September 5, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: *Physician Data Comments*
Physician_Data_Comments@CMS.hhs.gov
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for public comments on the potential release of Medicare physician data

Dear Sir or Madam:

AARP appreciates the opportunity to comment on the potential release of Medicare physician data. Medicare physician data are a critical element in drawing a meaningful picture of physician performance across a clinician's Medicare practice. The ability of the program to evaluate health care quality and how efficiently health care resources are used, as well as the ability to base payment, contracting decisions, and decision support for patients, rests on the availability of physician data.

As Medicare becomes an increasingly proactive purchaser of health care services, its leadership role in moving health care to a value-based system becomes more important. Medicare's payment policies influence policies in the private sector, as do the measures it selects to base provider payment. In addition, people on Medicare require affordable and high quality services. Full transparency through public release of all relevant data, including physician data, is essential for a vibrant, effective, and competitive marketplace in Medicare. Thus, the program itself, the people it serves, and the public at-large, have a vested interest in understanding how Medicare dollars are used by physicians and other health care providers.

In June 2008, AARP joined with other consumer and purchaser groups to file an amicus curiae brief in support of Consumer CheckBook/Center for the Study of Services' appeal to require the U.S. Department of Health and Human Services to release physician-identified Medicare claims (Amicus Curiae Brief of AARP, et al., filed in *Consumers Checkbook Center for Study of Services v. HHS*, 554 F.3d 1046 (D.C. Cir. 2009).

In this brief, we argued:

> *"Transparency of health care quality and cost information is (also) essential to improving oversight of the federal government's operations and activities, particularly its use of Medicare funds. As the agency responsible for administering health coverage for 43 million Medicare beneficiaries, HHS has the obligation to*

assure taxpayers and the public that Medicare spends its funds appropriately and efficiently."

In addition to improved oversight, we also argued that transparency of health care quality and cost information encourages providers and health plans to deliver high quality care; helps consumers make informed decisions about their care; and reduces health care spending. Finally, we argued that failure to release physician claims data undermines CMS's efforts to pursue value-based purchasing strategies. In our view, these arguments remain just as relevant and timely today as they were in 2008.

The recent court decision vacated the injunction the Department of Health and Human Services has relied on since 1979 to withhold public release of individual physician data. The request for comment acknowledges the consequences of not having this information available have become even more dire since the initial injunction. AARP believes the compelling need for public access to physician data far outweighs privacy concerns of physicians. Likewise, we strongly believe the public has a right to know how public funds are used by Medicare participating physicians. Therefore, we urge CMS to act quickly and decisively to release physician-level data.

AARP believes it is in the public interest to create a database that is searchable and permits analyses based on geography, condition, procedure, as well as patient or physician characteristics. The data should be fully disaggregated, for example, by individual claims, to conduct measurement of performance at the individual physician level. We recommend CMS develop the database to allow for a wide range of requests of all or parts of the data, and to respond to such requests quickly and inexpensively. Lastly, the need for this information must be balanced with the need to protect beneficiaries' privacy. Data should be accessible, so long as the independent analysts have the capacity to ensure patient privacy will not in any way be violated, personal health information will remain confidential, and the requester's analytic methods be fully transparent.

AARP thanks you for re-examining data transparency in light of recent legal developments. We look forward to working with you in ensuring beneficiaries and the public have the information they need to make informed care decisions. If you have any questions or comments, please contact Andrew Scholnick of our Government Affairs staff at ascholnick@aarp.org or 202-434-3770.

Sincerely,

[redacted]

David Certner
Legislative Counsel & Legislative Policy Director
Government Affairs

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AdvaMed
Advanced Medical Technology Association

Submitted electronically via Physician_Data_Comments@cms.hhs.gov

September 5, 2013

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS Request for Public Comments on the Potential Release of Medicare Physician Data

Dear Administrator Tavenner,

The Advanced Medical Technology Association (AdvaMed) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) request for public comments on the potential release of Medicare physician data.[1]

AdvaMed member companies produce the medical devices, diagnostic products and health information systems that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatments. These products and services improve patient care quality. In addition, they often improve efficiency by reducing the lengths of stay, allowing procedures to be performed in less intensive and less costly settings, providing early detection of disease and infections, and improving the ability of providers to monitor care, among other benefits. AdvaMed members range from the largest to the smallest medical technology innovators and companies.

While AdvaMed does not take a position on the broader question of the release of physician Medicare reimbursement payments generally, we believe CMS is presented with a unique opportunity to develop and implement an important policy that would protect Medicare beneficiaries when they receive care from physicians who may earn significant financial incentives by participating in an accountable care organization (ACO) under the Medicare Shared Savings Program (MSSP), the Pioneer ACO or Advanced Payment ACO programs, or in bundled payment initiatives.

For the reasons discussed below, AdvaMed believes the Secretary of Health and Human Services (HHS) should publicly disclose shared savings or gainsharing amounts earned by physicians in

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[1] CMS, Request for Public Comments on the Potential Release of Medicare Physician Data, August 6, 2013, available at http://downloads.cms.gov/files/Request-for-Public-Comment-rePhysician-Data-8-6-2013.pdf.

ACO programs and bundled payment initiatives. Specifically, we believe CMS should require ACOs (already required under 42 CFR § 425.308) and participants in the bundled payment initiatives to publicly disclose aggregated amounts of shared savings and Gainsharing rewards that the physicians participating in those programs receive. The ACOs and participants in the bundled payment initiatives should also release information about the methodology they use for distributing shared savings and Gainsharing rewards among participating physicians and other practitioners. Furthermore, CMS should publicly disclose, or require that ACOs or bundled payment initiatives publicly disclose, physician-specific information on the shared savings and gainsharing amounts that physicians receive as a result of their participation in the programs. AdvaMed does not take a position on the broader question of whether CMS should disclose personally-identifiable information on the total amount of Medicare payments made to a physician.

CMS' request for comments asks for input on three specific questions. We respond to each one in turn below.

