series used Medicare claims data to expose anomalous billing activity by Medicare providers, some of whom were later

indicted, suspended, or had their licenses revoked. More broadly, the series also raised questions as to whether the government is effectively mining the data at its disposal to prevent improper Medicare billing, and whether regulatory loopholes and other economic incentives encourage some doctors to disregard their patient's best interests and instead pursue unnecessary or high-cost procedures. *See* Exhibit 23, attached.

36. Other journalism organizations likewise have used payment data to uncover waste, fraud, and abuse. For example, PBS NewsHour and the Center for Investigative Reporting analyzed Medicare data and uncovered a pattern of suspicious diagnoses suggesting that California-based Prime Healthcare Services "encouraged [its] physicians to stop documenting syncope, which is fainting or dizzy spell, and instead use the term autonomic nerve dysfunction, which reimburses at a higher rate." They reported that "Medicare data for 2010 shows that, out of 468 cases of autonomic nerve disorder, 360 were reported by Prime hospitals, 90 times more often than the average California hospital." *See* Exhibit 24, attached.

37. Whistleblowers likewise have frequently used data and data analyses in qui tam cases. In January 2011, OIG reported in a letter to Sen. Charles E. Grassley that, as of January 4, 2011, there were 1,341 qui tam cases under investigation. Of these cases, 867 (65%) involve Medicare or Medicaid. *See* Exhibit 25, attached. In 2003, Tenet HealthCare paid $4.3 million to settle allegations that five of its Florida hospitals submitted fraudulent claims to Medicare by "upcoding" pneumonia diagnosis codes and that two of the facilities "upcoded" septicemia diagnosis codes for in-patient claims submitted for reimbursement. Three of the hospitals were named defendants in a False Claims Act suit filed by Health Outcomes Technologies, Inc., which analyzed publicly available Medicare claims data. *See* Exhibit 26, attached.

38. The value of the data is also evident within Medicare itself. Perhaps the single most effective innovation in Medicare fraud control in recent years has been the establishment of the joint OIG-DOJ Strike Forces. These are interagency initiatives to investigate and track down individuals and entities defrauding Medicare and other government health care programs. HHS reported in September 2011 that, since their inception in March 2007, Strike Force operations in nine locations have charged more than 1,140 defendants who collectively have falsely billed the Medicare program for more than $2.9 billion. *See* Exhibit 27, attached.

39. One key reason for the effectiveness of the Strike Forces, in the few cities where they exist, has been that they are "data driven." They use basically the same methods Dow Jones used – but with access to entire data sets rather than 5% samples – to look for subtle indications of fraud. As OIG Chief Counsel Lewis Morris told a Senate subcommittee in July 2011, "sophisticated data analysis, combined with field intelligence and traditional law enforcement techniques, have enabled us to more quickly identify fraud schemes and trends. The data-driven approach of the Strike Forces pinpoints fraud hot spots through the identification of suspicious billing patterns and targets criminal behavior as it occurs." *See* Exhibit 28, attached.

40. Just weeks ago, for example, a Texas physician and six others were arrested on charges related to a scheme that allegedly resulted in more than $350 million being fraudulently billed to Medicare for home health services. The operation, which Assistant Attorney General Lanny Breuer called "the largest alleged home health fraud scheme ever committed," was uncovered "[u]sing sophisticated data analysis [to] target suspicious billing spikes." DOJ analysists "discovered that in 2010, while 99 percent of physicians who certified patients for home health signed off on 104 or fewer people – Dr. Roy certified more than 5,000." *See* Exhibit 29, attached.

41. By contrast, restrictions on Medicare claims data – including this Court's injunction – hamper Medicare's effort to reduce fraud. In November, 2011, the OIG released a report finding that Medicare contractors, paid tens of millions to detect fraudulent claims, used inaccurate and inconsistent data that make it difficult to detect fraud. The report, attached as Exhibit 30, found that one program integrity contractor, surprisingly, referred only two cases of potential fraud to CMS between 2005 and 2008, and another did not refer any. Contractors told OIG that even *they* had difficulty obtaining data they needed, though access to real-time Medicare claims data is *critical* to controlling fraud. One told OIG it had to buy the data from another contractor, causing a month's delay.

42. In my view, effective public oversight of the Medicare program would be greatly enhanced by permitting broader access to the claims data itself. Anything less simply means that the press and the public are taking the government at its word when it says it is making progress in the war on Medicare fraud. When organizations like Dow Jones are permitted to analyze claims data, there are two benefits. First, they can supplement the fraud detection efforts of CMS, DOJ, and related agencies. This is a huge job, ever evolving as increasingly sophisticated individuals and groups find new ways to game the system, and the government suffers grossly inadequate levels of resources for fraud detection and investigation. Second, it allows the press and the public to monitor the government's control efforts, and point out those areas where they are obviously not working.

F. The value of public oversight of public spending has become conventional wisdom in a variety of government programs

43. Outside Medicare, the U.S. government has come to embrace the value of "crowdsourcing" accountability by making payment data public. For example, the "present and past annual salary rates (including performance awards or bonuses, incentive awards, merit pay

amount, Meritorious or Distinguished Executive Ranks, and allowances and differentials)" of nearly all federal employees (excluding certain national security personnel) are publicly available on the Internet. *See* 5 CFR. § 293.311. And the Federal Funding Accountability and Transparency Act (FFATA) of 2006 requires the Office of Management and Budget (OMB) to establish a single searchable website which includes for each Federal award: the name of the entity receiving the award; the amount of the award; information on the award including transaction type, funding agency, etc.; the location of the entity receiving the award; and a unique identifier of the entity receiving the award. USAspending.gov was launched in December 2007 to fulfill these requirements. Currently, Medicare providers are left out of such transparency provisions. Senators Charles Grassley and Ron Wyden have introduced the Medicare Data Access for Transparency and Accountability Act (S.756), a bill that would require that Medicare claims data be posted on USAspending.gov. *See* Exhibit 31, attached.

44. I have experienced this first-hand through my work on the Recovery Independent Advisory Panel. The American Recovery and Reinvestment Act of 2009 required the creation of a website "to foster greater accountability and transparency in the use of funds made available in this Act." The site, recovery.gov, displays for the American public the distribution of all stimulus funds by federal agencies and how the recipients are spending those funds. Some government officials have described this effect as akin to creating "a million Inspectors General" to monitor government spending. The site, recovery.gov, identifies recipients of contracts, grants and loans, and displays periodic and cumulative summaries of payments made to them. Recovery.gov, along with an increasing number of other Government websites, prominently features an invitation and readily accessible mechanism for any member of the public to report

their own suspicions of fraud, waste or abuse. Similarly, such sites provide recipients an opportunity to correct details that they believe to be incorrect.

G. Public disclosure of the data will enhance salutary deterrence, detect wasteful treatments and private insurance fraud, and allow the public to make informed decisions

45. I believe public disclosure of claims data would have salutary effects beyond enabling the capture of Medicare fraudsters after the fact.

46. First, crowdsourced accountability will doubtless help to deter fraud. With their claims kept secret, fraudsters know that their risk of detection stems from only the limited and overstretched capacity of government auditors and investigators. If the data were public, fraudsters would face the added deterrent of knowing that their billings were publicly available, and it would be much harder for them to predict the types or level of scrutiny that might be applied. Given the low recovery rate of fraudulently reimbursed funds, deterrence is preferable to catching perpetrators after the fact. Second, aside from fraud and abuse, the data is invaluable to those who investigate waste more generally. Dr. Donald M. Berwick, who led CMS until recently, told the *New York Times* in a December 3, 2011 article that 20 to 30 percent of health spending is "waste" that yields no benefit to patients. He listed five reasons for what he described as the "extremely high level of waste." They are: overtreatment of patients, the failure to coordinate care, the administrative complexity of the health care system, burdensome rules, and fraud. *See* Exhibit 32, attached.

47. Like fraud, waste thrives in the dark. Organizations – from newspapers to non-profit organizations to companies like Real Time Medical Data, LLC that assist healthcare clients in allocating resources efficiently – need the type of data at issue in this case to do their jobs. Congress acknowledged this when it recently made this very same data available to certain qualified entities, which are explicitly authorized to publish details on named providers. 42 CFR

§ 401.701 et seq. The *New York Times* on June 17, 2011 reported that it analyzed Medicare outpatient claims from 2008 and found that "hundreds of hospitals across the country needlessly exposed patients to radiation by scanning their chests twice on the same day." The *Times* reported that "[p]erforming two scans in succession is rarely necessary, radiologists say, yet some hospitals were doing that more than 80 percent of the time for their Medicare chest patients." *See* Exhibit 33, attached.

48. Third, this information is also useful in reducing fraud, waste, and abuse in the private health insurance market. As OIG Chief Counsel Lewis Morris told a Senate subcommittee in July 2011, "[i]t is axiomatic that most of the criminals who prey on the Nation's health care system are equal opportunity thieves – they defraud private health care insurance as well as the Federal health care programs." *See* Exhibit 19, attached. Thus, the data is useful for uncovering scams, tracking where in the nation particular scams are concentrated, establishing broader baselines against which an insurer's own data can be measured, and so forth. To pick just one example, Medicare is often a partial payer on particular claims, splitting the cost of a claim with a private co-insurer. While working as a fraud consultant to a private insurer, I showed that some providers double-bill Medicare and private insurers for procedures (particularly for treatments where there is some ambiguity about which insurer is "primary"), with the net effect that these providers receive, in total, more than 100% of the price of the services they provided. But private insurers, like the press, find it very difficult to obtain Medicare claims data in anything approaching a timely manner. This means that they are effectively prohibited from determining whether a provider is fraudulently double-billing.

