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Robert Wood Johnson Foundation

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Don Berwick, MD
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5059-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically to: http://www.regulations.gov

RE: Robert Wood Johnson Foundation comments on Availability of Medicare Data for Performance Measurement –File No. CMS-5059-P

Dear Dr. Berwick:

The Robert Wood Johnson Foundation (RWJF), the nation's largest philanthropy devoted exclusively to health and health care, respectfully offers these comments and recommendations regarding the proposed rule on Availability of Medicare Data for Performance Measurement–File No. CMS-5059-P.

Our nation faces an urgent need to improve the quality of health care while at the same time making the delivery of that care less wasteful, more efficient and affordable. A basic, critical ingredient in that high value health care imperative is information–information about the cost and quality of care. Health professionals, purchasers, consumers, patients and others need timely, accurate, helpful information on cost and quality to make smart decisions that, together, will help the nation achieve high value care. Alternatively, without that information, we will not achieve the goal of maximizing value in health care. In that spirit, we strongly support this new CMS authority to release Medicare data for performance measurement and public reporting purposes provided in Section 10332 of the Patient Protection and Affordable Care Act (ACA). Many have waited a long time for access to these data, so the pending release is an extremely welcome development.

As you know, RWJF is firmly committed to helping improve the quality and cost of American health care. As part of that commitment, RWJF supports 16 regional alliances across the country in the Aligning Forces for Quality initiative. Those regional alliances are helping their respective communities lead the nation toward improved health care quality and cost.

These 16 alliances all have strong and extensive experience constructing measures and publicly reporting measures for their local markets. When those alliances started their Aligning Forces work, only a handful systematically constructed and publicly reported performance measures on ambulatory care. Now, all 16 do. These alliance reports are, for the most part, all based on private payer administrative claims data. Several use state provided Medicaid data. Several also use or integrate data from clinical sources. Currently, RWJF support helps many of the 16 maintain this public reporting capability. To date, except for presenting inpatient based measures from Hospital Compare, most of these alliances do not, obviously, include Medicare data in their reports as they have not had access to that important data.

The proposed rule which details how CMS will exercise this data release authority is a thoughtful approach which discharges the statutory obligation while balancing the need for release of these data with the equally important need to protect beneficiary privacy. Again, though, access to these data is extremely important and could be a powerful assist to a variety of entities nationwide in their effort to promote high value care in both the private and public sectors–entities like the Aligning Forces alliances. We as a nation have an outstanding opportunity to use this unique data resource to support that urgent high value imperative. It is important, then, that CMS calibrate this rule to ensure the data maximally fulfills that potential. Given that importance, we believe the CMS release of the Medicare data should:

- **Maximize availability and minimize barriers**. CMS should work to get these data into the hands of entities reasonably experienced with handling data that will partner with CMS in the common goal of achieving high value care in the public and private sectors. Once CMS puts these data in the hands of those experienced entities, it should err on the side of maximizing availability of the data and minimizing barriers to use.

- **Promote innovative uses of the information**. These data used for publicly reported metrics have tremendous potential to drive high value oriented innovations. The release should promote innovative use of the data and guard against stifling that innovation with exuberant oversight.

- **Maximize transparency**. These data will only be helpful if they are used widely by key health care decision-makers. The release should promote maximal health care information transparency.

- **Be timely**. In order for decision makers to use these data to help the nation work rapidly toward high value health care, they need timely data. They need the freshest possible data, and they need it in usable, iterative cycles. Relatively old or stale data may be viable for research purposes; its utility, however, to help promote high value decision making and quality improvement is limited.

- **Ensure affordability**. These data have the potential to enhance the CMS goal of moving toward high value care and promoting value based purchasing. CMS should ensure that these data are affordable by those key marketplace allies who are similarly working toward those ends.

