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# Court of Appeals

**STATE OF NEW YORK**



In the Matter of the Application of

NYC ORGANIZATION OF PUBLIC SERVICE RETIREES, INC., LISA FLANZRAICH, BENAY WAITZMAN, LINDA WOOLVERTON, ED FERINGTON, MERRI TURK LASKY and PHYLLIS LIPMAN,

*Plaintiffs-Respondents,*

—against—

RENEE CAMPION, CITY OF NEW YORK OFFICE OF LABOR RELATIONS and CITY OF NEW YORK,

*Defendants-Appellants.*

## BRIEF FOR *AMICUS CURIAE* DR. DONALD BERWICK, MD, MPP, FRCP IN SUPPORT OF PLAINTIFFS-RESPONDENTS



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## STATEMENT OF AMICUS CURIAE

Dr. Donald Berwick, MD, MPP, FRCP, respectfully submits this amicus brief in support of Plaintiffs-Respondents the NYC Organization of Public Service Retirees, Inc., Lisa Flanzraich, Benay Waitzman, Linda Woolverton, Ed Ferington, Merri Turk Lasky, and Phyllis Lipman.[1]

The *amicus curiae* is currently president emeritus and senior fellow at the Institute for Healthcare Improvement, as well as a lecturer of Health Care Policy at Harvard Medical School. Dr. Berwick is a former Administrator of the Centers for Medicare and Medicaid Services ("CMS"), the federal agency that provides health coverage to over 100 million people, including through the oversight and administration of Medicare, Medicaid, and the Affordable Care Act. Dr. Berwick served as Administrator of CMS from July 7, 2010, to December 2, 2011 during President Obama's administration. In that role, he worked to advance CMS's missions of

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[1] No party or its counsel contributed content to this brief or otherwise participated in the brief's preparation. Dr. Berwick's counsel has discussed the timing for amicus briefs and the positions taken in this amicus brief with counsel for Plaintiffs-Respondents.

Plaintiffs-Respondents contributed money intended to fund preparation or submission of this brief, but, as noted above, did not contribute content to the brief or otherwise participate in the brief's preparation. The content and preparation was solely within the control of amicus curiae and his counsel.

strengthening and modernizing the country's health care system, and of providing access to high quality health care at lower costs.

Prior to his work at CMS, Dr. Berwick was the founder, President, and Chief Executive Officer of the Institute for Healthcare Improvement, a not-for-profit organization that advocates for organizations and communities to aim to improve patient population health and the quality of health care while reducing per capita cost.

Dr. Berwick has served on the faculties of both Harvard Medical School and the Harvard School of Public Health. A pediatrician by background, he previously served on the staffs of Boston's Children's Hospital Medical Center, Massachusetts General Hospital, and the Brigham and Women's Hospital. He also previously served as vice chair of the US Preventive Services Task Force, was the first "independent member" of the American Hospital Association Board of Trustees, and was chair of the National Advisory Council of the Agency for Healthcare Research and Quality. He also served two terms on the Institute of Medicine's ("IOM's") Governing Council, was a member of the IOM's Global Health Board, and served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry.

Dr. Berwick has published extensively on countless topics related to health care quality and improvement. He is the author or co-author of over 200 scientific articles and six books, and has received numerous awards for his contributions to the field.

As a leading authority on health care policy, Dr. Berwick has a strong interest in the outcome of this case. Dr. Berwick has studied, developed expert knowledge, and testified about the Medicare Advantage ("MA") model of delivering healthcare. He published extensively on the public policy implications of the MA program, and in particular, has analyzed the financial incentives for insurers that are inherent to MA programs, and how MA programs result in direct transfers of wealth from taxpayers to insurers with no demonstrable clinical benefit to patients.

As a leading expert in this field, Dr. Berwick respectfully suggests that this brief would be of assistance to the Court in considering this appeal.

## INTRODUCTION AND SUMMARY OF THE ARGUMENT

The core claim made by proponents of the MA healthcare model is that privatized MA healthcare plans are more efficient than traditional Medicare plans that rely on a "fee-for-service" payment structure ("the Medicare FFS model"). In essence, the claim is that the MA model provides

greater benefits to patients at reduced cost. Defendants-Appellants make this claim in the present appeal. *See* Br. at 7. But this claim is belied by the data.