49. Finally, and perhaps most important, public access to the data enables news organizations, researchers, and others to educate the public on the scope of waste, fraud and

abuse, and the frequent failure of government to effectively police Medicare. It lets the public know what the government is doing and what it is failing to do. And it better informs public debate about the allocation of government resources and the operation of vital public programs.

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

Executed on Friday, March 16th, 2012.

Malcolm K. Sparrow

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,

Plaintiffs,

v. Case No. 3:78-cv-00178-MMH-MCR

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,

Defendants,

DOW JONES & COMPANY, INC., *et al.*,

Intervenors.
_____/

DOW JONES & COMPANY, INC.'S REPLY IN SUPPORT OF MOTION TO VACATE PERMANENT INJUNCTION

Dow Jones & Company, Inc. ("Dow Jones") hereby replies to the Opposition ("Opp.") of Plaintiffs American Medical Association ("AMA") and Florida Medical Association ("FMA") (collectively, "Plaintiffs") and to the Response of Defendants Department of Health and Human Services and Kathleen Sebelius in Partial Support ("HHS Resp."), which both address the Motions to Vacate the 1979 Final Declaratory Judgment and Permanent Injunction in this case.[1]

[1] *FMA v. HEW*, 479 F. Supp. 1291 (M.D. Fla. 1979) ("1979 Injunction"). Though the parties refer to this as the "1979 *Injunction*," the Intervenors seek to vacate both the permanent injunction entered in 1979 and the declaratory judgment, on which the injunction rests. *See, e.g.*, Dow Jones Mot. 5 (seeking "order vacating the Final Declaratory Judgment and Permanent Injunction entered in . . . 1979"); *id*. 30. Indeed, the declaratory judgment and the injunction are inextricably intertwined, and vacation of both is required to secure effective relief. *See, e.g., Fla. ex rel. Bondi v. HHS*, 780 F. Supp. 2d 1256, 1305 (N.D. Fla. 2011) (declaratory judgment is functional equivalent of injunction given presumption Executive

A compelling case for vacating the 1979 Injunction has been made by Intervenors based on changes of fact and law, but the HHS response is nothing short of a game-changer – HHS, after 30 years, now joins the Intervenors in asking this Court to "lift" the 1979 Injunction. HHS leaves no doubt that the statutory and jurisprudential bases for the 1979 Injunction, such as they were, have completely eroded over the ensuing decades as this Circuit and others have ruled there is no statutory authorization for such an injunction, making "continued enforcement of the injunction improper." HHS Resp. 1. This plainly constitutes a "change[] in the governing laws or [their] interpretation" that "renders continued enforcement . . . detrimental to the public interest."[2]

In their Opposition, Plaintiffs acknowledge fundamental changes in the methodology for determining reimbursement amounts paid to physicians, the means of reimbursing physicians, and the degree of public disclosure of physician-identifying and other taxpayer subsidized information now mandated by law. They do not dispute that the size of Medicare and, with it, the fraud and abuse, have grown exponentially, government's ability to police the program is concomitantly outmatched, and Medicare electronic data is an invaluable tool to both detect fraud and monitor the government's efforts in that regard. They do not dispute the substantial evidence of fraud that Dow Jones has been able to marshal, even with the

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Branch officials will adhere to law as declared by court) (citing *Sanchez-Espinoza v. Reagan*, 770 F.2d 202, 208 n. 8 (D.C. Cir. 1985) (citing *Samuels v. Mackell*, 401 U.S. 66, 73 (1971))), *clarified*, 780 F. Supp. 2d 1307 (N.D. Fla. 2011), *aff'd in part, rev'd in part on other grounds*, 648 F.3d 1235 (11th Cir.), *cert. granted*, 132 S. Ct. 604 (2011). *See also Cal. v. Grace Brethren Church*, 457 U.S. 393, 408-09 (1982) (noting there is "little practical difference between injunctive and declaratory relief").

[2] Dow Jones Mot. 1-2, 18 (citing *Horne v. Flores*, 129 S. Ct. 2579, 2593, 2596-97 (2009)). *Accord* HHS Resp. 11-12; *see also id*. 17. *Cf., id*. 18 ("[C]hanges in the law and the facts can justify an agency change in position.").

limitations imposed by the 1979 Injunction. But they insist nonetheless that the more things change, the more things must stay the same, literally frozen in 1979. These changes have, however, fundamentally altered the calculus so that the privacy interests of physicians no longer clearly outweigh the compelling public interest in monitoring a program that now consumes one out of every eight federal dollars. As such, these "changes in the nature of the underlying problem . . . warrant re-examination of the original judgment" and "render[] continued enforcement detrimental to the public interest." *Horne*, 129 S. Ct. at 2593, 2596-97.

I. SINCE 1979, THE ELEVENTH CIRCUIT HAS RULED THAT THERE IS NO STATUTORY BASIS FOR THE 1979 INJUNCTION

Plaintiffs concede that "[t]his Court's permanent injunction was grounded in the Privacy Act and FOIA Exemption 6." Opp. 8 (citations omitted). As HHS detailed, however, it has become clear since 1979 that the remedies authorized under the Privacy Act, Freedom of Information Act ("FOIA"), and Administrative Procedure Act ("APA") – the only statutory grounds on which the 1979 Injunction issued or could have rested[3] – do not allow the far-ranging relief Plaintiffs were granted. With the 1979 Injunction, Plaintiffs sought and obtained broad relief prohibiting HEW from disclosing not only the 1977 Medicare data it planned to make public, but also *any* Medicare reimbursements that individually identify service providers. *FMA v. HEW*, 479 F. Supp. at 1297, 1311. As interpreted by the Eleventh Circuit, "the *FMA* injunction is broad," as it "enjoins disclosure of 'any list' of annual Medicare reimbursement amounts."[4] Judge Scott apparently presumed that the

[3] *See*, respectively, 5 U.S.C. § 552a, § 552, and § 501 *et seq.* & Ch. 7.

[4] *Alley v. HHS*, 590 F.3d 1195, 1207 (11th Cir. 2009); *see also id*. at 1209 ("*FMA* injunction simply is not limited to reimbursement amounts under the old payment system" but "plainly bars disclosure of 'Medicare reimbursement amounts' without any qualification").

Privacy Act allowed such injunctive relief, perhaps because a consensus had yet to emerge that the Privacy Act provided for injunctive relief in only two narrow circumstances, neither of which are present in this case.[5] But it is now settled law that the Privacy Act authorizes injunctive relief *only* to compel amendment of an individual's records held by an agency, or to order production of the records to that individual – and *not* the kind of sweeping prohibition the1979 Injunction embodies (or any similar relief).[6] Nor can FOIA serve as the vehicle for the injunctive relief Plaintiffs obtained. *See* HHS Resp. 13 (citing *FMA v. HEW*, 479 F. Supp. at 1301). Simply put, "FOIA is a disclosure [law] and does not provide a right of action to *enjoin* disclosure." *Brancheau v. Sec'y of Labor*, 2012 WL 140239, *2 (M.D. Fla. 2012) (citing *Chrysler v. Brown*, 441 U.S. 281, 285, 290-94 (1979)) (appeal pending).

As HHS rightly states, the proper vehicle for enjoining an agency from releasing records is judicial review under the APA. HHS Resp. 14-15 (citing, *inter alia*, *Chrysler*); *see also*, *e.g.*, *Canal Refining Co. v. Corrallo*, 616 F. Supp. 1035, 1037 (D.D.C. 1985). But the APA typically limits the scope of review and sweep of relief available.[7] In such "reverse

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[5] *Cell Assocs. v. Nat'l Insts. of Health*, 579 F.2d 1155, 1161-62 (9th Cir. 1978), was the first case to reach this conclusion, slightly predating the 1979 Injunction, though outside this Circuit. *See infra* note 6.

[6] HHS Resp. 13-14 (citing *Edison v. Dep't of the Army*, 672 F.2d 840, 846 (11th Cir. 1982)); *FAA v. Cooper*, 132 S. Ct. 1441, 1459 n.4 (2012) (Sotomayor, J. dissenting)). *See also*, *e.g.*, *Clarkson v. IRS*, 678 F.2d 1368, 1375 n.11 (11th Cir. 1982); *Doe v. Chao*, 540 U.S. 614, 619 n.1 (2004); *id*. at 635 (Ginsburg, J., dissenting); *Doe v. Chao*, 435 F.3d 492, 505 (4th Cir. 2006); *Haase v. Sessions*, 893 F.2d 370, 374 (D.C. Cir. 1990); *Hanley v. DOJ*, 623 F.2d 1138, 1139 (6th Cir. 1980); *Parks v. IRS*, 618 F.2d 677, 683-84 (10th Cir. 1980); *Kursar v. TSA*, 751 F. Supp. 2d 154, 162 n.5 (D.D.C. 2010).

[7] *See* HHS Resp. 15-16. Significantly, the Privacy Act, FOIA, and APA provide only limited waivers of sovereign immunity. *See*, *e.g.*, *Griffin v. U.S. Parole Comm'n*, 47 F. Supp. 2d 12, 16 (D.D.C. 1999); *Clarkson v. IRS*, 678 F.2d 1368, 1370-71 (11th Cir. 1982); *Geronimo v. Obama*, 725 F. Supp. 2d 182, 186 n.3 (D.D.C. 2010).