I. Background

In 1979, the United Stated District Court for the Middle District of Florida issued a permanent injunction which broadly prohibited the Secretary from disclosing "any list" of annual Medicare reimbursement amounts, "for any years," if disclosing such information "would personally and individually identify providers of services under the Medicare program who are members of the recertified class."[2] On May 31, 2013, the U.S. District Court Middle District of Florida vacated the injunction, "conclude[ing] that vacatur of the 1979 FMA Injunction is appropriate, and 'suitably tailored to the changed circumstance' in this case [internal citation omitted]."[3] With the injunction lifted, HHS is legally permitted to revise its policy on disclosing Medicare reimbursement payments to individual physicians in a manner that could identify individual physicians. The Department's policy on the release of physician information has not been updated since 1980, when HHS concluded that "the public interest in the individually identified payment amounts is not sufficient to compel disclosure in view of the privacy interests of the physicians found compelling by the courts."[4]

On August 6, 2013, in light of the vacatur of the 1979 injunction, CMS requested public comment on specific policies that will further the Department's 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.

II. Response to CMS Questions

1. Specific policies CMS should consider with respect to disclosure of individual physician payment data

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[2] *Fla. Medical Ass'n, Inc. v. Dep't of Health, Education & Welfare*, No. 78-178 (M.D. Fla. Oct. 22, 1979).
[3] *Fla. Medical Ass'n. Inc. v. Dep't of Health, Education, & Welfare, Dow Jones & Company, et. al.*, Case No. 3:78-cv-178-J-34MCR (filed 5/31/13).
[4] HHS, Announcement of Modified Policy on Disclosure of Information Following Federal Court Decisions on Disclosure of Amounts Paid to Individual Physicians Under the Medicare Program,45 Fed. Reg. at 79172 (Nov. 28, 1980).

AdvaMed recommends CMS adopt and implement a policy of transparency and physician payment disclosure specifically applicable within ACO programs and any bundled payment initiatives. The ACO and bundling payment initiatives have the potential to encourage quality care and efficient health care delivery. However, AdvaMed is concerned that in an effort to incentivize care coordination, efficiency, and reduced costs under ACOs and bundled payment initiatives, ACOs and bundled payment providers may create unintended incentives for individual providers to reduce costs of care even if this is not in the best medical interest of the beneficiary who is assigned to the ACO or is included simply because the beneficiary's physician chooses to participate in a bundled payment program.

With respect to the MSSP, for example, when HHS issued its MSSP Final Rule in November 2011, it concurrently issued an Interim Final Rule (IFC) describing the ACO Participation Waiver. Through the ACO participation waiver, the Department waived section 1899(f) of the Act, section 1877(a) of the Act (relating to the Physician Self-Referral Law), sections 1128A(b)(1) and (2) of the Act (relating to the Gainsharing Civil Monetary Penalty (CMP), and sections 1128B(b)(1) and (2) of the Act (relating to the Federal anti-kickback statute), with respect to an ACO and its participants as long as certain conditions described in the final rule are met. One condition is that "[t]he description of the arrangement is publicly disclosed at a time and in a place and manner established in guidance issued by the Secretary. Such public disclosure shall not include the financial or economic terms of the arrangement."[5]

Recognizing that there was inherent risk in the policy that the Department was introducing, HHS stated that "if we find that undesirable effects (for example, aberrant patterns of utilization) have occurred because of the waiver, we will revise this IFC to address those problems by narrowing the waivers."[6] HHS also stated that it is "exclud[ing] from the shared savings distributions waiver of the Gainsharing CMP situations in which a payment is made knowingly to reduce or limit *medically necessary* services to patients under the physician's direct care."[7] HHS explained that

> Knowing payments by a hospital to induce a physician to reduce or limit medically necessary care without providing acceptable alternative medically necessary care (for example, payments to discharge patients without regard to appropriate care transitions or payments to use a drug or device known to be clinically less effective) would not qualify for the waiver. We will interpret ''medical necessity'' consistent with Medicare program

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[5] 76 Fed. Reg. 68000-01 (Nov. 2, 2011). CMS also noted that "The third main safeguard included in these waivers is a transparency requirement that requires arrangements for which waiver protection is desired to be publicly disclosed. The public disclosure will include the description of the arrangement, but shall not include the financial or economic terms of the arrangement. Our decision to shield financial or economic terms from the public transparency requirement is premised, among other considerations, on potential antitrust implications. (We note that, while not subject to the public transparency requirement, the financial or economic terms of the arrangement are among the matters that must be documented pursuant to the documentation requirements of the waivers and made available to the Secretary upon request.)" 76 Fed. Reg. 68004.

[6] 76 Fed. Reg. 68008.

[7] 76 Fed. Reg. at 68005.

rules and accepted standards of practice. We also note that distributions of shared savings payments also may be structured to fit in the other waivers.[8]

AdvaMed is concerned that the MSSP Interim Final Rule and the waivers concurrently created are insufficient to protect beneficiaries from the unintended consequences that may result from arrangements where physicians are incentivized with personal financial rewards to reach savings in their care regimens. Similarly, in the case of bundled payment initiatives, where payment is set for a defined inpatient stay, or "episode of care," and physicians may be "permitted to share gains arising from the providers' care redesign efforts," AdvaMed believes there are inadequate beneficiary safeguards in place.[9]

Incentives for reducing costs have the potential to lead to stinting on care, denying needy specialty referrals or higher cost tests and interventions or selecting cheaper technologies, even when the specialty referrals or higher cost tests and interventions are the most appropriate treatment for the individual. Furthermore, the limited payment windows used to evaluate costs within the ACO and bundled payment initiatives provide significant disincentives to treat patients with interventions that demonstrate long-term value. This may lead to focus on short-term cost savings even when this is not in the best long-term interest of the patient.