Broken down to its component parts, this claim is founded on three inaccurate premises. ***First***, MA proponents claim that, relative to the Medicare FFS model, MA programs are associated with improved quality of care for individual patients. This claim is not supported by the data.

***Second***, they claim that, relative to the Medicare FFS model, MA programs align the cost of delivering care—paid for by the federal government—to the healthcare burden of both the individual patients and the aggregate overall population served. This claim is actually refuted by the data, which indicates that, as compared to FFS programs, MA programs result in overpayments to insurers. This is true even though the populations served by MA programs tend to suffer from similar or even lower health burdens as FFS populations. As explained below, these overpayments stem from MA's perverse business model, which incentivizes the over-use of diagnosis codes to make it appear as though MA beneficiaries are in poorer health than similarly-situated FFS beneficiaries, and thus require higher payments from the federal government to cover the costs of delivering care.

***Third***, proponents claim that the revenue for insurers that is generated by MA models—*i.e.*, the revenue derived from these excessive

overpayments—allows MA programs to improve healthcare infrastructure, and thus the quality and efficiency of care for patients enrolled in MA plans. However, the data suggests that most of the revenue generated from these overpayments are simply treated as increased profits for providers and plan sponsors, and do not result in better benefits, improved infrastructure, or higher-quality care for MA patients.

## ARGUMENT

### I. THE BUSINESS MODEL OF MEDICARE ADVANTAGE PROGRAMS

Medicare beneficiaries are given the option of enrolling in an MA program—where health care benefits are managed and paid by a private insurance carrier—or a program operated under the Medicare FFS model, where the federal government itself manages and pays claims. Even though MA plans are operated by private carriers, these plans are subsidized by the federal government via CMS. The business model of MA plans depend on these subsidies, and thus has been a topic for extensive debate within health care policy circles. Dr. Berwick co-authored a two-part article exposing what he dubbed the "Medicare Advantage Money Machine,"[2] spurring

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[2] Richard Gilfillan and Donald M. Berwick, *Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game*, Health Affairs, (Sept, 21, 2021), *available at*,

responses from MA advocates[3] and a further reply from Dr. Berwick.[4] The crux of the MA business model, as discussed in these articles, is described below.

Each year, MA plans submit a "bid" to CMS for payment, in which the plan sets forth the amount it expects it will need to cover costs for its average Medicare beneficiary. CMS adjusts its payments to MA plans using a "risk adjustment model" that converts a beneficiary's demographic and diagnostic information into a "risk score," meant to reflect the projected healthcare expense for an individual relative to their average health risk.

CMS uses a "Hierarchical Condition Category" ("HCC") risk adjustment system that pays a plan relative to the amount of HCCs that are created per patient in a plan's bid. Theoretically, higher HCCs are meant to reflect sicker populations. Higher HCCs thus result in higher CMS risk

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https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game.

[3] Donald Crane George C. Halvorson, *Medicare Advantage—The Emperor's Clothes: A Reply To Berwick And Gilfillan*, Health Affairs, (Aug. 17, 2022), *available at*, https://www.healthaffairs.org/content/forefront/medicare-advantage-emperor-s-clothes-reply-berwick-and-gilfillan.

[4] Richard Gilfillan and Donald M. Berwick, *The Emperor Still Has No Clothes: A Response To Halvorson And Crane*, Health Affairs, (Jun. 06, 2022, *available at*, https://www.healthaffairs.org/do/10.1377/forefront.20220602.413644.

scores, which in turn result in higher payments to cover a beneficiary's elevated expected costs of care.

Therefore, MA plans are incentivized to submit as much diagnostic information as possible to increase the amount of MA payments received from CMS. As plans code more diagnoses per patient, CMS's risk scores go up, and CMS provides more money in subsidies. As a result, increasing CMS risk scores has become part of the business model of MA plans. By submitting as many diagnosis codes as possible, MA plans access greater and greater amounts of public funds.