FOIA" cases, the APA allows enjoining release of only those records an agency has stated it will release or plans to release. *E.g.*, *Doe v. Veneman*, 380 F.3d 807, 819 (5th Cir. 2004). Hence, a "plaintiff seeking to prevent disclosure under FOIA *has no remedy until* the agency determines [] it will release . . . information." *Brancheau*, 2012 WL 140239, *2 (citing *Veneman*, 380 F.3d at 814) (emphasis added).

The current data is wholly different in scale, in form and in substance. The records now are many terabytes of electronic data, containing payment information calculated based on published rates for billings submitted and paid electronically, offering a degree of accuracy and granularity wholly absent from the 1977 tally of annual reimbursements that were the subject of the 1979 Injunction.[8] Thus, while the APA may permit an injunction reaching agency records and factual circumstances that are actually before a court, it could not have supported relief that reaches as far as the 1979 *FMA* Injunction. *See, e.g.*, *Gulf Oil v. Brock*, 778 F.2d at 842-43. And it certainly cannot control here, where thirty years have passed, the nature of records differs from those in the case(s) that came before, the agency's thinking has evolved, *see* HHS Resp. 17-18, and the FOIA Exemption 6 and Privacy Act calculus has shifted. *See* Dow Jones Mot. 20-30; *see also infra* § II.

HHS is thus correct that "there is no longer any statutory basis for" the 1979 Injunction. HHS Resp. 16. That reality alone is grounds for vacating the 1979 Injunction. *Cf.*, HHS Resp. 12 ("A change 'in either statutory or decisional law' can justify Rule 60(b)(5)

[8] Even if substantially equivalent data sets may warrant like treatment under the APA, this would apply only if the new records are derivatives, summaries, or similar "repurposing" of the original records, not to records that are simply of like nature. *See Doe v. FBI*, 936 F.2d 1346, 1356 (D.C. Cir. 1991) (discussing *FBI v. Abramson*, 456 U.S. 615, 625 (1982)). *Cf.*, *Gulf Oil Corp. v. Brock*, 778 F.2d 834 (D.C. Cir. 1985).

relief.") (quoting *Agostini v. Felton*, 521 U.S. 203, 215 (1997)). As an alternative, it qualifies as "any other reason that justifies relief" pursuant to Rule 60(b)(6). Even if there were not a change in the law, "a mistake in the application of the law," particularly when accompanied, as here, by other changes, can be remedied under Rule 60b(6). *Ritter v. Smith*, 811 F.2d 1398, 1401 (11th Cir. 1987).

II. PLAINTIFFS HAVE NOT REFUTED THAT THE PUBIC INTEREST IN MONITORING THE MEDICARE PROGRAM OUTWEIGHS ANY PRIVACY INTEREST OF PROVIDERS RECEIVING TAXPAYER DOLLARS

Plaintiffs concede, as they must, that the 1979 Injunction must be vacated under Rule 60(b)(5) if circumstances have so changed as to make applying it no longer equitable.[9] And they concede that the Court must examine changes of law and/or fact that bear on whether disclosure of records at issue would be a "clearly unwarranted invasion of personal privacy" under FOIA Exemption 6, 5 U.S.C. § 552(b)(6), and the Privacy Act.[10] Yet, in the face of substantial evidence showing that controlling law now counsels in favor of disclosure, that

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[9] *See* Opp. 6. *Accord* Dow Jones Mot. 18; HHS Resp. 11-12 (citing *Horne v. Flores*, 129 S. Ct. at 2596-97; *Agostini*, 521 U.S. at 215); *see also supra* note 2. Plaintiffs' quibbles regarding the standard of review lack merit. Opp. 7-8. That *Horne* was an institutional reform case, where 60(b) relief may be "more often appropriate than in other cases," *id*. 8, is irrelevant. The same standard applies outside the institutional reform context. *See, e.g., City of Duluth v. Fond du Lac Band of Lake Superior Chippewa*, 2011 WL 5854639, *5-6 (D. Minn. 2011); *Alliance for Wild Rockies v. Bradford*, 2012 WL 1119745, *3 (D. Mont. 2012). By contrast, the stricter standard Plaintiffs advocate, Opp. 7 (citing *United States v. Swift & Co.*, 286 U.S. 106 (1932)), predates the Federal Rules of Civil Procedure, which adopted a more flexible approach. *E.g., Fond du Lac Band of Chippewa*, 2011 WL 5854639, *6 (citing *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 380 (1992) (construing *Swift*)). In any event, the standard as stated by Dow Jones tracks the language of the rule itself, and this Court has already indicated *Horne* provides the applicable standard. *See FMA v. HEW*, 2011 WL 4459387, *15 n.17 (M.D. Fla. 2011).

[10] *See* Opp. 2 (citing, *inter alia*, *Consumers' Checkbook v. HHS*, 554 F.3d 1046 (D.C. Cir. 2009)). *Accord* HHS Resp. 18-19; Dow Jones Mot. 2, 6, 20, 27.

any privacy interests which may have supported the injunction in 1979 have diminished with changes in law and policy, and that the magnitude of public interest in physician-identifying Medicare reimbursement data has grown, Plaintiffs bafflingly claim that the *only* relevant change since 1979 is the D.C. Circuit's *Consumers' Checkbook* decision, 554 F.3d 1046. *See* Opp. 2, 9-11. As *Checkbook* declined to release Medicare data in 2009, Plaintiffs claim, three decades of evolved fact and law must be irrelevant and only *Checkbook*, a decision that turned on a materially different request and a materially different record, is controlling.

A. Plaintiffs have not shown why the Court should disregard the law of the Circuit as expressed in *News-Press*

Dow Jones detailed why the 1979 Injunction is "no longer equitable" in light of case law developed since 1979. Fed. R. Civ. P. 60(b)(5). Perhaps most important, this Circuit has clarified that those who receive public money cannot expect to keep those government payments secret in light of the "enormous" public interest in knowing whether an agency "is a good steward of (sometimes several billions of) taxpayer dollars." Dow Jones Mot. 21-22 (quoting *News-Press v. DHS*, 489 F.3d 1173, 1192, 1202, 1206 (11th Cir. 2007)).

In response, Plaintiffs claim that there must be no such change because *Consumers' Checkbook* did not order release of Medicare data.[11] Plaintiffs argue *Consumers' Checkbook* "rejected some of the precise arguments made . . . in this case," including those involving the "public interest in disclosure [that lies] in avoiding [Medicare] fraud and abuse." Opp. 9-10. If this *argument* was rejected, however, it was certainly not on its merits. Medicare waste,

[11] *Consumers' Checkbook* pre-dates the Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA"), and HHS rules effectuating its data-access provisions, 42 C.F.R. § 401.701 *et seq.*, all of which factor into balancing the privacy and public interests in physician-identified Medicare reimbursement data. Dow Jones Mot. 15, 24-25; *see also infra*, Section II.B.

fraud, and abuse – the key to *this* case, and the subject of both extensive expert testimony and reporting in *The Wall Street Journal* – was, at most, an afterthought in *Consumers' Checkbook*. The public interests asserted by Checkbook in the district court were assessing quality of care and the experience level of Medicare providers: (1) whether Medicare accepts and pays physicians with insufficient experience to perform difficult procedures; (2) whether it allows under-qualified doctors to tackle high volumes of difficult procedures; and (3) whether Medicare physicians' practices conform to extant guidelines. 502 F. Supp. 2d 79, 84 (D.D.C. 2007). The appellate court concluded that this information did not serve to allow "the public to determine what HHS [is] 'up to,'" Opp. 10 (citing 554 F.3d at 1059), but rather speaks only to the efficacy of physician conduct.

Conspicuously absent from the district court's recitation of public interests asserted by Checkbook, however, is the data's value in monitoring the government's ability to police Medicare fraud and abuse. It was first discussed on appeal, *see* 554 F.3d at 1054, where the court rejected it as "an unsupported suggestion" that was not accompanied by "any evidence of alleged fraud the requested data would reveal." *Id*.; *see also id*. at 1055 n.5. It is thus not the case, as Plaintiffs claim, that "*Consumers' Checkbook* expressly acknowledged the evidence submitted by Checkbook – similar to the evidence submitted by Dow Jones here – that 'Medicare is especially susceptible to fraud.'" Opp. 27-28. To the contrary, the appellate court (referring to Checkbook as CSS) said:

> CSS next contends that disclosure of the requested data will serve the public interest by revealing fraudulent Medicare claims made by physicians . . . . But CSS has not provided any evidence of alleged fraud the requested data would reveal. In *United States Department of State v. Ray*, the Supreme Court rejected the respondents' "asserted [public] interest [under

> FOIA Exemption 6] in ascertaining the veracity of the interview reports" prepared by the State Department based on interviews with Haitian nationals involuntarily returned to Haiti. The respondents had not presented "a scintilla of evidence . . . that tends to impugn the integrity of the reports." The Court noted: "If a totally unsupported suggestion that the interest in finding out whether Government agents have been telling the truth justified disclosure of private materials, Government agencies would have no defense against requests for production of private information." Similarly, if an unsupported suggestion that an agency may be distributing federal funds to a fraudulent claimant justifies disclosure of private information, the agency would have no defense against FOIA requests for release of private information.