One way to monitor for a connection between suspiciously high financial gains by individual physicians and the withholding of the most appropriate treatments and technologies due to cost would be to publicize the amount of shared savings or Gainsharing amounts that physicians receive as a result of their participation in an ACO or bundled payment initiative. This information could then be coupled with data on the treatments and technologies that the beneficiary who is assigned to the ACO or treated by the bundled payment provider receives. AdvaMed strongly urges CMS to create and implement policies that would allow for such disclosure and transparency that will protect Medicare beneficiaries and uphold quality in the Medicare program. To this end, AdvaMed recommends that CMS and individual ACOs and bundled payment initiatives make available to the public both aggregated data and individual physician shared savings and Gainsharing rewards received by practitioners participating in these programs.

Finally, AdvaMed, as well as the Office of Inspector General of HHS (OIG), have repeatedly raised concerns with the characteristics and operations of many Physician-Owned Distributors (PODs).[10] PODs can also raise the possibility of improperly incentivized physician decision-making, and for that reason, OIG has labeled them "inherently suspect."[11] AdvaMed recommends that any disclosure of Medicare reimbursement information concerning an individual physician also note whether that physician has an ownership interest in a POD. CMS will already have access to much of this information through the disclosure requirements of applicable GPOs (including most PODs) under the Physician Payment Sunshine Act, which

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[8] 76 Fed. Reg. at 68005.
[9] See, e.g. CMMI, Bundled Payments for Care Improvement (BPCI) Initiative: General Information, Episode 1, available at http://innovation.cms.gov/initiatives/bundled-payments/.
[10] See Special Fraud Alert: Physician-Owned Entities, Office of Inspector General, 2013; AdvaMed Statement on Physician-Owned Entities (available at: http://www.advamed.org/POD)
[11] Special Fraud Alert: Physician-Owned Entities, Office of Inspector General, 2013.

passed as part of health care reform in 2010 in the ACA (and is further addressed below).[12] For any physician ownership of a POD not captured by the Sunshine Act, AdvaMed recommends that CMS create and implement a policy of physician self-disclosure of POD ownership.

2. Weighing the Patient and Public Interest Against Physician Privacy Interest

In implementing a policy of physician payment disclosure and transparency, as described above, it is necessary to consider whether there is a physician privacy interest at stake in the Medicare reimbursement information, and whether such interest outweighs the patient and public interest in having access to the information. Physicians do have a privacy interest in their personal income. Shared savings or Gainsharing amounts, however, constitute only a portion of a physician's total income. Disclosing this subset of information, therefore, does not breach a physician's reasonable expectation that his total income should be a private matter.

Moreover, where reimbursement information is limited to shared savings and Gainsharing amounts earned from specific Medicare programs, such as ACOs and bundled payment initiatives, AdvaMed believes that even if there is some personal privacy interest remaining, such privacy interest is outweighed by the public's interest in safeguarding the safety of beneficiaries in these programs. These programs have vulnerabilities embedded in their design that put beneficiaries' safety and care at risk and must be counterbalanced by Agency safeguards, such as transparency and disclosure.

Physicians may argue that the values publicized as shared savings or Gainsharing amounts could be taken out of context and harm their personal or professional reputation. Congress has addressed a similar argument, however, in the context of the Physician Payment Sunshine Act. Under the Sunshine Act, annual payments or transfers of value provided to physicians or teaching hospitals by applicable drug and device manufacturers must be reported annually to the Secretary, who will then make these data public. The Sunshine Act also requires manufacturers, GPOs, and most PODs to report the nature and value of any physicians' ownership in the entity. In passing the Sunshine Act, Congress determined that information that might indicate inappropriate financial inducements should be disclosed and the public interest in disclosure outweighed privacy concerns.[13]

In sum, patients have a great interest in knowing the financial incentives provided to their physicians, and knowing the shared savings or Gainsharing amounts that their physicians have earned as a direct result. Knowing the specific amounts of physician shared savings and Gainsharing amounts will inform Medicare beneficiaries and help deter physicians from stinting on beneficiary care (e.g. withholding or not utilizing interventions known to be clinically effective) in order to benefit financially. Furthermore, if physicians know the data will be made public, they could be deterred from becoming involved in improper practices at all. Finally,

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[12] See section 1128G of the Social Security Act, as added by section 6002 of the ACA.

[13] See also, CMS, Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests; Final Rule, 78 Fed. Reg. at 9459 (Feb. 8, 2013). (stating that "We recognize that disclosure alone is not sufficient to differentiate beneficial financial relationships from those that create conflict of interests or are otherwise improper.... However, transparency will shed light on the nature and extent of relationships, and will hopefully discourage the development of inappropriate relationships and help prevent the increased and potentially unnecessary health care costs that can arise from such conflicts.")

knowing that physician shared savings and Gainsharing amounts will be publically available will also keep CMS accountable to fulfilling its responsibility to identify provider outliers and to target more effectively the agency's program monitoring activities for assessing a program's performance.

For these reasons, AdvaMed strongly believes that the patient interest in having access to physician reimbursement data in the form of shared savings and Gainsharing amounts outweighs physician privacy interest in such data. While physicians may argue that they have privacy interest in the financial information itself, in weighing this privacy interest against patient interest in disclosure of Medicare payment information, including physician-identifiable reimbursement data, AdvaMed believes protecting Medicare beneficiaries is greater.

3. Form in which CMS Should release information about individual physician payment

AdvaMed believes the Secretary of Health and Human Services (HHS) should publicly disclose shared savings or gainsharing amounts earned by physicians in the MSSP and bundled payment initiatives. Specifically, we believe CMS should require ACOs and participants in the bundled payment initiatives to publicly disclose aggregated amounts of shared savings and Gainsharing rewards that the physicians participating in those programs receive. The ACOs and participants in the bundled payment initiatives should also release information about the methodology they use for distributing shared savings and Gainsharing rewards among participating physicians. CMS should also publicly disclose, or require that ACOs or bundled payment initiatives publicly disclose, physician-specific information on the shared savings and gainsharing amounts that physicians receive as a result of their participation in the programs. This information should at a minimum be posted on CMS and ACO and bundled payment participant websites.

With respect to the disclosure of individual physicians' involvement with a POD, AdvaMed recommends that CMS include a notation or asterisk next to each individual physician's name to signify that physician's POD ownership.