This payment structure—which aligns insurers' profits with increasing the number of diagnostic codes submitted for each patient—has given rise to various strategies on the part of MA plans, all of which increase overall costs. For example, some plans simply pay providers to code more diagnoses by using "pay for performance" metrics.[5] Many MA insurers use "percentage of premium" contracts to share the profits of increased risk scores with providers—a practice which, in turn, incentivizes providers to

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[5]Optum Inc., *Intense Provider Engagement, Prospective Risk Adjustment With High Intensity Provider Engagement*, (2016), *available at,* https://www.optum.com.br/content/dam/optum3/optum/en/resources/sell-sheet/Optum-Intense-provider-engagement.pdf.

increase the number of diagnoses they submit. Providers have been known to use various tactics to look for additional diagnoses that can be coded. For example, one popular strategy is to screen beneficiaries for peripheral vascular disease, which delivers an extra $2,800 per year per patient, by ordering carotid ultrasound studies, even though the US Preventive Services Task Force recommends against such screening for the general population.[6] Another technique to increase the numbers of diagnostic codes submitted by providers is for an insurer to vertically integrate—to purchase the providers outright so that they can ensure optimal coding, often using sophisticated artificial intelligence software to assist in the process.[7]

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[6] U.S. Preventive Services Task Force, *Asymptomatic Carotid Artery Stenosis: Screening,* (Feb. 02, 2021), *available at*, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/carotid-artery-stenosis-screening.

[7] CMS has itself recognized that upcoding is a significant problem with MA providers and has begun to take steps to address the issue. In January 2023, CMS rolled out new payment rules for some of the diagnostic codes that are consistently being overused, such as for diabetes and vascular disease. Because the roll-out envisions a three-year implementation period, the impact of these reforms, which are modest relative to the problem, are unknown. *See* Center for Medicare Advocacy, *Center for Medicare Advocacy Statement on Recent Medicare Advantage Payment Policies and Proposals*, (Feb. 03, 2023), *available at*, https://medicareadvocacy.org/center-for-medicare-advocacy-statement-on-recent-medicare-advantage-payment-policies-and-proposals/.

By contrast, in traditional FFS Medicare plans, healthcare providers generally code only enough diagnoses to justify the use of a specific procedure or service that the provider is seeking payment for from CMS. In the Medicare FFS model, diagnostic codes do not, without more, increase payments to providers. This difference in coding practices as between private MA and Medicare FFS plans has been shown to result in significant overpayment by CMS to MA plans relative to traditional Medicare. The Medicare Payment Advisory Committee ("MedPAC"), an independent, non-partisan legislative branch agency established by the Balanced Budget Act of 1997, documented approximately $140 billion in MA overpayments from 2008-2020.[8] A recent study estimates that MA overpayments for 2023 total approximately $75 billion.[9]

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[8] Richard Gilfillan and Donald M. Berwick, *Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game*; Health Affairs, (Sept, 21, 2021), *available at*, https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game.

[9] USC Schaeffer Center, *Overpayments to Medicare Advantage Plans Could Exceed $75 Billion in 2023, USC Schaeffer Center Research Finds)*, *available at*, https://healthpolicy.usc.edu/article/overpayments-to-medicare-advantage-plans-could-exceed-75-billion-in-2023-usc-schaeffer-center-research-finds/.

Studies have also shown that increased diagnoses codes do *not* reflect sicker patient populations, as the system was purportedly designed to capture. A recent study conducted by a team of United Healthcare Group's Optum employees (the "Optum Study") is illustrative. The authors sought to demonstrate the effectiveness of MA plans in improving care quality and efficiency, as well as in "aligning Medicare payment with the health burden of the population."[10] The study compared two separate populations of 158,156 Medicare beneficiaries, one of which was enrolled on MA plans and the other on Medicare FFS plans. The two populations were matched up in terms of prevalence of certain serious conditions (as reflected by HCCs), including heart attacks, strokes, intestinal obstructions and perforations, and leukemia. Notably, the FFS population appeared to be in poorer health, as the MA population had 14% fewer cancers and 37% fewer transplants.

However, the MA patients were coded with almost twice (1.9 times) as many HCCs per person versus the FFS population. The study reveals a stunningly high prevalence of HCCs in the MA population that are less

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[10] Kenneth Cohen, MD; Omid Ameli, MD, DrPH; Christine E. Chaisson, MPH; et al., *Comparison of Care Quality Metrics in 2-Sided Risk Medicare Advantage vs Fee-for-Service Medicare Programs*, (Dec, 21, 2022), *available at*, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2799376

severe, but yet provide opportunities for more documentation, and thus higher payment from CMS. For example, vascular disease was coded 3.6 times more often in the MA population, with just over one half of the entire MA population (50.7%) coded as having vascular disease, versus only 14% in the FFS population being coded as such. It is well-documented that MA plans maximize the vascular disease HCC by sending staff into MA patient homes with digital diagnostic devices to try and find the slightest hint of sclerosis, even where such a diagnosis has little or no clinical relevance.[11]

In sum, MA plans are incentivized to submit as many diagnoses codes as possible to create a misleading *appearance* of sicker populations that require more expensive care. These reporting incentives have resulted in billions of dollars in overpayment by CMS to MA plans as compared to traditional FFS Medicare plans.