554 F.3d at 1054. Conversely, in this case, copious evidence of actual fraud and waste was marshaled, distinguishing it from *Consumers' Checkbook*'s "unsupported suggestions."[12]

Even as they emphasize *Consumers' Checkbook*, Plaintiffs ignore more relevant developments. They suggest that *News-Press* and *Multi Ag Media LLC v. USDA*, 515 F.3d 1224 (D.C. Cir. 2008), represent more of the same because they applied the "same balancing analysis" as *FMA v. HEW*. *See* Opp. 11-12. To be sure, *Multi Ag* and *News-Press* applied the same legal standard on the privacy/public-interest balance, but they *came out the other way* on a very similar issue, deciding that disclosure of management of taxpayer dollars outweighs whatever disclosure reveals about an individual's financial situation. Dow Jones

[12] Defending the D.C. Circuit decision, the Solicitor General likewise argued it rested on "fact-bound conclusion that the [] data petitioner [sought] . . . would not . . . be useful for any of the public-interest[s] . . . posit[ed]." Br. of Fed'l Resp'ts in Opp'n to Cert., *Consumers' Checkbook v. HHS*, No. 09-538, 2010 WL 942805, *8 (U.S. Mar. 15, 2010). The AMA went a step further in its reply brief on appeal, claiming Checkbook's insistence that the "frequency of performance of a particular procedure" was "evidence of expertise" undercut its belated claim that frequency of procedures would reveal fraud. Reply Br. for Movant-Intervenor American Medical Association, *Consumers' Checkbook v. HHS*, No. 07-5343, at 9-10 (D.C. Cir. July 1, 2008).

Mot. 21, 23-24. This reflects a relevant change in law, especially as *News-Press* (and not *Consumers' Checkbook*) is the law of this Circuit.

For example, *News-Press* clarified that "those who receive a governmental benefit" cannot expect to keep those payments secret. *Id*. (quoting 489 F.3d at 1202).[13] Simply pointing out that this holding came under the same legal standard applied in *FMA v. HEW* misses the point. Plaintiffs likewise seek to distinguish *Multi Ag Media*, which ordered disclosure of records identifying individuals receiving agriculture subsidies, on grounds that patients rather than HHS select recipients of Medicare reimbursements. Opp. 12. But the programs here and in *Multi Ag Media* are more similar than Plaintiffs realize, in that the government *does* decide which providers qualify for Medicare reimbursements. It even

[13] By using the term "government benefit," *New-Press* distinguished government payment data from the type of highly personal records protected by the Privacy Act. 489 F.3d at 1202 (Exemption 6 was "'intended to cover detailed Government records on an individual which can be identified as applying to that individual and not the facts concerning the award of a pension or benefit'") (citation omitted). It did not distinguish government payments classified as "benefits" or relief from other government payment data. Thus, the DC Circuit relied in part on *News-Press* in releasing data on agricultural subsidies intended *not* to aid particular farmers but to "promot[e] a stable and abundant American food supply," because "there is an obvious legitimate public interest in how taxpayers' money is being spent, particularly when the amount is large." *Multi Ag Media*, 515 F.3d at 1226 (citation omitted). If anything, the rationale for release is far stronger in the case of professionals being paid for their services. *News-Press* concerned disaster victims who "may feel some stigma" when their lack of private insurance and status as home renters is revealed, but the court nonetheless found the public interest in the management of government payments outweighed those privacy interests. 489 F.3d at 1202. By contrast, "[p]ractitioners who contract with the government to provide medical services in exchange for federal payments perform a quasi-public function." *Public Citizen Health Research Group v. HEW*, 477 F. Supp. 595, 603-04 (D.D.C. 1979), *rev'd on other grounds*, 668 F.2d 537 (D.C. Cir. 1981).

excludes from Medicare physicians who defraud the system, one reason claims data provides insight into how well the government carries out its functions in this regard.[14]

B. Plaintiffs failed to meaningfully refute that providers' interest in privacy has diminished

Dow Jones's Motion also showed that the privacy interest of the providers in what they receive from taxpayers has significantly diminished as this same information has been released to the public. HHS regularly released this same Medicare claims data to RTMD as matter of course from 2001 to 2007 under FOIA requests, without a single complaint from a provider. Dow Jones Mot. 24. The Affordable Care Act of 2010 *requires* HHS to release this data to "qualified entities," who are then *required* to publish that data and may identify payments to individual providers. *Id.* 24-25. Congress has so roundly repudiated the notion that Medicare payments should be secret that it *mandated* publication of this information through the ACA and introduced bipartisan legislation aimed at nullifying the 1979 Injunction. *Id.* 15-16, 24-25. Meanwhile, Medicare payment data no longer sheds light on

[14] Plaintiffs also cite several cases for the general and noncontroversial proposition that "courts have often" found "a privacy interest in nondisclosure of [identities] in connection with financial information." Opp. 13-14. However, *Lepelletier v. FDIC*, 164 F.3d 37 (D.C. Cir. 1999) (cited Opp. 13, 23), identified a privacy interest in depositors' names and amounts owed, but only "a slight one," *id.* at 47-48. *Painting & Drywall Work Pres. Fund, Inc. v. HUD*, 936 F.2d 1300 (D.C. Cir. 1991) (cited Opp. 12-13, 19, 27), and *Nat'l Ass'n of Retired Fed. Employees v. Horner*, 879 F.2d 873 (D.C. Cir. 1989) (cited Opp. 13), both found identifying individuals and funds they were to receive triggered privacy interests in avoiding solicitation, 936 F.2d at 1303; 879 F.2d at 878, a rationale for nondisclosure the Supreme Court later criticized. *Sorrell v. IMS Health, Inc.*, 131 S. Ct. 2653, 2669 (2011). In any case, Dow Jones has never disputed that, in some contexts, individuals have privacy interests in their financial information. Rather, Dow Jones made clear that it depends on the character-istics the information reveals, and the likely consequences of disclosure. Dow Jones Mot. 21, 24. Ultimately, Plaintiffs do not – and cannot – really dispute that "[o]ver the last 33 years, FOIA['s role] as a broad disclosure statute" has grown, as has the recognition that "even [if] there [is] some minimal privacy interest . . ., [it] shrinks considerably" when public funds are at stake. *Id.* 20, 22-23 (citing cases).

what a provider charges non-Medicare patients. *Id.* 25. Plaintiffs have not refuted that a number of developments that diminish the privacy interests underlying the 1979 Injunction. *Id*. 24-27. In most cases, they do not even try.

First, Plaintiffs do not dispute that, after the 1979 Injunction (and after *Checkbook*), the ACA began to require that physician payment data must be released publicly, diminishing privacy interests therein. *Id*. 24. Plaintiffs attempt to undermine the ACA's import by noting that its release procedures limit disclosure to "qualified entities" and build in various procedural safeguards. Opp. 23, 33-34. But the requirements for the organizations that *process* the data do not change the fact that the ACA requires Medicare reimbursement data of individually identified doctors to be made public, showing Congress sees the value of public disclosure. Plaintiffs seem to believe "qualified entities" are a necessary buffer to tell the public what the reimbursement figures mean (and do not mean), *id*., and apparently would prefer that others – like the media, or members of the public themselves – not take it upon themselves to digest the information. Putting aside the arrogance of that position – typified by the claim that the public and the press cannot be expected to understand such esoteric concepts as the difference between a doctor's revenue and her profit, Opp. 14-15 – that is not what the ACA requires. Rather, it *requires* public release of data, whether or not a physician so identified objects.[15]

[15] Plaintiffs cite another federal law, the Health Care Quality Improvement Act of 1986, as "significant" in its failure to release data on medical malpractice payments, sanctions, and adverse professional review actions. Opp. 15 (citing 42 U.S.C. § 11101 *et seq.*). But that statute has nothing to do with income data or government expenditures and involves, if anything, far more sensitive information.

And FOIA itself rejects the "only we know best" attitude Plaintiffs espouse and reflects the judgment that citizens – and the press as their surrogate – can be trusted with such information. *See, e.g.*, *Freedom of Information Act*, Memorandum for the Heads of Executive Departments and Agencies, 74 Fed. Reg. 4683 (2009) (FOIA "is the most prominent expression of a profound national commitment to ensuring an open Government. At the heart of that commitment is the idea that accountability is in the interest of the Government and the citizenry alike. The Freedom of Information Act should be administered with a clear presumption: In the face of doubt, openness prevails."). Just because agency records subject to FOIA may be misleading, or even actually inaccurate, is irrelevant to whether they must be disclosed. *See, e.g.*, *Public Citizen Health Research Group v. HEW*, 477 F. Supp. 595, 603-04 (D.D.C. 1979) (withholding under Exemption 6 not warranted even though privacy interest was implicated and "[d]isclosure of physician identities . . . raise[d] the prospect of misleading publicity, possibly unwarranted professional and public criticism, and damage to professional reputation"), *rev'd on other grounds*, 668 F.2d 537 (D.C. Cir. 1981); *see also Petroleum Info. Corp. v. Dep't of Interior*, 976 F.2d 1429, 1436 (D.C. Cir. 1992); *Morton-Norwich Prods., Inc. v. Mathews*, 415 F. Supp. 78, 81 (D.D.C. 1976).

Second, Plaintiffs effectively concede through their silence that the risk of introduced errors in Medicare reimbursement data – a concern the court noted *sua sponte* when granting the 1979 Injunction, *see FMA v. HEW*, 479 F. Supp. at 1297 – has been greatly reduced with the advent of electronic billing. *See* Dow Jones Mot. 25-26.

Third, Plaintiffs do not dispute that Medicare payment data no longer offers any insight into the rates individual providers charge and collect for their service, which, in turn,

comprises their total income. *Id*. 25. Plaintiffs attempt to explain away this development, arguing "the privacy interest of physicians that justified withholding reimbursement records in 1979 . . . is in physicians' income, not in the amount they charge . . . on a per-procedure basis" because rates "are provided to any patient or insurer who asks." Opp. 18-19. Of course, aggregate reimbursement totals also are available to insurers paying the bills, and information about patient care is available both to patients and their insurers. As Plaintiffs take pains to point out, limited release upon request is different than public release. In any event, whether front and center in 1979, any concern about competitors knowing a physician's customary charges for specific procedures has vanished with the advent of published reimbursement rates set by HHS.