Recommended adjustments to the proposed rule:

Given the general points above, we have the following specific recommendations that would strengthen and improve the proposed rule:

1. *Broad release and minimized barriers.* CMS should release these data to the maximum extent possible under the law, consistent with adequate protections for beneficiary privacy and data security. The proposed rule allows for release of the data to a successfully applying Qualified Entity (QE) that meets a range of eligibility, operational and governance requirements and agrees to pay the CMS data fee. We strongly encourage CMS to balance the need for a rigorous process to identify QEs with the practical need for broad release of these data. Generally, CMS should ensure that those QEs that receive the data have demonstrated appropriate experience and capacity to measure and report results using this sort of data. CMS should then focus on penalties for those very few entities that might be irresponsible with the data–which will be the extreme exception–rather than create an elaborate and potentially onerous system that seems to presume mismanagement of the data. The proposed rule in some ways seems framed by a fear that the released Medicare data may in some way be harmful to providers. Current public reporting experience for Aligning Forces and other initiatives in dozens of regions across the country demonstrates that providers have generally collaborated in the measurement and reporting process with consumers and purchasers to make quality and cost information public to everyone's benefit. Specifically:

    - **The requirement that a QE demonstrate expertise and sustained experience of three or more years could be an unnecessary barrier to safe, useful release of the data**. For example, the 16 Aligning Forces alliances as well as an increasing number of other regional entities across the country are publicly reporting performance measures constructed from private commercial plan data. Most of these reporting leaders, however, have not been public reporting such metrics for a full three years. An arbitrary three year experience requirement would likely disqualify a number of otherwise potentially suitable QEs.

    - **The proposed rule seems to require that a QE have a full, rigid, in-house array of capability which could needlessly disqualify an otherwise perfectly suitable potential QE**. Many of the entities currently reporting measures contract for some services to assist them with the measurement and reporting effort. Nevertheless, these reporting entities have proved to be careful stewards of that private data.

    - The proposed rule sensibly requires the QE to allow for a review and reconciliation process of constructed measures with affected providers and suppliers. QEs, however, likely will be working to help CMS achieve wide transparency of information constructed from these data to promote high value decision-making. This review process could be cumbersome, so **CMS should assist QEs with a centralized or streamlined review and reconciliation process**, to the extent possible.

2. *Potential innovation.* The Medicare data has the potential to promote an array of innovation that could accelerate progress toward high value care. As the Department of Health and Human Service and the Department's Chief Technology Officer, Todd Park, are showing through the HHS Health Data Initiative–it is important to release data, of course. It is, however, even more important and powerful to make the data available in ways that others can readily use it to add value. The proposed rule, unfortunately, misses some potential opportunities to promote innovative uses of the data and in some instances may hinder innovation. Specifically:

   - We strongly support the proposed requirement that QEs publicly report measures constructed from these data. At the same time, public reporting alone of the measures constructed from these data will not be sufficient to promote high value care. The proposed rule does not explicitly or necessarily prevent the use of the measures for activities like payment reform, but it does not explicitly allow it either. Section 10332 of the ACA, similarly, does not preclude other uses of the measures constructed from these data. The proposed rule, however, does include some fairly severe statements about potential misuse of the measures. **The proposed rule should explicitly allow for use of measures constructed from these data in payment reform efforts and other activities designed to promote high value care**–not just public reporting.

   - **The proposed rule should explicitly allow for integration of data from both claims and clinical sources**. The proposed rule requires that QEs have the ability to combine the Medicare data with data from other sources. The proposed rule, however, explicitly seems to include other claims data sources yet does not explicitly include data from clinical sources. Clearly, national efforts to promote meaningful use of health information technology envision a robust use of clinical data integrated into measurement construction. The rule for use of Medicare data should as well.

   - We strongly support the requirement that QEs use standard measures endorsed by the National Quality Forum (NQF). We also, however, acknowledge that the field still does not have sufficient measures to provide result and outcome oriented information that consumers and purchasers, for instance, need to make good care decisions. In fact, locally developed measures are often important to garner physician acceptance of the measurement effort. Locally developed measures are also often the proving ground for measures that ultimately go to NQF for endorsement. We certainly support the flexibility for alternative measures provided in the proposed rule. The proposed requirements, however, for a formal comment and rule-making process in order to use innovative measures is onerous and could chill use of these data for that sort of needed measurement innovation. Further, these proposed requirements regarding alternative measures could also inadvertently establish a potentially confusing "near-endorsement" alternative to the NQF endorsement process for those alternative measures that are not quite NQF endorsed yet nonetheless use Medicare data. **The rule should allow for flexibility in the use of the data for alternative measures without establishing an entirely new cumbersome and confusing measure approval or pseudo-endorsement process.**