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[11] The Capitol Forum, *Signify Health: Company Requires Clinicians to Perform PAD Test for Some Patients Even When Clinicians Don't Think it is Medically Necessary; Experts Say Data Does Not Support Performing PAD Test on Asymptomatic Patients,* (Nov. 18. 2021), *available at,* https://thecapitolforum.com/signify-health-company-requires-clinicians-to-perform-pad-test-for-some-patients-even-when-clinicians-dont-think-it-is-medically-necessary-experts-say-data-does-not-support-performing-pad-t/

## II. OVERPAYMENT DOES NOT INCREASE CARE QUALITY OR EFFICIENCY

Proponents of the MA model of care argue that overpayments from CMS are a feature, not a bug, as the larger federal subsidies ostensibly allow them to offer greater benefits to patients at reduced cost. *See* Br. at 7. But this argument is not borne out by the data. Instead, the data suggests that the vast majority of overpayments simply result in increased profits for the private for-profit insurers who operate MA plans.

### A. *MA Plans Have Not Been Proven To Improve Health Care Quality.*

MA proponents claim that MA plans result in higher quality care for patients, but this claim has never been borne out by the data.

The authors of the Optum Study reported that the MA population had 17% lower inpatient utilization rates and 11% lower emergency room use as compared to the Medicare FFS population. They concluded that the MA model is thus "associated with improved health outcomes and care efficiency."[12] As support, the authors cite to another study sponsored by Aetna which also found lower inpatient cost in MA populations.

The basic assumption underlying these studies is that a low rate of inpatient stays reflects better healthcare outcomes. But this assumption is

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[12] *Supra* note 10.

flawed and misleading. Studies have shown that MA plans depress inpatient stay figures by arbitrarily denying patients access to inpatient care, or downgrading patients to "observation status" in at least 30% of inpatient stays.[13] These downgrades are not a reflection of the kind of care the patient actually needs or the quality of patient care they actually receive; they are simply changes in an *artificial* re-classification (driven by the lower costs associated with patients on observation status) that give a false impression of lower utilization rates and thus, less-sick patients.

The studies that purport to show better outcomes for patients treated under MA plans—and, by extension, that MA plans must somehow result in higher quality care—are thus unreliable. In fact, other studies suggest the opposite conclusion, such as one study that combined observation stays with inpatient stays (thus mitigating the arbitrary categorization decisions described above) and saw a higher total for MA populations versus FFS populations.[14] Further research is required to definitively conclude whether

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[13] Richard Gilfillan and Donald M. Berwick, *The Emperor Still Has No Clothes: A Response to Halvorson and Crane*, Health Affairs, (Jun. 06, 2022), *available at*, https://www.healthaffairs.org/do/10.1377/forefront.20220602.413644.

[14] Avalere Health Data Analysis, *Positive Outcomes For High-Need, High-Cost Beneficiaries*, Center For Innovation In Medicare Advantage, (Dec.

MA plans result in better, equal, or worse quality care as compared to FFS populations. At minimum, however, the data simply does not support the conclusion that MA plans result in higher quality care.

In fact, there is evidence indicating that certain tactics utilized by healthcare providers in MA plans to cut costs result in lower quality care. A simple example is the limited network of providers available to patients under MA plans—insurers cut costs by forcing patients to their preferred "in-network" medical providers who have contracted with the insurers to accept reduced rates, lest the patient pay increased "out-of-network" rates or risk having to pay entirely out of pocket for services. Such a tactic decreases the pool of doctors a patient can choose from, which sometimes leads to patients choosing a less desirable provider for their situation.

