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September 5, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Room 341D-05, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: REQUEST FOR PUBLIC COMMENTS ON THE POTENTIAL RELEASE OF MEDICARE PHYSICIAN DATA

Dear Ms. Tavenner,

The Pacific Business Group on Health (PBGH) is pleased to respond to the August 6 request for comment on the potential release of Medicare physician data. PBGH strongly supports the release of physician-specific Medicare data as it is a critical input to gain a more complete picture of the care provided by individual physicians, contributing to health improvement and cost containment.

PBGH leverages the strength of its 60 member companies, who provide health care coverage to 10 million Americans and their dependents, to improve the affordability and quality of health care. As part of this work, PBGH administers a Qualified Entity – the California Healthcare Performance Information System – and therefore has in-depth experience in analyzing Medicare and commercial claims data and publically reporting information on physician performance.

This perspective informs our response to each of the areas of interest you posted in the request for comment below:

1. **Whether physicians have a privacy interest in information concerning payments they receive from Medicare and, if so, how to properly weigh the balance between that privacy interest and the public interest in disclosure of Medicare payment information, including physician-identifiable reimbursement data;**

We believe CMS can successfully balance the public and private interest in disclosing Medicare claims data for several reasons.

First, health care spending growth has become a key national concern and Medicare claims data is a core tool to manage those costs. Over the last decade, workers have seen health care costs rise over three times faster than their wages without a corresponding improvement in quality. National expenditures are expected to increase from $2.8 trillion in 2012 to $4.8 trillion in 2021[i]. This threatens both Medicare's sustainability and our nation's competitive advantage.

In the right context, claims data can illuminate opportunities to manage spending while improving or maintaining quality. For example, PBGH member employers have taken advantage of commercial claims analysis and reporting to reduce costs and improve the health of their employees. CalPERS and Anthem identified a five-fold variation in prices for knee and hip replacement surgery. By setting a "reference price", CalPERS members on average paid 26.3% less for these procedures due to hospitals reducing their prices to meet the reference price[ii]. Safeway similarly analyzed paid claims data to find that colonoscopy prices in a given area varied by eight times – after implementing a reference price, Safeway saved an estimated 35% of potential costs by encouraging employees to shop for more affordable yet quality providers[iii].

However, commercial claims from select health plans alone are inadequate to understand national and physician-specific trends in cost and quality that employers, consumers, and providers so critically need. Reliability of the information drawn from claims data increases with the volume of the claims. Since Medicare is by far the largest payer, it is the optimal source to include in paid claims analyses. CMS has already begun to release Medicare claims data to a small number of entities via the Qualified Entity program established under Section 10332 of the Affordable Care Act.

Consider an entity that has collected financial claims data from all payers in their region, including Medicare. They would be able to display the average dollar amount collected for a knee replacement by a given surgeon across all of his or her patients, adjusting for relative risk. Empowered with this information, purchasers and consumers would be able to identify the most efficient providers, potentially lowering costs system-wide.

Secondly, physicians themselves have a vital interest in the information stemming from Medicare claims to improve their practice. By revealing trends in quality and resource use across individual practitioners and groups, those physicians can understand how they perform relative to their peers and identify high performing peers who may be good sources for referral. In a payment system that increasingly rewards value over volume, analyzing claims becomes more important to better manage resources.

Medicare has incorporated some total cost of care information for Medicare fee-for-service patients into their CMS Physician Quality and Resource Use Reports that are confidentially delivered to providers. However, more rich information could be reported by releasing the claims to entities that can combine them with other sources of data, creating a more accurate and complete representation of physician performance. The public would also benefit from such reports for the purposes of selecting providers and services that perform more affordable, quality care. The privacy concern is minimal as Medicare rates today are based on standardized fees that are already available to the public.

Third, there are existing methods to balance concerns about data inaccuracy or misinterpretation of the data while also making critical information available to the public. CMS should expand the Qualified Entity program to route Medicare data through trusted entities that have experience handling and interpreting claims data in ways that benefit their audiences.

Simply releasing Medicare claims information to the public could lead to misinterpretation of the data and would not deliver meaningful information. An intermediary is needed to "interpret" the data for the public, for the providers and industry as a whole. Such interpretation would allow for: i) per capita adjustment, ii) any adjustments needed based on geography, payer or patient mix, iii) organizing information in a meaningful way to be used, and iv) ensuring data is used carefully to avoid unintended consequences such as higher cost of a service being interpreted to mean it is also of higher quality.

Medicare Qualified Entities (QEs) and other entities with adequate expertise and safe data handling processes are best suited to interpret claims data for the public. QEs must demonstrate expertise in quality and cost measurement, risk adjustment, combining data from multiple payers, correcting measurement errors, and implementing rigorous data privacy and security policies. These entities have the tools to convert raw claims data into information that is useful for consumers, providers, purchasers and other stakeholders seeking to improve health care.