III. Conclusion

Again, thank you for the opportunity to comment on this important matter regarding updating the Agency's policy on the release of physician Medicare payment data. Should you have any questions or if we can be of any assistance, please do not hesitate to contact me at rprice@advamed.org or 202-434-7227

Sincerely,

[redacted]

Richard Price
Senior Vice President
Payment and Health Care Delivery Policy

AQIPS | ALLIANCE FOR QUALITY IMPROVEMENT AND PATIENT SAFETY

September 5, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attn: *Physician Data Comments*
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically to Physician_Data_Comments@cms.hhs.gov

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

The Alliance for Quality Improvement and Patient Safety ("AQIPS") appreciates the opportunity to comment regarding the importance of releasing Medicare physician data.

AQIPS is a national nonprofit association that assists its members to build a safer health care system. AQIPS leads efforts to measurably improve patient safety and the quality of patient care by fostering the ability of patient safety organizations ("PSOs"), as authorized by the Patient Safety and Quality Improvement Act of 2005, to provide patient safety services to the health care system. PSOs support unique collaborations across providers to create a learning environment, and AQIPS serves as a voice for the PSO community to enhance quality improvement activities. Accordingly, we are very pleased to offer the following comments for your consideration on the crucially important issue of access to Medicare physician data.

There is universal agreement among politicians and policymakers that we must improve the quality of health care while containing costs to avoid bankrupting the health and wealth of the nation. Data transparency is central to this mission.

Physicians are increasingly held accountable for the cost and quality of care through programs such as Medicare Shared Savings, but physicians have limited tools empowering them to make data-driven and evidence-based decisions in their daily practice of medicine. PSOs collect, aggregate, and disseminate learning and best practices from data regarding patient safety, but that work is necessarily limited by the amount and value of the data available. Releasing Medicare claims data to the public will fuel a tremendous amount of learning about and improvement of the quality and cost of health care.

The real value of public Medicare data will be realized through the innovation that it catalyzes. Technology developers and researchers are the more likely initial consumers of this data than patients and physicians. Release by CMS of the Medicare claims data will trigger a proliferation of new technological tools to help physicians and patients make well-educated care decisions.

AQIPS | ALLIANCE FOR QUALITY IMPROVEMENT AND PATIENT SAFETY

Examples of such tools include analytics built into health IT workflows that will give physicians a comprehensive view of a patient's medical history, including which medications or health care services have been reimbursed on a patient's behalf. These technologies, already common in nearly every other sector of our data-driven economy, are desperately needed in health care.

New value-based, accountable care delivery and payment models are increasingly replacing the fee-for-service model that prevailed in the 1970s. The success of these models depend on their ability to monitor and control the quality and cost of care, which in turn depends on increased claims data availability and transparency. As we focus on improving health care in this nation through new models, the broad public interest in releasing paid claims data must increasingly outweigh the privacy interests of physicians.

Additionally, technology has evolved enormously since the 1970s. When the injunction was issued in 1979, sophisticated data analytics technology barely existed, and it was certainly not widely available to business and consumers. Therefore, at that time, if the data was publicly available, its usefulness was limited to detecting fraud and ascertaining the income of physicians. Today, however, PSOs and other groups provide robust technology platforms capable of turning Medicare paid claims data into actionable insights to improve care quality. This increase in computing power greatly expands the potential of and the public interest in paid claims data. Further, the same expansion of technology creates new ways to safeguard legitimate privacy interests with protective measures.

AQIPS strongly supports the ongoing data liberation efforts within HHS and appreciates the opportunity to provide feedback on how to best include paid claims data in those efforts.

Sincerely,

Stephanie Zaremba, on behalf of
AQIPS Board of Directors

THE ALLIANCE
Employers moving health care forward

September 5, 2013

Department of Health and Human Services,
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Attention: *Physician Data Comments*

Dear Sir or Madam:

Thank you for your request for public comment on the potential release of Medicare physician data. I write on behalf of the 190 employers and employer organizations that are members of The Alliance. The Alliance is a not-for-profit cooperative owned by employers that provide self-funded health benefits to more than 80,000 employees and their family members across three states. Our mission is to move health care forward by controlling costs, improving quality, and engaging individuals in their health. Health care transparency is critically important to accomplishing our mission.

The Alliance has been providing information on cost and quality of health providers to our members for many years, and we have learned that patients desire information on individual physician performance on quality metrics. When patients seek care, they generally do so at the individual physician level as opposed to the hospital level, and they deserve information on the quality of care provided by individual physicians. Moving forward on the release of this data is critical for the following reasons:

- Publicly available data will enable patient advocacy organizations and consumers themselves to make informed decisions about their choice of physicians, where quality information is most relevant to them;
- Physician-level data is critical for payment innovations pursued by many employers that look to reward value over volume;
- We know from our own reporting efforts that when cost and quality information are made public, providers respond by improving care at far greater rates than when information is unavailable or is shared only on a private basis.
- Medicare data is necessary to lay the foundation for physician quality reporting programs.

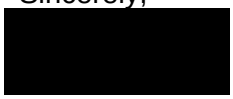
We also believe it is important that this quality information be as complete and accurate as possible. Basing quality measurement on the full spectrum of a physician's care, including care provided to Medicare patients, increases the accuracy of the measurement and reduces the risk of sending conflicting and confusing quality messages to patients and providers.

In order to maximize use and usability of the data, we recommend that CMS:

- Release the data as broadly and in as much detail (i.e. line-item claim details) as possible
- Ensure that the fees for use of, or access to, the data are reasonable
- Refrain from restrictions that would hinder the sharing of data
- Make the data available in machine-readable format
- Include national provider identifiers (NPI) to allow for ease of integration with other datasets, such as all-payer claims databases

We applaud the increased commitment to data transparency displayed by CMS in recent years, and we encourage CMS to further this commitment through the broader release of Medicare physician data. Thank you for the opportunity to provide these comments. If you have any questions or would like to discuss these suggestions further, please do not hesitate to contact me at (608) 210-6615.