Further, chief among insurers' cost-cutting tactics is the inappropriate use of "prior authorization," a process by which an insurer denies coverage for a medical procedure as not "medically necessary"—even when a doctor tells the patient otherwise. This process results in the patient having to either pay out of pocket for the treatment or foregoing it altogether; both options

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2020), *available at,* https://www.bettermedicarealliance.org/wp-content/uploads/2020/12/BMA-High-Need-Report.pdf.

result in the insurer minimizing its spending. MA prior authorization requirements are particularly notorious for inappropriately denying services. A recent report from the U.S. Department of Health and Human Services found that millions of denials under such requirements are unwarranted and unjustified, as evidence by the fact that 75% of denials that are appealed end up being reversed.[15] Relevant to quality of patient care, these long appeal procedures inevitably result in delays in necessary care, even when reversals occur, which is often seriously damaging to a patient's health. For example, a recent survey from the American Medical Association found that 94% of physicians reported delays in necessary treatment due to prior authorization procedures. Worse yet, 33% reported "serious adverse events" requiring medical intervention; 19% reported a "life-threatening event" or medical intervention needed to prevent permanent impairment or damage; and 9%

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[15] Christi A. Grimm, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, U.S. Dep't of Health and Human Services Office of Inspector General, (Apr. 2022), *available at*, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

reported permanent bodily damage, disability, congenital anomaly/birth defect, or death due to the delays.[16]

In sum, not only are MA proponents' claims of increased care quality dubious according to the data, but many signs point to a contrary conclusion: fewer choices for providers and lower quality care for patients.

### *B. MA Plans Do Not Align CMS Payments To The Healthcare Burden Of Populations They Serve.*

The data clearly refutes the claim that MA plans function to align the cost of healthcare, as subsidized by CMS, with the actual healthcare burdens of the populations they serve. The Optum Study, which erroneously concluded as such, is again illustrative.

Assume, for the sake of argument, that the MA population reviewed in the Optum Study has the same health burdens the Medicare FFS population that was studied.[17] For 2024, CMS projects the actual total average cost per person for the entire Medicare population—MA-covered

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[16] American Medical Association, *2022 AMA Prior Authorization (PA) Physician Survey*, (2022), *available at*, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[17] This assumption is itself suspect. There is evidence to suggest that the MA population covered by the Optum Study was actually, on the whole, healthier than the Medicare FFS population due to, as discussed above, the lower rates of cancer and transplants among the former.

and Medicare FFS-covered—to be approximately $1,200 Per Beneficiary Per Month ("PBPM").[18] But, based on CMS's risk adjustment system, as described above, the projected PBPM cost for Medicare's FFS patients is $1,026, whereas the potential MA premium is $1,379 PBPM, for a difference of $353 PBPM, or excess potential payments of $4,272 per individual on an annual basis. Across the 158,156 individuals comprising the MA population in the Optum Study, the excess payment from CMS comes to approximately $670 million annually.

In other words, all else being equal, CMS's risk adjustment system results in payments to MA plans to cover healthcare costs in an amount 34% higher than the cost for FFS patients. This discrepancy cannot be explained by the suggestion that the MA-covered population is, in general, sicker than the Medicare FFS population. In fact, the opposite may be true. But, at a minimum, the two populations studied have a comparable healthcare burden—and yet the disparities in payments exist, with greater payments

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[18] Centers for Medicare & Medicaid Services, *2023 Medicare Advantage Ratebook and Prescription Drug Rate Information*, (2023), *available at*, https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsratebooks-and-supporting-data/2023

consistently going to MA plans. It is thus impossible to conclude that MA plans align the payments from CMS to the actual cost of care.

### *C. There Is No Evidence That Excess Revenue To MA Plans Results In Improved Quality And Efficiency Of Care.*

Finally, MA advocates argue that any excess revenue MA plans receive due to CMS overpayments simply allow for improved quality of care. The data does not support this argument. MedPAC has long reported that differences in care quality between Medicare FFS and MA programs are impossible to quantify, indicating a lack of investment by MA programs in that area. Regardless, the notion that $353 PBPM in excess payments to MA plans is being used to improve quality of care is flawed.

Take, for example, the cost of electronic healthcare records ("EHR") systems, many of which include care management and quality improvement capabilities. EHR systems are estimated to cost $1,200 per user per year.[19] Spread across an average physician panel of 2,000 patients, they would add about $20 PBPM in costs. As another example, high-end care coordination costs may add an additional $30 PBPM. Even adding the cost of the MA "Quality Bonus" program, which rewards MA plans on a quality star rating

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[19] Software Path, *What Practices Look For When Selecting EHR (2022 EHR Report),* (Jan. 18, 2022), *available at,* https://softwarepath.com/guides/ehr-report.

scale, would only add an additional $36 PBPM. Together, at the high end, these costs come in at less than $90 PBPM, a figure dwarfed by the additional $353 PBPM attributed to MA plans.