Consider the following selected use cases for which routing Medicare claims data through QEs and other experienced entities will serve a critical need for beneficiaries, providers, purchasers and policymakers:

Key Audience	Role of Intermediary in Interpreting Claims Data
Cost-sensitive Medicare beneficiaries	Organizes cost data into meaningful information products such as episode bundles (e.g. "price of a cataract treatment") so that the beneficiary could compare their expected costs
Cost-sensitive commercial beneficiaries	Provides a reference point for what should be a "reasonable" fee for a particular service by presenting the range of prices and quality scores for that service
Accountable Care Organizations / Patient-Centered Medical Homes	Provides insight into relative resource use and performance within a provider group across the entire patient population to help entities manage cost and quality
Individual physicians seeking to maximize performance	Aggregating multiple data sources to produce complete, risk-adjusted picture of performance relative to peers
Private and public purchasers, policymakers	Demonstrate where physician practice patterns cannot be explained by patient acuity or differences in care quality to inform the design of interventions

2. **What specific policies CMS should consider with respect to disclosure of individual physician payment data that will further the goals of improving the quality and value of care, enhancing access and availability of CMS data, increasing transparency in government, and reducing fraud, waste, and abuse within CMS programs;**

CMS should release the Medicare claims data through intermediaries who can confirm that information products developed from the claims data will be useful to patients, providers, purchasers and payers to help them make informed, value-based decisions about seeking and delivering care. Medicare should release the full set of claims data, including allowed amounts (total paid by Medicare and the

beneficiary), for the purposes of ascertaining both the cost and the quality of services and presenting that information to the public. Entities will require the full set of claims as opposed to just Part B as many episodes of care involve different portions of hospital, medical and drug coverage.

QEs already receive Part A, B and D data and are charged with publically reporting information on provider performance using a set of measures approved by consensus. Policies built around the QE program are a good place to start. However, we recommend certain adjustments be made to the QE policies to ensure Medicare data is more available and useful for the public:

- Allow access to Medicare claims data by capable entities beyond the current QEs. CMS should reconsider the mandate of three years experience in all aspects of claims data and measurement to be eligible for the QE program.
- Allow broad use of the data for purposes consistent with the Affordable Care Act such as pay for performance, public reporting, provider network contracting, quality improvement, and provider performance incentive activities. This would better leverage the data and put it in the hands of more providers, consumers and researchers for improvement and transparency.
- QEs should be allowed to generate revenue for data analytics and performance improvement support services. Public reporting has the opportunity to galvanize provider interest in improvement and QEs need the support to be able to extend their analytic capabilities.
- Expand the ability for QEs to test measures with the obligation to report once the methodology is sound to ensure the measure does not have any problematic properties. For example, QEs must take adequate time to test and appropriately refine each measure based on the unit of accountability, attribution methods, outlier methodologies, benchmarking, and risk adjustment, among other aspects.
- Ensure Medicare data is provided to the QEs in a timely manner, consistent with the commercial market. Currently, the lag in Part D data is 18 months which is a year beyond the timeframe of commercial payers.
- Publically reported results on provider performance should be integrated into Physician Compare so that individual practitioner-level results are available to all.

Simply disclosing individual physicians' annual Medicare reimbursement payments will be inadequate to further goals of improving the quality and value of care. Thus, we encourage CMS to expand and build upon the QE program so data is put to use to advance health and health care improvement.

3. The form in which CMS should release information about individual physician payment, should CMS choose to release it (e.g., line item claim details, aggregated data at the individual physician level).

Full line item claim details, including allowed amounts, should be released to more QEs in a timelier manner so they can incorporate this data into measures and products for public and non-public uses. Without the full set of claims information, entities will be limited in their ability to combine the data with other sources and to analyze and interpret the data in a meaningful way.

In the request for comment, CMS provided the example of a request for information about annual Medicare reimbursement payments to individual physicians. However, annual reimbursement data aggregated at the individual physician level would not be immediately useful to the public unless it is paired with other information to put it in context, such as the volume of Medicare patients each physician sees. Cost data should be combined with quality data or presented in such a way that raises the importance of considering quality in decisions about providers, treatments and health care services.

Policymakers may be able to use aggregated physician reimbursement data to identify fraud and abuse cases, but payment data alone would not be useful to the public to advance quality and the value of care.

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We believe that the release of Medicare data to Qualified Entities adequately protects physicians' interest in the privacy and accuracy of their information and provides essential information to improve the cost and quality of health care.

If you have any questions, please contact Bill Kramer, Executive Director for National Health Policy or Alana Ketchel, Senior Manager.

Sincerely,

David Lansky
President & Chief Executive Officer

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[i] Centers for Medicare and Medicaid Services, Office of the Actuary, *National Health Expenditure Projections, 2011-2021* (Washington: CMS, 2012), available online at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

[ii] CalPERS. "Hips and Knees Reference Based Pricing Evaluation". CalPERS Pension & Health Benefits Committee Agenda Item 7. June 18, 2013. http://www.calpers.ca.gov/eip-docs/about/committee-meetings/agendas/pension/201306/item-7.pdf

[iii] Campagna, S. Comments re: OCIIO-9992-IFC. Safeway. September 17, 2010. http://www.dol.gov/ebsa/pdf/1210-AB44-0207.pdf