Sincerely,



Amy Moyer
Manager of Value Measurement

August 29, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Mail Stop 314G
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Request for Public Comments on the Potential Release of Medicare Physician Data (August 6, 2013)

Dear Administrator Tavenner:

I am contacting you on behalf of the more than 17,000 members of the American Academy of Dermatology Association (AADA) to share our comments responding to the Request for Comments (RFC) on the Potential Release of Medicare Physician Data published August 6, 2013. The AADA is committed to excellence in medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology and dermatopathology; and supporting and enhancing patient care to reduce the burden of disease. We appreciate the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) and hope CMS will take the AADA's concerns and recommendations into consideration when formulating future policy.

General Comments/Remarks

The AADA supports transparency that provides accurate health care information for patients and timely, clinically relevant data to help physicians provide high quality, high value care. We commend CMS for its commitment to these goals, and we support CMS' dedication to protecting the privacy of Medicare beneficiaries by precluding public disclosure of information that could reveal patient-identifiable information. We submit, however, that physician privacy interests go hand in hand with patient privacy interests. We question, too, whether the release of Medicare data would uncover fraud.

American Academy of Dermatology Association

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For more than 40 years a court injunction prohibited CMS from providing requesters access to physician-level Medicare payment data. Recently, a challenge to that injunction was successful. The reviewing court, however, did not address whether the information protected from disclosure by the 1979 injunction should be disclosed now or ever. Additionally, that court's ruling left in place the Department of Health and Human Services (HHS) policy, adopted in 1980, concluding that "the public interest in the individually identified payment amounts is not sufficient to compel disclosure in view of the privacy interests of the physicians."

Physician Right to Privacy

The AADA believes physicians have a privacy interest in information concerning payments they receive from Medicare. Accordingly, the AADA strongly opposes any change in the current HHS policy regarding the release of individual physician data. To guide you in policy development, we offer our thoughts and concerns on how CMS should properly weigh the balance between the physician's privacy interest and the public interest in disclosure of Medicare payment information.

Patient Access to Care

We strongly urge CMS against any release of information attributed to an individually named physician. The range of healthcare-related issues, which is piquing the interest of political and social activists, appears to be steadily increasing. There are many procedures and treatments--including prescribing Thalidomide or Isotretinoin--drawing criticism or protest from various groups. We believe that disseminating physician Medicare data could have the effect of placing information about the physician's relationship with his/her patients and their care—which some individuals or groups may find controversial--into the public arena. In turn, this may stigmatize patients who seek treatment from that particular physician. We are concerned, too, for the safety of both physicians offering treatments and the patients who seek those treatments.

In addition, in response to an acute shortage of dermatologists in some areas, dermatologists have hired multiple physician assistants and nurse practitioners to increase patient access. These paraprofessionals report their services under the billing number of the supervising physician. This greatly inflates the reporting physician's income without obvious explanation. Publically vilifying these physicians is not only inaccurate and unfair, but may result in their termination of these paraprofessionals, with a resulting decrease in access to care for Medicare beneficiaries, in order to normalize their practice profiles.

Accuracy of Data

The AADA questions the utility of releasing provider-level Medicare data. We are concerned that the public dissemination of raw Medicare claims data, which does not provide patients with helpful information on quality measures or treatment options, can be misleading. The AADA is concerned that physician-level Medicare data, while potentially useful in identifying outliers, are unreliable for assessing physician quality. CMS itself has previously submitted that Medicare claims data "would not shed light directly on the quality of the physicians

performing those services." *Alley v. United States Dep't of Health and Human Servs*., 590 F 3d 1195 (11th Cir. 2009), HHS Brief at 32. When discussing the Patient Quality Reporting Initiative (PQRI), CMS stated, "We recognize that there continues to be a number of limitations associated with claims-based reporting since the claims processing system was developed for billing purposes and not for the submission of quality data." Medicare Data for Performance Measurement proposed rule, 75 Fed. Reg. at 40,170. In addition, provider-level claims data could be used to derive extensive information about doctors—such as prescribing patterns, procedures performed, decision-making patterns, and information on names and frequencies of procedures performed by physicians. Yet, we counsel, the raw number of performed procedures—without accurate outcomes data--is not indicative of proficiency.

In addition, for many services that physicians provide in hospitals and other facilities, the success of the procedure can depend significantly on the availability of specialized resources and staff and on perioperative risk procedures in place at the facilities. Any rankings based upon Medicare claims data could not be adjusted for such important health status and quality factors as a patient's stage or severity of disease, co-morbidities, family history, cognitive function, and other factors that can influence the outcome of a medical procedure.

We also ask CMS to consider the adverse unintended consequences of selective reporting—already a problem in the medical industry. When entities or private citizens publish only information that presents a particular procedure or treatment in a biased view, it makes it more difficult for physicians and patients to make informed decisions about health care.

We believe that data divorced from its context is flawed. The context determines the urgency, granularity of detail, authority, and level of certainty required for an acceptable interpretation and reliable utility. Without context, an entity and/or private citizen could take the data and make incorrect assumptions. We have concerns, too, about how efficiency/overutilization could be measured without tracking the individual patient, which presents obvious privacy issues. As we move toward greater data transparency, we cannot leave data accuracy and its context behind.

In our comments to the Medicare Data for Performance Measurement proposed rule in 2011, we advocated for the use of non-claims data in conjunction with Medicare claims data to enhance the accuracy of any quality measures that may be developed. We believe that clinical and registry data is more reliable than claims data. Registry data results in more accurate measures of the quality of patient care. Given the proven advantages of clinical registry data, we strongly believe that clinical data registries should be encouraged as alternative data sources.

In the event that Medicare information is released, we urge CMS to provide the physician an opportunity to review and correct incorrect information before it is made public. We advocate that CMS take every precaution possible to ensure the accuracy and context of that data. Moreover, we urge CMS to preclude public release of physician-level Medicare data until there is a reliable methodology for holding those who use the released data accountable for the information they present.