Fourth, Plaintiffs do not dispute that this same information was released to Alley for years, without a single complaint. Dow Jones Mot. 24; Alley Mot. 14. Plaintiffs claim, without support, that "Physicians whose information was wrongly disclosed to Alley were not aware of the disclosure, and for that reason cannot be expected to have complained about it." Opp. 22. It is difficult to imagine this is the case, since (among other things) the fact was discussed by the Eleventh Circuit in the *Alley* litigation. It was also emphasized, among many other places, in a report to the AMA membership at its 2009 annual meeting.[16]

Nor do Plaintiffs dispute that they were unable to produce any evidence to support the claim that doctors might exit Medicare if the data were publicly available. Plaintiffs claim

[16] *See* http://www.ama-assn.org/resources/doc/hod/a-09-bot-reports.pdf, at 105 ("For several years, Alley and RTMD had submitted FOIA requests to HHS for information concerning Medicare payments for Alabama and surrounding states. The requested information, which was similar to that [] in the *Consumers' Checkbook* case, would identify amounts received by specific physicians. Until 2007, HHS routinely supplied the requested documents.").

"Dow Jones suggests that physicians are indifferent to maintaining the privacy of Medicare reimbursement records because the Associations did not produce in discovery any surveys suggesting that doctors might exit Medicare were the public to gain access to payment information." Opp. 24 n.6 (quotation marks omitted). But Dow jones did not request "surveys" in discovery, it requested *surveys or any other evidence* that providers might exit Medicare if taxpayer expenditures were removed from the veil of secrecy. Dow Jones Mot. 26. Neither Plaintiffs nor HHS provided any evidence. This is not surprising; as the prospect that physicians would leave Medicare if there was a chance their reimbursement payments could be made public (Opp. 24 n.6) is far-fetched. As Dow Jones noted, by all accounts the biggest issue facing Medicare providers over the last several years has been the cap on reimbursements and the threat that it will be lowered even further. Dow Jones Mot. 26-27; *cf.*, Tuttle Declaration [dkt 57] ¶ 6. And yet, even with the specter of even more severe austerity in the program, Medicare participation has become nearly universal. Even when Congress passed the ACA, requiring public release of Medicare payment data HHS to release Medicare claims data, there was no outcry from physicians about leaving Medicare.

In lieu of such objective evidence, Plaintiffs put forward Declarations by two of their own trustees which purport to "establish that physicians who treat Medicare beneficiaries . . . have a substantial privacy interest in their financial information." Opp. 14. Putting aside the self-serving nature of declarations from their own trustees, these claims are inadequate on their face. For example, Plaintiffs trumpet Dr. McAneny's claim that "[p]ublication of her revenues from Medicare would suggest to patients, who do not have access to Dr. McAneny's cost information and who lack sophistication regarding the costs involved,

that she actually nets over $15,000 each time she administers [a drug] to a patient." Opp. 14-15. As Professor Malcolm Sparrow's declaration made clear, nearly every other entity paid with taxpayer dollars has this payment information posted on government-run, publicly available websites. Dow Jones Mot. 15-16. That this is the best argument Plaintiffs can muster – *i.e.*, that this Court should keep taxpayer spending secret because non-physicians are incapable of understanding the difference between revenue and profit – is deeply telling.

Plaintiffs' last-ditch effort is to claim that their members have a reliance interest in secrecy. This is wrong on the law. While an explicit government promise of confidentiality, "made in good faith and consistently honored, should generally be given weight on the privacy side of the scale," even it "should not be given determinative weight where the public interest in disclosure is high and the privacy interest in the information would otherwise be low." *Washington Post Co. v. HHS*, 690 F.2d 252, 263 (D.C. Cir. 1982). Among other reasons, "to allow the government to make documents exempt by the simple means of promising confidentiality would subvert FOIA's disclosure mandate." *Id.* Here, there was no cause for reliance, let alone an explicit promise. Plaintiffs cite just a single, unpublished decision withholding similar data in the three decades between the 1979 Injunction and *Consumers' Checkbook*, while ignoring the fact that *Consumers' Checkbook* explicitly declined to rule on the 1979 Injunction and the Eleventh Circuit in *Alley* strongly suggested the time had come to vacate it. Plaintiffs also ignored legislative action to open these records. Perhaps most importantly, Plaintiffs fail to explain why settled expectations are relevant to the only question currently before the court – whether the injunction should be enforced *prospectively*.

C. Plaintiffs have not disputed Dow Jones's showing that the interest in being able to monitor use of public funds has grown since 1979

Even if Plaintiffs *had* shown a substantial privacy interest, that is not enough under Exemption 6. Instead, the privacy interest must clearly outweigh the interest in disclosure. As Dow Jones's Motion made clear, Medicare has grown *twenty-fold* in nominal dollars, and nearly three-fold as a percentage of the total federal budget, since 1979. Meanwhile, the Attorney General labeled Medicare fraud the "number two crime problem in America" and the General Accounting Office classified it as "high risk for fraud, waste, abuse, and mismanagement." Dow Jones Mot. 9-10.

Yet again, Plaintiffs *do not dispute* the extensive evidence regarding the scope of Medicare fraud, its growth, or its causes. Plaintiffs respond with a collective shrug, arguing "[f]raud also existed in 1979" and that " the only question before the Court in analyzing FOIA Exemption 6 is whether the requested records would allow the public to monitor government performance" rather than "whether releasing them would serve generally salutary policy goals." Opp. 27-28. But the fact that Medicare fraud is not entirely new does not mean its explosive growth is not a changed circumstance. And monitoring Medicare fraud, and the government's efforts to combat it, is of course relevant to evaluating "government performance."

Dow Jones came forward with extensive evidence that Medicare fraud has exploded since 1979 due in part to a transition to electronic billing, as well as evidence that these more timely, more accurate records make public oversight over the Medicare program far more feasible. Plaintiffs *concede* this change to electronic billing "has assuredly occurred since 1979," Opp. 30, but claim the change is meaningless because, "if fraudsters are able to obtain

Medicare funds and 'vanish' before even HHS is aware of the fraud, it is simply implausible that an outside entity like Dow Jones could somehow prevent the fraud." Opp. 30. Plaintiffs are incorrect. The press and public have played a role in uncovering fraud, waste, and abuse in the Medicare system. *See* Dow Jones Mot. 12-14. The mere fact of public access to and disclosure of the data deters fraud and abuse *before* it occurs. *Id.* 30. Even *Consumers' Checkbook*, on which Plaintiffs primarily rely, opined that "the requested data would serve the public interest by allowing the public to 'more easily determine whether [the government] is catching cheaters and lawfully administering its subsidy and benefit programs.'" 554 F.3d at 1054-55. Plaintiffs are dismissive of the added value that public and press scrutiny provides, but law enforcement is *not*. Sparrow Decl. ¶ 46. Indeed, the press may have access to whistleblowers who, for obvious reasons, may be reluctant to speak with law enforcement. The public and press cannot take the place of law enforcement in chasing fraud and Dow Jones has never made such an assertion. But the shift to electronic billing has both increased Medicare fraud and strengthened the public interest in overseeing Medicare, while at the same time providing the public better tools for doing so.

Indeed, Plaintiffs cannot meaningfully dispute that Dow Jones and others have used claims data to uncover fraud and expose inadequacies in government oversight. Plaintiffs instead counter that Dow Jones "ultimately reported on only two dozen physicians and half a dozen practices or hospitals 'as likely cases of fraud or abuse,' *id.* – a number that is less than 0.0037 percent of the total number of providers whose records Dow Jones was permitted to examine." Opp. 29. Putting aside that Plaintiffs apparently believe "only" a couple dozen cases of suspected waste, fraud, and abuse are *de minimis* and the irony that the limitations

imposed by the 1979 Injunction *at Plaintiffs' insistence* are the reason there are not more, Plaintiffs' characterization is inaccurate. What Dow Jones *actually* said was:

> [A]pproximately 75,000 providers among approximately 811,785 providers in the 5% sample of Medicare beneficiaries contained in the Carrier File to which Dow Jones had access had billing totals two standard deviations above average by procedure, and 5,000 had billing totals five standard deviations above average by specialty ….
>
> Dow Jones identifie[d] approximately two dozen individual physicians as likely cases of fraud or abuse, and at least half a dozen practices and/or hospitals, accounting for an unknown number of physicians. These are cases where Dow Jones was able to supplement its statistical suspicions, which ran into the tens of thousands, with additional information. But as also discussed in the Declarations, the ability to supplement its suspicions was limited by Dow Jones's Data Use Agreement with CMS (the "DUA"), which precluded Dow Jones from disclosing information about individual doctors even in the course of newsgathering unless Dow Jones independently identified them as malfeasors.