- **The rule should streamline the process for approving measure and reporting innovation**. The proposed rule also requires that a QE obtain approval in advance for the proposed measures it will construct with the data as well as a proto-type of the report it will use. If the QE, however, needs to make adjustments to that list of measures or the reporting format, it must obtain new CMS approval in order to make those changes. It seems likely that a QE will need to make a variety of reasonable adjustments to the measures it constructs or improvements and enhancements to the public reports it produces. In fact some Aligning Forces alliances are on third, fourth or fifth report versions that they have improved iteratively based on input from many different stakeholders and technical advice. The requirement for subsequent approvals for each of these improvements is a chilling barrier to smart and safe use of the data that perhaps CMS could lower.

3. *Transparency.* CMS should maximize the availability of the Medicare data where possible and not limit the data release to a single QE in a particular geographic area, allowing it to have sole access to the data. These data are a national and public resource. They should be available to as many QEs in a market as possible. Specifically:

    - **The rule should allow different QEs to produce reports based on the Medicare data in the same geographic market**. Consumers and other decision makers can certainly decide which presentation in their market best serves their individual purposes.

4. *Timely, fresh data.* While the Medicare data have tremendous potential to promote and accelerate work toward high value care, the utility of the data decreases markedly if the data are old or stale. For instance, a number of Aligning Forces alliances receive claims and clinical data from private and Medicaid sources that would be much newer and fresher than the Medicare data proposed here. Specifically:

    - **The rule should provide for the freshest Medicare data possible provided as frequently as possible**.

5. *Affordability.* Medicare data are unique national resources with great potential to promote and accelerate work toward high value care. Most QEs that will be using the data for public reporting purposes will be assisting the nation and CMS in that effort toward high value care. Those QEs will, in essence, be assisting beneficiaries and taxpayers in the public effort to improve the value of care. Consider, again, that an increasing number of entities prepare public reports, including all 16 of the Aligning Forces alliances. Most of those receive private commercial plan data. Several receive Medicaid data. In none of the 16 Aligning Forces instances do the commercial plans charge fees for the private data. Similarly, none of the states charge for the Medicaid data. Further, a number of the commercial plans also provide technical assistance to the alliances with regard to the data, also without charge.

   The Aligning Forces experience presents the somewhat ironic scenario of the private sector and states assisting these alliances in the effort toward high value without charge, while the federal public sector would be imposing a relatively large and, in many instances, arguably exorbitant and chilling fee for similar data and assistance. Clearly, Section 10332 requires that CMS charge for the cost of pulling the data, but given the role the QEs will play as a CMS partner toward high value for beneficiaries, the fee should be limited to the cost of pulling data, alone. If, however, the fee remains as proposed, it will likely be well beyond the point of affordability for nearly all 16 Aligning Forces alliances and presumably other similar entities.

   - **The proposed fees are too high for many otherwise potentially viable and helpful QEs**. Private plans currently are not charging potential QEs for private claims data. States do not charge potential QEs currently for Medicaid data. QE's would be partners with CMS–helping CMS and the nation achieve high value care. CMS should minimize the fees charged for these data that QEs will in turn use to create publicly available information that helps improve the cost and quality of care for Medicare beneficiaries.

   - Further, **CMS should also consider a sliding scale fee structure** depending, for example, on a non-profit value focused QE mission. CMS could also make a fee allowance for those QEs that pay particular attention to racial, ethnic and primary language care disparities in the measures they select and publicly report–particularly if such QEs focus on stratifying, for instance, reported metrics by race, ethnicity and primary language.

Thank you for this opportunity to comment. We appreciate your leadership of this critically important effort to put this national resource to work improving health and health care across the nation. Please contact Dr. Michael Painter at 609-627-7659, with any comments, questions or concerns.

Sincerely,

John R. Lumpkin

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