We are particularly concerned with the artificial utilization increase by use of paraprofessionals, and non-Medicare billing physicians such as fellows, who all use the same individual's billing number (see above).

Data Market/Secondary Uses

In addition, the AADA urges CMS to consider the implications of releasing physician Medicare data on the data market. There is an active and growing marketplace for health care data, and as data becomes richer and more liquid, more possibilities to monetize physician data will emerge. The AADA is concerned about the secondary uses of data obtained from physicians' records.

We believe that physician privacy, as well as patient privacy, must be central to all new standards and policies addressing this expanding industry. We urge CMS to develop policies, standards and legal/regulatory remedies regarding the secondary use, abuse and misuse of health data before any physician data is released.

Physician Profiling

In addition, the AADA opposes the release of physician payment data because we are concerned that entities may inappropriately use the Medicare data to rank physicians based solely on cost, without employing risk adjustment measures to assure more accurate physician comparisons and without providing prompt appeal mechanisms to physicians to verify and correct data believed inaccurate. This paradigm is not unheard of. It is being used by some private insurers to exclude physicians from provider networks, and ultimately, to limit patients' access to care.

We believe that physician profiling, based on claims-driven data for cost of care provided by dermatologists, is inappropriate as it fails to account for other critical non-economic factors and clinical risk adjustment criteria. The AADA steadfastly opposes economic profiling of dermatologists based solely on charges and claims data and believes dermatologists--who are doing the difficult and therefore more expensive cases--should not be excluded from provider networks or portrayed as outliers. We are concerned, too, that the cost-profiling methodologies that insurers and others may use have the potential to harm access to procedures and treatments for patients with complex skin conditions by creating a perverse incentive for physicians not to treat certain beneficiaries to avoid a negative efficiency profile. Accordingly, we urge CMS to consider the potential consequences of publicly disseminating physician Medicare data.

Conclusion

The AADA appreciates the opportunity to provide comments on physicians' privacy interests and the potential release of Medicare physician data. We look forward to additional opportunities to comment on the best ways to continue to protect the privacy and confidentiality of both beneficiaries and physicians and to provide feedback that may help guide policy development.

Please contact Richard Martin, JD, Assistant Director, Regulatory Policy, at (202) 842-3555 or RMartin@aad.org if you require clarification on any of the points or would like more information.

Sincerely,

Dirk M. Elston, MD, FAAD
President, American Academy of Dermatology Association

CC:
Lisa A. Garner, MD, FAAD, Vice President
Brett M. Coldiron, MD, FAAD, President-Elect
Suzanne Olbricht, MD, FAAD, Secretary-Treasurer
Marta Jane VanBeek, MD, MPH, FAAD, Chair, Council on Government Affairs, Health Policy, and Practice
Elaine Weiss, JD, Executive Director and CEO

September 3, 2013

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, D.C. 20201

Re: Physician Data Comments

Dear Administrator Tavenner:

Thank you for the opportunity to comment on the potential release of Medicare physician data. The American Academy of Emergency Medicine (AAEM) is the specialty society of board certified emergency medicine physicians. A primary component of AAEM's mission is to support fair and equitable practice environments for emergency physicians. The principal of "open books" is a central part of this vision, and AAEM believes that physicians should have the right to see what is being billed and collected for their professional services.

At present, many contract management groups (CMGs) do not allow emergency physicians to have access to these billing records. This is not only a fairness issue, but it also has legal implications because emergency physicians are held responsible for their billings and collections. CMS will approach both physicians and billing companies if they feel that excess charges are being made. Denying a physician the ability to see what is billed in their name places them at an increased risk of being audited.

AAEM is opposed to fraud and abuse in the Medicare system. Emergency physicians can serve as an important defense against billing fraud, but only if they are allowed to see what is being collected in exchange for their services. As part of the release of this data, AAEM encourages CMS to produce a separate document that goes directly to the individual physician that discloses how much the physician received from Medicare during the reporting period. The physician can then compare this data with the reports from the CMG or billing company. AAEM advocates for a transparent system that will result in better patient outcomes and more efficient Federal healthcare programs.

For these reasons, AAEM supports the release of Medicare physician data that is being considered by CMS. However, we believe that there should be several disclosures and acknowledgments by CMS to accompany the release of this data. First, we support the inclusion of a statement noting that the monies listed may not be paid directly to the physician. This is particularly

important to our specialty because nearly all emergency department physician models require reassignment of payment to a billing entity. As a result, the actual reimbursement to a physician may vary greatly depending on contractual arrangements between a physician and the CMG or billing entity. Second, CMS should consider an acknowledgment regarding the limitations of this data, principally that it does not represent the final amount of money earned by a physician in exchange for their services, but is the reimbursement before malpractice insurance, billing, and numerous other costs inherent to the expensive practice of medicine.

From a policy perspective, AAEM believes it is important to give the public a complete and open assessment of how Federal dollars are spent in our healthcare system. The inclusion of this information that would accompany the release of Medicare physician data would help bring additional transparency to the system and further inform the public on the cost of medicine.

We appreciate your work on this important issue, and thank you for the opportunity to comment on this matter.

Sincerely yours,

William T. Durkin, Jr., MD, MBA, FAAEM
President

September 5, 2013

Electronic Submission via Physician_Data_Comments@cms.hhs.gov

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attn: Physician Data Comments
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Public Comments on the Potential Release of Medicare Physician Data
(http://downloads.cms.gov/files/Request-for-Public-Comment-rePhysician-Data-8-6-2013.pdf)

To Whom It May Concern:

The American Association of Nurse Anesthetists (AANA) welcomes the opportunity to provide our views concerning CMS' request for public comments on the Potential Release of Medicare Physician Data. We applaud the efforts of CMS to improve transparency of healthcare information and recognize the potential value of sharing Medicare claims data in an appropriate manner to drive innovation to improve health and healthcare.