See Opp., Ex. F. In other words, Dow Jones identified nearly 10% of providers – 75,000 – as billing in a way the government considers to be indicative of fraud. The reporters and editors working on the Series selected some of these 75,000 for follow-up. Despite onerous restrictions in place due to the 1979 Injunction, they were able to corroborate that dozens were likely involved in wrongdoing. This included individuals later indicted or stripped of their medical licenses. Plaintiffs dispute *none* of this.[17]

As much as Plaintiffs may deride the idea of permitting the press and the public to "act as a self-appointed OIG," Opp. 31, Plaintiffs concede by their silence that this same

[17] Nor is it relevant that some of those identified by Dow Jones were already under government investigation. The interest asserted here is not in deputizing the press to act as healthcare police. The interest is monitoring fraud and the government's ability to combat it.

principle is the norm with government expenditures. Dow Jones Mot. 15-16. The concept of public oversight over public expenditures *should* not be novel to Plaintiffs, given that their constituents are among the largest recipients of taxpayer dollars. Dow Jones showed how the government has embraced the value of "crowdsourcing" accountability by making payment data public. For example, the salaries of nearly all federal *employees*, including doctors, have been public under federal regulations issued in 1985. Payments to lawyers appointed by courts to represent indigent defendants, along with payments to outside lawyers retained by the government, are public as well. *See* Dow Jones Mot. 15; 1 C.F.R. § 305.87-3. More generally, the American Recovery and Reinvestment Act of 2009 required the creation of "recovery.gov," which shows the distribution of all Recovery funds by federal agencies and how recipients spend those funds. Dow Jones Mot. 15.

In the past, Plaintiffs claimed Medicare doctors were uniquely immune from oversight because they were not government employees. *See*, *e.g.*, Br. for Movant-Intervenor American Medical Association, *Consumers' Checkbook v. HHS*, No. 07-5343, at 25 (D.C. Cir. May 1, 2008). Faced with the fact that private lawyers paid with government funds are subject to transparency requirements, Plaintiffs try out a new distinction: "It is patients, not HHS, who select treating physicians. This fact demonstrates the inaptness of Dow Jones' comparison of public disclosure of physicians' income from Medicare to disclosure of the salaries of government employees and payments to government-appointed lawyers." Opp. 16 (citation omitted). This is wrong as a factual matter, because HHS regulations *do*

determine which providers qualify to participate in Medicare.[18] But even were Plaintiffs not wrong on the facts, it is unclear why the role of government and patient in choosing providers should distinguish between uses of public funds that are kept secret, and those that are subject to public oversight.[19]

Finally, Plaintiffs do not refute that the 1979 Injunction is so reviled that Senators Grassley and Wyden have recently introduced bipartisan legislation specifically to override it – surely a dubious distinction for a decades-old district court injunction. Seeking to make lemonade out of lemons, Plaintiffs claim that the fact this bill has not yet passed "is evidence of Congress's view that no changes in Medicare or the state of medicine generally justify altering the current state of the law, as reflected in this Court's judgment." Opp. 33. It defies logic – and displays willful blindness to how Congress works (or fails to work) – to claim Congress "ratifies" a court decision when a bill to overturn that decision is introduced but not immediately passed. Nor does *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 414 n.8 (1975), cited by Plaintiffs (Opp. 33), stand for that proposition. Rather than simply fail to pass a bill,

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[18] *See, e.g.*, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//Quick_Reference_New_Provider.pdf, at 1 ("In order for providers or suppliers to participate in and receive payment from the Medicare Program, they must meet the eligibility requirements for program participation. For some providers, this includes a certification of compliance with the conditions of participation, or standards, set forth in Federal regulations.").

[19] Similarly, one AMA trustee complains that "I am neither a government employee nor a government contractor. I am a private physician. That some of the patients I treat happen to be insured by the Medicare program should not give the government license to disclose my income from that program." McAneny Decl. ¶ 20. Dr. McAneny may not consider herself a government contractor, but that does not change the fact that she, like private lawyers retained to represent governmental entities or indigent clients, receives *public* money. With that money comes public oversight. As Senator Grassley explained, there is no reason for Medicare providers to be uniquely exempt from oversight. Dow Jones Mot. 16.

Congress in that case *explicitly* "ratified [one] construction of the Act." According to the Court, "[a] Section-by-Section Analysis of the Conference Committee's resolution notes that '(a) provision limiting class actions was contained in the House bill and specifically rejected by the Conference Committee.'" It is one thing to say a Court should not read into a statute a provision that was explicitly rejected by a conference committee in favor of an alternative approach. It is quite another to say that every bill that does not immediately become law is an endorsement of the status quo.

Similarly, that "HHS has also repeatedly confirmed its commitment to maintaining the confidentiality of the records," Opp. 25, is grounds for *vacating* the injunction, not maintaining it. Though in the past it acquiesced in the 1979 Injunction's conclusion that this data should not be released, HHS has carefully explained that it must be free to evaluate the balance between the public and private interests on a case-by-case basis, as FOIA requires. HHS has recognized that it is required to "review . . . agency policy" and "reflect any changes in the facts and the law, and not outdated assumptions and legal frameworks long since abandoned." HHS Resp. 18. That the government has not engaged in that inquiry since 1979 does not mean it must forever enforce an injunction that, it is now clear, went beyond the statutory authority to issue and does not adapt to the changes in the program it is tasked with overseeing.[20]

[20] Plaintiffs today filed a twenty-two page supplemental brief in response to HHS, without seeking leave as required by Local Rule 3.01(c). Presuming it is not stricken, *see U.S. v. Morse*, 2007 WL 3379771 (M.D. Fla. 2007) (Howard, J.), Dow Jones may request the opportunity to respond after reviewing Plaintiffs' supplemental brief.

CONCLUSION

The Rule 60 pleadings the parties have filed compel a conclusion that changes in the contours of issues *FMA v. HEW* decided in granting the 1979 Injunction, in the governing law underlying it, and in public policy, render continued enforcement "detrimental to the public interest" and no longer equitable. *Horne*, 129 S. Ct. at 2593, 2596-97; Fed. R. Civ. P. 60(b)(5). As HHS has pointed out, the statutory bases do not now support the sweeping permanent relief issued in 1979. Increased public disclosure of government payment data in general – and Medicare payment data especially – and the expanding role of Medicare in the scheme of federal programs and expenditures, as well as changes in FOIA and privacy law, have combined to erode the 1979 Injunction's legal and factual underpinnings. Dow Jones, therefore, respectfully moves for an order vacating the Final Declaratory Judgment and Permanent Injunction entered in this case on October 22, 1979.

Dated: May 24, 2012

Respectfully submitted,

By: /s/ Laura R. Handman_____

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I hereby certify that, on May 24, 2012, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system which will send a notice of electronic filing to the following:

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

FLORIDA MEDICAL ASSOCIATION, INC., *et al.*,

Plaintiffs,

v. Case No. 3:78-cv-00178-MMH-MCR

DEPARTMENT OF HEALTH, EDUCATION & WELFARE, *et al.*,

Defendants,

DOW JONES & COMPANY, INC., *et al.*,

Intervenors.
_____/

DOW JONES & COMPANY, INC.'S SUPPLEMENTAL MEMORANDUM IN SUPPORT OF MOTION TO VACATE PERMANENT INJUNCTION

Dow Jones & Company, Inc. ("Dow Jones") hereby submits its Supplemental Memorandum in support of its Motion to Vacate Final Declaratory Judgment and Permanent Injunction. *See FMA v. HEW*, 479 F. Supp. 1291 (M.D. Fla. 1979) (the "1979 Injunction"). After discovery, extensive briefing, and oral argument, it is clear that "changes in the nature of the underlying problem, [ ] in governing law[s and their] interpretation" and "new policy insights" combine to render continued enforcement of the 1979 Injunction "detrimental to the public interest," and "no longer equitable."[1] And, the parties agree that the Privacy Act cannot serve as the legal basis for the Injunction. HHS Resp., 13-14; Dow Jones Reply, 3-4; Transcript of Motion Hearing, June 20, 2012 ("Tr."), 87:2-14. *See also* Tr., 8:25-10:10,

[1] *Horne v. Flores*, 557 U.S. 433, 447-48, 453 (2009); F.R.C.P. 60(b)(5); *see also* F.R.C.P. 60(b)(6) (judgment may be revisited for "any other reason that justifies relief"). *Cf.*, HHS Resp., 18 ("[C]hanges in the law and the facts can justify an agency change in position.").

12:21-14:1. Accordingly, the viability of the 1979 Injunction must be analyzed solely under the Administrative Procedure Act ("APA"). But doing so compels the conclusion that the 1979 Injunction must be vacated.

I. THE 1979 INJUNCTION'S BROAD SWEEP IS UNSUPPORTED UNDER CURRENT LAW AND THE CHANGED NATURE OF THE RECORDS

Even accepting *arguendo* the 1979 Injunction was initially proper under the APA to enjoin disclosure of specific records then before the Court,[2] it broadly prohibits disclosing not only lists of annual totals of 1977 Medicare reimbursements then planned for release, but *any* Medicare reimbursements that identify *any* individual doctor for *any* year. 479 F. Supp. at 1297, 1311; *see* Dow Jones Reply, 3. And it bars HHS from even *considering* releasing such data based on changed circumstances, except by coming to this Court for modification of, or relief from, the Injunction. *Alley v. HHS*, 590 F.3d 1195 (11th Cir. 2009). That is not how the Freedom of Information Act ("FOIA"), the APA, and judicial review thereunder, are intended to work, nor does it allow HHS to assess in the first instance any changed circumstances, as the APA requires. *See, e.g., INS v. Ventura,* 537 U.S. 12, 17 (2002).

As only "specific, concrete decisions or actions already made or taken," and "not [] hypothetical future [] actions" may be challenged, APA injunctions are limited to particularized actions rather than far-off, future undertakings.[3] In FOIA cases, an agency decides

[2] As explored at hearing, the 1979 Injunction decision was not clear on whether relief issued under the APA or Privacy Act. Tr., 7:1-9:25. That lack of clarity alone is reason to vacate the 1979 Injunction under a "change in governing law," *supra* note 1, as *Edison v. Dep't of the Army*, 672 F.2d 840, 846 (11th Cir. 1982), and *Clarkson v. IRS*, 678 F.2d 1368, 1375 n.11 (11th Cir. 1982), decided post-1979, held that the Privacy Act does not authorize such injunctions.

