



Sound Policy. Quality Care.

September 27, 2010

Donald Berwick, MD, Administrator
Centers for Medicare and Medicaid Services
Mail Stop C5-19-16, 7500 Security Blvd
Baltimore, MD 21244-1850

Re: Availability of Medicare Data for Performance (September 20, 2010 Listening Session on Section 10332 of the Patient Protection and Affordable Care Act)

Dear Dr. Berwick,

On behalf of the undersigned members of The Alliance of Specialty Medicine, a coalition of 11 medical societies, we appreciate the opportunity to offer feedback on Section 10332 of the Patient Protection and Affordable Care Act (the Affordable Care Act), which requires the Secretary of the Department of Health and Human Services to make claims data available to qualified entities for the evaluation of the performance of providers on measures of quality, efficiency, effectiveness, and resource use. The Alliance supports efforts to help physicians better understand the quality and cost of their care and to provide them with tools that will allow for the continuous improvement of care. However, we caution CMS to move carefully in implementing programs that result in public reporting of performance data and that rely solely on claims data to make such determinations.

Under the Affordable Care Act, the Secretary must make Medicare Parts A, B, and D claims data available to qualified entities for performance measurement purposes by January 1, 2012. The Act includes specific requirements to which a qualified entity requesting data must adhere. Our comments are categorized according to these requirements:

1) Qualified entities must submit a description of the methodologies it will use to evaluate the performance of providers and suppliers;

The Alliance appreciates the level of transparency offered under this provision, and encourages CMS to develop, in consultation with clinical experts and other relevant stakeholders, standardized minimum requirements that qualified entities must adhere to in order to ensure that analyzed data is valid, reliable, and consistent. At a minimum, measures need to be based on sound science and must take into account not simply cost, but also quality.

2) Use standard/endorsed measures, or alternative measures if the Secretary so determines;

We continue to believe that physician measures used under this program should be limited to those that have been developed by relevant clinical experts under a transparent, consensus-based process and subsequently vetted and endorsed by the National Quality Forum (NQF). This requirement is critical to ensuring that entities use a common set of measures, which have been properly evaluated for fairness and accuracy, and which can be aggregated and compared across broad populations for meaningful analysis. If CMS is to permit the use of alternative

measures under this program, these alternative measures should be used only on a provisional basis and when systematically vetted measures as described above do not exist. The Secretary should require that these provisional measures be endorsed by the NQF within a reasonable time frame (e.g., 12 months) if they are going to continue to be used under this program. Standardization of measures will help minimize the use of multiple varying sets of similar measures, minimize confusion among both patients and physicians, and minimize the administrative burden of collecting data so that physicians can focus more time on providing high quality care.

3) Include data made available under this subsection with claims data from other sources in the evaluation of performance of providers of services and suppliers;

If eligible entities are to combine private payer data with public payer data, it is critical that the same analytic standards and safeguards apply to both sets of data. Measures applied to private payer data must come from the same standardized set as those used under Medicare (i.e., developed through a consensus-based, physician-led process). Analytics—including risk adjustment and attribution methodologies--- should also adhere to a consistent, reliable, and previously agreed upon formats. Processes must be put in place to ensure the seamless integration of private payer and Medicare data.

When data is combined from various sources, it is also critical that performance analyses remain transparent about the sources of the data and the mechanisms used to combine that data.

4) Only use data made available, and information derived from, an evaluation of the performance of providers and suppliers for the reports required by this provision;

We appreciate that the legislation places limitations on the data that qualified entities can use in its performance reports. However, we request that CMS take into consideration the increasing use of registries and other clinical databases that allow for the collection of more robust data. At some point in the near future, and under a standardized, regulated process, qualified entities should also be permitted to incorporate non-administrative data sources into their reports since such data helps paint a more accurate picture of the quality of care being provided.

5) Include in the reports an understandable description of the measures, risk adjustment methods, physician attribution methods, other applicable methods, and data specifications and limitations;

This provision is critical to ensuring that the public, as well as the physicians being measured, understands the methodological techniques used to make determinations about physician quality and effectiveness. Since many of these techniques are often methodologically complex, qualified entities should take great care to ensure that explanations are easily digestible by both physicians being measured and the average consumer relying on such reports. It is especially critical that public reports include a clear description of the limitations of the data and that physicians have an opportunity to include their own commentary about a performance evaluation alongside any public reported data.

6) Receive prior review by the Secretary of the format of proposed reports;

The Alliance requests that the Secretary work with physician experts and other relevant stakeholders to determine minimum appropriate standards for reports. The format of such

reports should be relatively consistent across qualified entities and should result in the clear and comprehensible presentation of data and the analytic mechanisms used to derive that data.

7) Make the information available confidentially, to any provider or supplier prior to the public release of such report;

We greatly appreciate that physicians will have the opportunity to confidentially review data prior to it being released to the public. It is just as critical that physicians also are given an opportunity to discuss with the performance evaluator any questionable determinations and correct any errors prior to the data being released to the public. Physicians should be given at least one month to review data prior to public reporting. CMS, working with qualified entities, should announce review periods through a CMS press release to give the widest notice that it is occurring. We also strongly believe that physicians should have the opportunity to include comments in the public report describing why he/she believes the measure results came out as they did. Furthermore, it is imperative that an appeals process be made available to physicians who feel they were inaccurately measured prior to the public release of data.

8) Only include information on a provider of services or supplier in aggregate form.

The Alliance is very supportive of this provision, especially when it comes to public reporting, since many measures do not produce adequate sample sizes to allow for fair or accurate determinations of individual physicians. As CMS continues to work with stakeholders to test the most accurate ways to measure physician performance, we urge the agency to encourage the use of broader, less specific analyses.

The Alliance of Specialty Medicine appreciates the opportunity to offer these comments and looks forward to continuing to work cooperatively with CMS in order to address these important issues. If you have any questions about our comments and recommendations, please contact Rachel Groman, MPH, at 202-628-2072 or rgroman@neurosurgery.org.

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