Executive Summary

The AANA supports CMS' commitment to greater data transparency in the healthcare marketplace because it helps incentivize safe, higher quality care at lower cost for consumers. We recognize CMS's paradigm shift to release aggregate data on such topics as Medicare spending, utilization and quality, including this year's public release of the average charges for the most common inpatient and outpatient services across the country. At this critical juncture, we encourage CMS to partner with the AANA and other stakeholders to develop policies that will assure reliability and validity of this information while protecting against potential abuses and misunderstanding. We support the appropriate use of Medicare claims data in a manner

which provides meaningful and accurate information and offer the following comments in response to the specific questions posed in the CMS request for public comment.

Background of the AANA and CRNAs

The AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, and AANA membership includes nearly 47,000 CRNAs and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 34 million anesthetics to patients each year in the United States, according to the 2012 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia in the United States for 150 years, and high-quality, cost-effective CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989 have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNA services include providing a pre-anesthesia patient assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and in some states are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[1] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[2]

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[1] Paul F. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic$.* 2010; 28:159-169.

[2] B. Dulisse and J. Cromwell, "No Harm Found When Nurse Anesthetists Work Without Physician Supervision." *Health Affairs*. 2010; 29: 1469-1475.

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the principal anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.[3] Nurse anesthesia predominates in Veterans Hospitals and in the U.S. Armed Forces. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities, and the offices of dentists, podiatrists, and all types of specialty surgeons.

Question #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 support an evenhanded approach to balancing the privacy interests of Part B providers, their patients and their employers against the public's interest in disclosure of Medicare payment information. In the specialty of anesthesia, reimbursement is sufficiently nuanced that the potential for consumers and others to draw incorrect conclusions from the release of raw data is substantial, leading unwittingly to incorrect healthcare decisions. Steps must be taken to provide the information that is not misleading or subject to misinterpretation. For this reason it is critical that CMS work alongside anesthesia and pain care stakeholders such as the AANA to establish appropriate ways to use and disclose this data so that patients and providers can easily understand and act on the information.

We recognize that as CMS has continued to expand access to data, CMS has also made significant efforts to protect its data integrity through existing safeguards. Congress recognized the need for balance between public reporting and provider privacy interests in the Qualified Entity (QE) program[4] included as part of the Affordable Care Act. As implemented through a 2011 final rule, this provision allows entities to receive Medicare claims data for the purpose of

[3] U.S. Government Accountability Office (GAO). Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Services. Report to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives. GAO-07-463. July 2007;15. http://www.gao.gov/new.items/d07463.pdf

[4] Medicare Program; Availability of Medicare Data for Performance Measurement, final rule. 76 FR 76542, Dec. 7, 2011. http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/pdf/2011-31232.pdf

publishing data for quality improvement while at the same time allowing providers to correct their information. We support including and expanding similar protections for disclosure of Part B claims data.

However, Medicare payment for anesthesia services is calculated differently from other physician payment in the physician fee schedule. These distinctions require careful consideration as release of raw data may generate conflicting reports and inaccurate conclusions. Medicare reimburses anesthesia services using an anesthesia fee schedule that includes two components: base units (ranging from 3 – 25 based on the complexity of the service) and time units (one per 15 minutes). Medicare multiplies the sum of base and time units by a dollar value anesthesia conversion factor (anesthesia CF) updated annually based on the value of anesthesia work, practice expense and liability expense. Like the physician conversion factor, the anesthesia CF varies by Medicare geographic region. The American Society of Anesthesiologists publishes a list of base units in its annual Relative Value Guide (RVG)[5] the Medicare agency evaluates the RVG recommendations and accepts most of them for calculating Part B payments for anesthesia services. Thus base units are the same for each provider for the same cases.

The primary distinction between the anesthesia fee schedule and the regular physician fee schedule is that the anesthesia fee schedule recognizes variable time based on the actual time of the service. By contrast, the physician fee schedule incorporates a fixed time into the relative value of each service. The reason for this distinction is that anesthesia time is largely dependent upon the time that the operating practitioner takes to complete a given procedure. This system ensures that Medicare pays accurately for anesthesia time, and does not penalize those anesthesia professionals who work with slower operating practitioners. Therefore, without knowledge of the time of the procedure (not controlled by anesthesia provider but by the operating physician), payment data is incomplete. Those services that CRNAs provide that are not anesthesia services, such as chronic pain management services, emergency intubations and line insertions, are paid according to the general physician fee schedule and not the anesthesia fee schedule.

[5] 2013 Relative Value Guide® A Guide for Anesthesia Values. American Society of Anesthesiologists, 2013

The Medicare anesthesia payment system has several additional anomalies. Similar to general physician payment, Medicare reimburses CRNAs and anesthesiologists 100 percent of a fee for personally providing anesthesia care. There is also a payment for "anesthesiologist medical direction" that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are capable of and are often providing patient access to high quality anesthesia care unassisted. An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases, a total of 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA receives the remaining 50 percent of the fee for the case. To add to the complexity, anesthesiologists may also bill using a different methodology for medically supervising five or more cases, resulting in payment of 3 or 4 base units per case. Whether or not medical direction or supervision is involved in a particular case can add significant complexity to interpreting reported reimbursement data for both anesthesiologists and CRNAs.

Another unique characteristic of anesthesia payment systems is the fact that Part B payments may not capture the entire amount paid to an individual anesthesiologist for anesthesia services to Medicare beneficiaries. According to a nationwide survey of anesthesiology group subsidies[6], hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. Some 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms pays an average of $3.2 million in anesthesiology subsidies. Anesthesiology groups receive this payment from hospitals in addition to their direct Part B professional billing. This subsidy will be invisible within the context of public reporting of Medicare data although it adds substantially to the cost of care by certain providers.

[6] Healthcare Performance Strategies. Anesthesia Subsidy Survey, 2012.

Another consideration is that for the vast majority of our members, as well as for more and more physicians, billing rights are assigned to another entity. In this case, Part B payments may not reflect the actual dollars paid to the provider.

Due to these many unique characteristics of anesthesia payment methodology, we would greatly appreciate the opportunity to work closely with CMS to establish a methodology to publicly share data in a way that improves quality, efficiency and access.