[3] HHS Resp., 14-16 (citing 5 U.S.C. § 706 and, *inter alia*, *Norton v. S. Utah Wilderness Alliance*, 542 U.S. 55 (2004); *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871 (1990); *Fanin v. Dep't of Veterans Affairs*, 572 F.3d 868 (11th Cir. 2009)); Tr., 39:16-41:1. *See also infra* § II.

whether or not to release *specific* records, a court reviews and affirms, or enjoins *as to those records*, and that decision controls only those, or essentially identical, records – leaving the agency free to decide whether to release other records under other requests if the analysis differs under the FOIA (or related laws, like the Privacy Act). *Brancheau v. Sec'y of Labor*, 2012 WL 140239, at *2 (M.D. Fla. Jan. 18, 2012) (citing *Doe v. Veneman*, 380 F.3d 807, 814 (5th Cir. 2004)).

As the AMA conceded, a court cannot "prohibit … disclosing future information that is different in some way." Tr., 14:14-17. The data now at issue is "different," not just in "some way," but in every material way. In 1979, the Court considered bare lists identifying doctors and how much money each doctor received in the aggregate annually from Medicare. *FMA v. HEW*, 479 F. Supp. at 1294, 1297. *Now*, there are terabytes of electronic data that are far richer, reflecting payment for specific procedures, the reasons for each procedure, and the frequency and number of procedures performed, to name just a few details. *See, e.g.*, Decl. of Michael Allen ("Allen Decl."), ¶¶ 2-3; Dow Jones Mot., 29-30; Dow Jones Reply, 5. This shines a light on much more than a gross total of taxpayer money a doctor receives from Medicare – rather, it allows the public to learn whether they are paying for unnecessary or improper procedures, or procedures which were never performed, whether there have been unlawful or unethical kickbacks or self-dealing, and how well the government prevents and pursues a myriad of other problems. This granularity and what the data reveals not only shows how different it is from gross annual totals, but how much the public interest in its disclosure has grown. If "reverse FOIA" injunctive relief for records that are merely "substantially similar" is "too broad," *see* Dow Jones Reply, 5 n.8 (citing *Gulf Oil Corp. v. Brock*,

778 F.2d 834, 842-43 (D.C. Cir. 1985)), the 1979 Injunction, which has continued over the decades to encompass plainly dissimilar records, *id*. at 18-20; Dow Jones Mot., 11-15, 29-31, is even more flawed.

Disclosure of taxpayer money paid to Medicare providers identified by name is vital, as the Court put it, "for the data to accomplish [its] purpose[]," Tr., 45:4-6, which, under the FOIA, is "shedding light on what the government is up to." *News-Press v. DHS*, 489 F.3d 1173, 1206 (11th Cir. 2007). As FOIA and Exemption 6 law has evolved, privacy claims by recipients of public funds are squarely disfavored – particularly if the only "private" characteristic revealed relates to funds received[4] – while legislative and policy developments have reinforced the tilt toward disclosure.[5] If and when HHS is unbound from the 1979 Injunction and can consider the changes in data, the public's interest in accessing such data, and FOIA and Privacy Act law, there will be a heavy burden on HHS (or anyone objecting to release) to show the privacy interests *substantially outweigh* the public interest in disclosure. *See*, *e.g.*, *DOD v. FLRA*, 510 U.S. 487, 502 (1994). *See also News-Press*, 489 F.3d at 1198.

The uncontroverted evidence shows how, with access to the data at issue, the press, public and non-profits can uncover Medicare waste, fraud and abuse and, by extension, blind spots in governmental oversight. Dow Jones Mot., 13-14, 29-30, & Decl. of Malcolm Sparrow ("Sparrow Decl."), *passim*. As Dow Jones' expert explained, to "pinpoint where the government is lagging," one must "analyze the data, follow leads, and interview sources."

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[4] As has been clear throughout this case, the issue has never been privacy of *patients*, whose identities are closely guarded. *See*, *e.g.*, Dow Jones Mot., 2, 6, 12, 21, 23.

[5] Dow Jones Mot., § II.B (citing, *inter alia*, *News-Press*, 489 F.3d at 1190-92, 1205-06; *Wash. Post Co. v. Dep't of Justice*, 863 F.2d 96, 100 (D.C. Cir. 1988); *Wash. Post Co. v. Dep't of Agric.*, 943 F. Supp. 31, 35-36 (D.D.C. 1996); *Multi Ag Media LLC v. Dep't of Agric.*, 515 F.3d 1224 (D.C. Cir. 2008); Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA")); Dow Jones Reply, 7-11.

Sparrow Decl., ¶ 3; *cf. id*. at ¶ 47 (press, non-profits and healthcare-assisting companies need data like individually identifiable information "to do their jobs."). *See also id*., Ex. 19, 4-5. The *Journal*'s Deputy Page 1 Editor confirmed doctors' names are needed to inform investigators, referring doctors, and the public of wrongdoers revealed in the CMS data, and that inaccessibility of identifying information hinders necessary follow-up. Allen Decl., ¶ 18. And Dow Jones' investigative reporter similarly cited impediments from his inability to use doctors' names in investigating and confirming waste, fraud and abuse, noting it is essential to "interview current and former employees and colleagues … about billing patterns" as part of the process. Decl. of Mark Schoofs (Schoofs Decl.), ¶ 11. Inability to discuss specific doctors imposes "a severe limitation" on finding all but the most obvious violators. *Id*. at ¶ 15; s*ee also id*. at ¶¶ 19, 21, 23.

Such limits have pronounced effects. It is "important to have individualized information [in] evaluating larger groups, because aggregating [] data across [] individuals may obscure patterns … indicative of fraud."[6] Dead doctors in Medicare's paid claims, Sparrow Decl., ¶ 16; Ex. 14, cannot be found via CMS identifiers – the names are needed. It is "easy … to escape scrutiny" if, in talking with medical boards, staff, or doctors, those pursuing waste, fraud and abuse cannot discuss particular providers. *Id*. at ¶ 21. The deterrent for those considering fraud also is thus undercut absent a risk of disclosure. *Id*. at ¶ 34. Similarly, while "the public [can] report … suspicions of fraud, waste or abuse" via tools like re-

[6] Sparrow Decl. ¶ 34. It would have been impossible, for example, to identify recipients of copious payments from spine-device makers as doctors who also perform substantially higher than average numbers of surgeries using that equipment. Allen Decl., ¶¶ 20-21. Finding "quick hit" perpetrators also can depend on knowing doctors' names, especially where they incorporate using a fictitious name and submit claims thereunder. Sparrow Decl., ¶ 23.

covery.gov, *id*. at ¶ 44, doing so is greatly aided by having names to attach to their concerns. The need for doctors' names associated with Medicare reimbursement data here is directly analogous to the press' need for addresses of disaster aid recipients in *News-Press* (in which the Eleventh Circuit expressly recognized that addresses would ultimately lead reporters to names based on public records).[7] Whether it is FEMA grants or Medicare reimbursements, absent the ability to know the who, what, and why, the public cannot assess whether the government is doing a good job administering these many billions of taxpayer dollars.

II. AMA'S OVERSTATED PROCESS CONCERNS CANNOT OVERCOME A RULE 60 SHOWING THAT COMPELS VACATING THE 1979 INJUNCTION

An injunction as flawed and outdated as the 1979 Injunction – which is all Dow Jones must show to justify vacatur under Rules 60(b)(5) or (6) – cannot be rescued by overblown process concerns about repetitious litigation and/or lack of notice that CMS data may be released. As to whether any ongoing or imminent release requires injunctive relief, Tr., 30:2-7, 30:15-25; 33:17-34:8; 35:1-3, the answer is clearly "No." Even where circumstances arguably differed, HHS returned to the Court for guidance, rather than plowing ahead on its own.[8]

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[7] 489 F.3d at 1205. Specifically, in *News-Press*, the Eleventh Circuit accepted the important role that interviewing recipients of FEMA funds played in assessing whether an agency is a "good steward" of taxpayer funds. *Id*. at 1192-93, 1205. *See id*. at 1192 (criticizing district court for giving "inadequate weight to the substantial light that would be shed on FEMA's activities *directly* from [] release of the addresses") (emphasis added); *see also id*. at 1193 & n.22 (noting that "in order to verify the appropriateness of an award, the OIG itself was often forced to interview recipients"). Access to doctors' identities in CMS data also is vital to accurate inferences and conclusions drawn therefrom: if there is a legitimate reason for being a statistical outlier (*e.g.*, more than one provider billing to one provider number), there is no way to verify as much, absent follow-up investigation, which requires doctors' names. *See* Schoofs Decl., ¶ 24.

[8] *FMA v. HEW*, No. 78-178-Civ-J-S, Order (Dec. 12, 1982) ("1982 Order"). At hearing, AMA mused whether Dow Jones' Data Use Agreement ("DUA") (Decl. of Maurice Tamman ("Tamman Decl."), Ex. A), and limited receipt of CMS data, violated the Injunction. Tr., 25:14-19. Notably, this issue was *never* raised prior to the hearing, despite repeated opportunities during publication of the *Secrets of the System* series and/or in the nearly 18 months of litigation since, and the Court accordingly should disregard the argument entirely. *See* Tr., 105. In any case, the release to Dow Jones was a "routine use." *See* Tamman Decl. Ex. 1 (DUA) at 1 (stating that the "project referenced in this agreement[ ] has been determined by CMS to provide assistance to CMS in monitor-

It continued honoring the Injunction, even as the factual setting and legal landscape plainly evolved, including as recently as in *Consumer's Checkbook*. *See, e.g.*, AMA Reply, 2, 3; Tr., 8:19-20.

