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RE: Implementation of Section 10332 of the Patient Protection and Affordable Care Act, Availability of Medicare Data for Performance Measurement

The Consumer-Purchaser Disclosure Project is a collaboration of leading national and local employer, consumer, and labor organizations committed to improving quality and affordability of health care through the use of performance information to support consumer choice, payment, and quality improvement. Our support for transparency of provider performance grows out of urgent concerns about quality, safety, and cost and consumers having to make health care decisions “blind”. Other industries provide comparative information on performance to enable consumer decision-making. Health care should be no different. In fact, there is a greater imperative for releasing Medicare data to the public – patients’ lives and well-being are at stake. CMS should move swiftly to making this information available to qualified entities. In fact, we strongly encourage CMS to do this prior to the deadline set in the law.

The availability of Medicare data for performance measurement is key to achieving a system that uses value to inform decisions about care and payment, both in the public and private sector. It is a public good that should be shared broadly with qualified entities, as long as protections of patient privacy and data security are in place, and there should be flexibility to promote innovative measurement activities. What follows are recommendations for making this data available.

Qualified Entity Requirements – The law delineates requirements that must be fulfilled for a qualified entity to receive the data. Organizations that have experience presenting performance information to consumers would be natural recipients for the data. These include Chartered Value Exchanges, Aligning Forces for Quality, consumer organizations, employers, health plans, and private vendors. It also leaves discretion to the Secretary to include other requirements, “such as ensuring security of data”. When doing so, the Secretary should only consider matters of the same general nature as “ensuring data security.” This might include requirements to protect the privacy of Medicare beneficiaries or forbid the data to be used for marketing to providers.

Fostering Public-Private Partnerships – The Patient Protection and Affordable Care Act includes a wide array of provisions intended to improve the health care delivery system and control costs including: public reporting of cost and quality, value-based purchasing, accountable care organizations, and comparative effectiveness research. Many parallel efforts in these areas are occurring in the private sector. Having adequate data for valid and reliable reporting is paramount to the success of these initiatives; combining Medicare with private

sector data will greatly contribute to the robustness of these efforts. We have seen in the Better Quality Information pilots that CMS fee-for-service and commercial PPO data can be successfully combined. We must quickly build and expand on that and other work.

Balance the need for standardization with the need for innovation – We support the use of measures that, as the law delineates, would be “more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures”. The Secretary should exercise flexibility when assessing whether measures that are not endorsed by NQF or other similar entities should be applied to Medicare data. Standardization of measures facilitates comparisons across different providers, allowing consumers access to more useful and meaningful information. However, the current portfolio of nationally endorsed measures is too limited to meet the needs of consumers; there are, for example, too few physician-level measures of health outcomes, functional status, efficiency, resource use, etc. It’s therefore critical that the Secretary leaves room for innovation -- recognizing that performance measurement is an evolving field. Allowing for measures like reporting volume by procedure by physician for various high-risk procedures where there is reason to believe that volume (i.e., experience) is a partial predictor of outcome is imperative. Flexibility will also be vital to addressing consumers’ diverse information needs that stem from demographic and geographic differences, and varying nature of local delivery systems. We also recommend the use of non-NQF endorsed measures follow the criteria in [The Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs](#) (the “Patient Charter”), which is supported by a variety of stakeholders. When consulting with appropriate stakeholders, as required under the law, the Secretary should ensure that consumers and purchasers are a part of that. Additionally, we think it is important that CMS consider measures from a variety of measure developers and not just from those being measured.

Reporting of information – Information should be reported at the most granular level whenever feasible (e.g., individual physician level, not just the practice group level) to support consumer decision-making and quality improvement. For example, patients need information on individual physician performance. Physicians may operate as part of a team, but patients often will still select individual physicians. Additionally, the information should facilitate comparisons across relevant providers and not allow variations across providers to be unduly obscured. For many consumers, measurements with misclassification error of up to 20% may be preferable to no measurements. We believe reporting “in an aggregate form” refers to the requirement that qualified entities aggregate Medicare data with claims data from other sources.

Linking patient records – Patients may see multiple providers in the course of their care, particularly patients with chronic conditions. To get a comprehensive picture of the care that a patient receives, CMS must make it possible for information on how the patient was cared for across different providers to be linked, but at the same time create patient records that are de-identified to maintain privacy, permit lawful release, and avoid HIPAA complications.

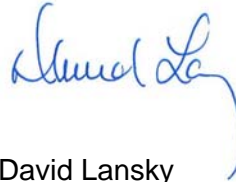
Provider engagement encouraged – As outlined in the Patient Charter, we support involving those being measured in the development and reporting process. In particular, engagement of providers early in the process helps garner their support and can reduce issues when reports are released. We support having a reconsideration process for issues related to integrity of data and reporting. Providers should have the opportunity to present information to support what is believed to be inaccurate results; however, it should be done within a reasonable timeframe so as not to become a barrier to publicizing results.

We believe fostering value-based decision making is critical to improving the quality and affordability of health care. Releasing Medicare data to support these initiatives is important for both the public and private sector. We appreciate your consideration of our recommendations. We would like to continue to work with you on implementing reporting initiatives in ways that benefit consumers, provide meaningful and valid information, and improve the quality of care.

Sincerely,



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