If the vast majority of this $353 PBPM is not going to better care and better benefits for patients, it is reasonable to infer that the bulk of increased payments function to increase profits for providers and MA plan sponsors. At minimum, there is simply no data supporting the conclusion that the excess payments are increasing the quality of healthcare care for MA populations.

## CONCLUSION

For the foregoing reasons, Dr. Berwick respectfully submits that the core substantive claims regarding MA versus Medicare FFS Medicare plans, as echoed by Defendants-Appellants, are not borne out by the data. Rather than delivering higher quality care at lower costs, the data suggests that MA plans are being substantially overpaid at taxpayers' expense, without any demonstrable clinical benefit to patients.

Dated: January 22, 2024
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## CERTIFICATE OF COMPLIANCE

I certify pursuant to 500.13(c)(1) that the foregoing brief was prepared on a computer using Microsoft Office Word, using typeface Times New Roman, 14 pt. font, and that the total word count for all printed text in the body of the brief, exclusive of the statement of the status of related litigation; the corporate disclosure statement; the table of contents, the table of cases and authorities and any addendum containing material required by subsection 500.1(h) of this Part is 3,798 words.

Dated: January 22, 2024
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COURT OF APPEALS
STATE OF NEW YORK

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In the Matter of
NYC Organization of Public Service Retirees, Inc., et al.,

*Plaintiffs-Respondents*,

-against-

Renee Campion et al.,

*Defendants-Appellants*.

---

**AFFIRMATION OF SERVICE**

APL-2023-00086

Eric Abrams, an attorney duly admitted to practice in the courts of this State, hereby affirms under penalty of perjury that the following statements are true:

1. I am an attorney at the firm of Emery Celli Brinckerhoff Abady Ward & Maazel LLP, counsel for proposed Amicus Curiae Dr. Donald Berwick, MD, MPP, FRCP in connection with the above-referenced appeal.

2. On January 22, 2024, I caused to be served a true and correct copy of (1) the Notice of Motion for Leave to File Amicus Curiae Brief on Behalf of Dr. Donald Berwick; (2) the Affirmation in Support of same; and (3) the [Proposed] Brief of Amicus Curiae via Federal Express, by causing the depositing of a true copy thereof, enclosed in two envelopes addressed as shown below, into the custody of Federal Express for overnight delivery, prior to the latest time

designated by the service for overnight delivery.

New York City Law Department
ATTN: Chloe Moon
100 Church St., New York, NY 10007

Walden Macht & Haran LLP
ATTN: Jacob Gardener
250 Vesey Street, 27th Floor New York, NY 10281

Dated: January 22, 2024
New York, New York

EMERY CELLI
BRINCKERHOFF ABADY
WARD & MAAZEL LLP

Eric Abrams

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*Attorney for Proposed Amicus Curiae*

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STATE OF NEW YORK )
COUNTY OF NEW YORK ) SS: **AFFIDAVIT OF SERVICE**

Edward Gutowski, being duly sworn, deposes and says: I am not a party to the action, and I am over 18 years of age.

On the 22nd day of January 2024, I served 3 true copies of the within

**BRIEF FOR AMICUS CURIAE DR. DONALD BERWICK, MD, MPP, FRCP IN SUPPORT OF PLAINTIFFS-RESPONDENTS**

upon the attorneys at the addresses indicated below, by the following method(s):

| Contact | Firm | Address | Delivery Method |
|---|---|---|---|
| Chloe Moon | New York City Law Department<br>*Attorneys for Defendant-Appellant* | 100 Church Street<br>New York, New York 10007 | FedEx Next Business Day |
| Jacob Gardener | Walden Macht & Haran LLP<br>*Attorneys for Plaintiff-Respondent* | 250 Vesey Street, 27th Floor<br>New York, NY 10281 | FedEx Next Business Day |

**Sworn to me this:**
January 22, 2024

Nadia R. Oswald-Hamid
Notary Public, State of New York
No. 01OS6101366
Qualified in Kings
Commission Expires November 10, 2027

**Case Name:** IMO NYC Organization of Public Service Retirees, Inc. v. Campion
**Index Number:** APL-2023-00086
**Docket No:**