Even now, in supporting vacatur, HHS has not said that it will release data formerly subject to the Injunction. HHS Resp., 18-19; Tr., 31-34, 37:13-16; AMA Opp., 25. Rather, HHS seeks only freedom to revisit whether, on a proper FOIA request, data must be released based on "changes in the facts and the law, and not outdated assumptions and legal frameworks," HHS Resp., 18; *see* Tr., 38:5-39:2 – precisely as the APA intends. *See INS v. Ventura, supra*. Nor is there credible concern that vacating the 1979 Injunction will lead to the immediate release of physician-identifying data absent notice and a chance for input by those affected, as HHS committed to such on the record, "in the event these issues are … reexamined."[9]

Nor would AMA have to bring "completely redundant lawsuit[s] every year" were the 1979 Injunction lifted. *See* Tr., 10:23-11:5, 14:18-15:17; HHS Reply, 14. *If* the instant motions are granted and a FOIA request is filed for CMS data formerly subject to the Injunction, and *if* HHS finds records should be released, and *if* AMA brought a reverse FOIA action

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ing, managing and improving Medicare and Medicaid programs or the services provided …; and the user agrees to … comply[] with … the Privacy Act," and reflecting that the "data [] reside in a CMS Privacy Act System of Records"); Partial Opp. of HHS to Dow Jones' Motion to Intervene, 9 ("disclosures to Dow Jones were made under the 'routine use' exception to the Privacy Act, 5 U.S.C. § 552a(b)(3), which creates an exception to the Privacy Act for disclosure of information in connection with certain uses described in the Federal Register"); Tr., 36:18-37:5. As such, the release was allowed by the Privacy Act, 5 U.S.C. § 552a(b)(3), (e)(1)(C), (e)(4)(D), and the 1979 Injunction and the 1982 Order, and was subject to restrictions derived from the Injunction.

[9] Tr., 32:23-33:1; *see also* HHS Resp., 19 ("HHS would not undertake any [] change … without providing interested parties, including [] plaintiffs in this action, adequate notice and an opportunity to [be] heard"). *Cf., Gulf Oil*, 778 F.2d at 841-42. In fact, HHS' FOIA rule already provides an analogy for such an approach, in its treatment of material that when submitted is designated confidential trade-secret or commercial matter but then later becomes subject to a FOIA request. *See* 45 C.F.R. §§ 5.65(c)(1), (d)(1) & (3), (e)(1).

and prevailed by showing privacy interests clearly outweighing the public interest,[10] there is no reason AMA would have to return to court year after year. On the next FOIA request for the same or essentially identical data, basic administrative law constrains HHS from refusing to follow precedent,[11] including in reverse-FOIA cases. *E.g.*, *Taylor Energy Co. v. Dep't of Interior*, 734 F. Supp. 2d 112, 126 (D.D.C. 2010). Or, to avoid acting arbitrarily and capriciously, HHS would have to explain why release is required or permitted despite such precedent.[12] The fact that AMA will have to exercise, post-vacatur, the same procedural remedies that apply to everyone else is not grounds to retain a 30-year-old injunction that reached too far prospectively when issued, and is now outdated and works to obstruct processes and interests served by the APA, FOIA, the Privacy Act, and Rule 60(b).

III. THE ACA SERVES ONLY TO UNDERSCORE THE PUBLIC'S INTERESTS IN LIFTING THE 1979 INJUNCTION AND IN OBTAINING FULL ACCESS TO CMS' PHYSICIAN-IDENTIFYING DATA

The enactment of the ACA's Medicare Data Performance Measurement provision and HHS' adoption of implementing rules, which together anticipate some availability of CMS data to "qualified entities" and public reports by them, is not a substitute for access to CMS data under FOIA, or for vacating the 1979 Injunction. *See* 42 C.F.R. § 401.701 *et seq*. First

[10] This may, of course, necessitate those opposed going to court and showing release is arbitrary and capricious under relevant precedent. But that does not put AMA in worse position than it is now, where if a release arguably in violation of the Injunction were imminent, judicial proceedings still must be invoked (not unlike, *e.g.*, *Consumers' Checkbook* and *Alley*).

[11] *E.g.*, *Pottsville Broad. Co. v. FCC*, 105 F.2d 36, 40-41 (D.C. Cir. 1939), *rev'd on other grounds*, 309 U.S. 134 (1940); *Valdez v. Schweiker*, 575 F. Supp. 1203, 1204-05 (D. Colo. 1983); *Neuvirth v. Astrue*, 2011 WL 2470676, at *5 (E.D. Wash. June 20, 2011).

[12] *FCC v. Fox Television Stations*, 556 U.S. 502, 515, 517 (2009); *MDL-1824 Tri-State Water Rights Litig.*, 644 F.3d 1160, 1194 n.29 (11th Cir. 2011); *Miami-Dade County v. EPA*, 529 F.3d 1049, 1066 n.12 (11th Cir. 2008); *Mahon v. Dep't of Agric.*, 485 F.3d 1247, 1260 (11th Cir. 2007); *Burlington N. & Santa Fe Ry. v. Surface Transp. Bd.*, 403 F.3d 771, 776-77 (D.C. Cir. 2005); *Petroleum Commc'ns, Inc. v. FCC*, 22 F.3d 1164, 1172 (D.C. Cir. 1994).

and foremost, the ACA will not make available to the public the CMS data at issue here. It makes claims data available only to "qualified entities," not the public, and seeks to foster "evaluation of … providers and suppliers," not of the government, or whether the government allows fraud, waste or abuse to go unchecked.[13] The ACA in this connection thus has relatively little to do with letting "citizens [ ] know what the *Government* is up to," which of course is FOIA's *raison d'etre*. *News-Press*, 489 F.3d at 1190 (emphasis added) (quoting *Nat'l Archives & Records Admin. v. Favish*, 541 U.S. 171, 171-72 (2004)).

The obligation of HHS to make agency records available to the public under FOIA is not supplanted by the ACA. To be sure, other laws "operate[ ] as part of the larger FOIA framework" by, for example, triggering Exemption 3 for "materials protected under other federal statutes."[14] But the ACA is not a form of "other federal statute" that exempts records from disclosure. Quite the opposite – it is an *additional* avenue, separate from FOIA, for the *release* of certain information, in designated circumstances, for a particular purpose. *See supra*, 8-9. The ACA is thus, for present purposes, all about more disclosure, not less.

For a statute to "supersede" FOIA – as would have to be held to not vacate the 1979 Injunction for reasons of the ACA's enactment – it must explicitly provide for such displacement. *E.g.*, *Grasso*, 409 F.3d at 75 (comparing 26 U.S.C. §§ 6103, 6110). Nothing in this provision of the ACA or its legislative history suggests Congress intended it to diminish or supersede the ability to obtain CMS data under the FOIA, or to somehow "ratify" the 1979

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[13] *See, e.g.*, 76 Fed. Reg. 76542 (2011); 42 C.F.R. §§ 401.707-711; *see also* RTMD Mot., 9-11. *Compare Consumers' Checkbook v. HHS*, 554 F.3d 1046, 1053 (D.C. Cir. 2009).

[14] *E.g.*, *Surgick v. Cierella*, 2010 WL 2539418, at *3-4 (D.N.J. June 15, 2010) (citing, *inter alia*, *Maxwell v. Snow*, 409 F.3d 354, 357-58 (D.C. Cir. 2005); *Grasso v. IRS*, 785 F.2d 70, 74-75 (3d Cir. 1986), and noting similar authority in Fifth, Ninth *and Eleventh* Circuits).

Injunction, as AMA contends. Nor does the fact that the government may be subject to some kind of self-oversight affect the duty to make agency records available under FOIA, which is designed as a *public* check on government. Indeed, in *News-Press*, the Eleventh Circuit rejected FEMA's suggestion that Inspector General and Senate investigations diminished the public interest in disclosure under FOIA. *See* 489 F.3d at 1194.

Rather than being some kind of FOIA substitute or usurper, the ACA's relevance here is that it further reflects how the balance of privacy and public interests has shifted in the 30-plus years since the 1979 Injunction.[15] The ACA diminishes expectations of privacy insofar as the statute and its implementing regulations *require* published reports that may, indeed, identify individual doctors, including even if they object, or claim reports are erroneous.[16] At the same time, these provisions of the ACA recognize the increased public interest in and value of disclosure of Medicare data, including that which identifies specific practitioners.

IV. CONCLUSION

For the reasons set forth in its Motion and Reply, at hearing, and herein, Dow Jones respectfully moves for an order vacating the Final Declaratory Judgment and Permanent Injunction entered in this case on October 22, 1979.

Dated: August 20, 2012

[15] *See* Dow Jones Mot., 27-28 (citing, *inter alia*, *News-Press*, 489 F.3d at 1191, 1196-97, 1202, 1205; *Washington Post Co. v. HHS*, 690 F.2d 252, 261-62, 264 (D.C. Cir. 1982)).

[16] *See* Dow Jones Mot., 9-11, 24-25 & n.9 (citing 42 U.S.C. § 1320a–1327h; 42 C.F.R. § 401.717); *see also* RTMD Mot., 9-11.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on August 20, 2012, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send a notice of electronic filing to the following:

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