Question #2: What specific policies should CMS 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?

We encourage CMS to engage CRNAs and other providers to design transparency policies that will provide actionable information to improve the quality of anesthesia and pain care. To ensure data integrity, disclosure policies should allow providers to review and correct errors. A significant educational effort will be required for consumers and others accessing the information due to the multi-factorial nature of anesthesia reimbursement. We strongly support policies that adopt or expand existing safeguards for any public reports emanating from disclosure of claims data.

We believe CMS should tie individual physician charge data to the volume of cases the provider performs in order to further the agency's goals of improving 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. Studies show that in some cases the more procedures that a provider performs, the less the complication rates and the better the outcomes for the patient. While data may include CPT codes, volume of cases and reimbursement associated with them, it should not include charges since there is no benefit of this information to the consumer. After all, Medicare pays according to an approved schedule rather than as a percent of charges.

Question #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)

The AANA believes that the form in which CMS releases information about individual payment, should CMS choose to release it, should guard patient privacy and protect standard unique provider identifiers from fraud and abuse.

Information should be provided as aggregate data at the individual provider level. For the reasons stated above, release of raw Medicare claims data appears to have little value in contributing to quality, cost or access aims. We recommend that if information is released about individual payment, a meaningful representation of time duration, co-morbidities and the presence or absence of medical direction or supervision be included.

We thank you for the opportunity to comment on this request. We continue to endorse efforts that improve access to quality anesthesia and pain care with maintaining the privacy of Medicare providers and patients. We welcome the opportunity to work with CMS to establish a transparent and meaningful way to address the public's interest in disclosure of claims and payment data while providing appropriate safeguards for anesthesia and pain care data integrity. Should you have any questions regarding these matters, please feel free to contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Dennis C. Bless, CRNA, MS
AANA President

cc: Wanda O. Wilson, CRNA, PhD, AANA Executive Director
Frank J. Purcell, AANA Senior Director of Federal Government Affairs
Christine Zambricki, DNAP, CRNA, FAAN, AANA Senior Director Federal Affairs Strategies

saving faces | changing lives®

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Miro A. Pavelka, DDS, MSD
President

Robert C. Rinaldi, PhD, CAE
Executive Director

September 3, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: *Physician Data Comments*
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Re: August 6, 2013 HHS Request for Public Comments on the Potential Release of Medicare Physician Data

To Whom It May Concern:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional association that represents more than 9,000 oral and maxillofacial surgeons in the United States, I commend the Centers for Medicare and Medicaid Services' commitment to greater transparency in the health care system. The AAOMS, however, has concerns with regards to measures outlined in an August 6, 2013 call for comments pertaining to the most appropriate policy for the agency to follow regarding the release of Medicare physician payment data.

The AAOMS believes that disclosing annual Medicare reimbursement payments to individual physicians may violate privacy interests of both physicians and their patients. If reimbursement data is reported by each patient interaction or event, sophisticated information analyzers could use payment date and codes to speculate on the disorders for which the patient is being treated even if the patient's information is not identifiable. Disclosure of gross payment information (i.e., total Medicare payments per month) also has drawbacks. Patients could improperly imply that a physician incorrectly submitted a claim simply because the gross amount seems large in their opinion. Furthermore, reporting a total amount to the public would not provide an audit path to insure that billing was correct.

With respect to the second question of what specific policies CMS should consider with disclosing individual physician payment data to further the goals of improving the quality and value of care and reducing fraud and waste, the AAOMS believes that beneficiary explanation of benefits (EOBs), which encourages patients who have any concerns about fraud or abuse to contact CMS and/or the Medicare Contractor, already serves as an excellent tool for improving quality and value of care. Conducting formal audits of individual providers is more reasonable, presuming that auditors would

be much better informed about CPT and ICD-9 codes, HIPAA code sets, related services, and appropriate charges than the typical patient. The AAOMS also supports making published reports available to the public regarding average rates of payment for certain types of services. Individual patients could then inquire through their CMS contractor if they suspect impropriety.

Should CMS decide to release individual physician payment information, the AAOMS believes that such information should be aggregate only and should include the total number of hours worked by the physician to provide the billed services so that patients can appreciate an hourly compensation rate. Furthermore, we recommend that publically disclosing such data should also be done first as a pilot project, in select areas, with an outcomes assessment, comparing cost and efficacy of such published methods to conventional audits before deciding to move forward with implementing on a national basis.

In conclusion, the AAOMS believes that there is a risk with disclosing physician payment information as it may degrade the physician-patient relationship when there is no cause nor benefit for doing so. We support efforts to individually audit suspicious cases and announce convictions as a more effective way to prevent fraud and abuse that preserves the privacy of the compliant majority than the gross release of individual doctor-patient financial data.

The AAOMS appreciates your consideration of our comments. Should you have questions, please contact Karin Wittich, CAE, Associate Executive Director, Practice Management and Governmental Affairs, at (847) 233-4334 or via e-mail at karinw@aaoms.org.

Sincerely,

Miro A. Pavelka, DDS, MSD
President

The American College of Physician Executives (ACPE) is a non-profit organization whose membership represents more than 11,000 active, executive-level physician leaders in all types of health care organizations across the U.S. and in 46 countries. As an organization with nearly 40 years of experience, ACPE has educated and trained nearly 100,000 physicians with leadership and management skills. This letter is to provide comment to the Centers for Medicare and Medicaid (CMS) on the issues regarding the potential release of Medicare reimbursement data on individual physicians in light of the recent lifting of a 1979 federal court injunction preventing disclosure of this type of data.

Prior to preparing this comment, ACPE conducted a survey of its membership to determine if there was any consensus of opinion. The results from this simple survey were almost evenly split. When asked if they thought data about Medicare payments to physicians should be made public, 46 percent of responding ACPE members said no and 42 percent said yes. An additional 12 percent were unsure. The survey was delivered via email to all ACPE members and 588 responded. Participants were also invited to share their comments.

This equally divided opinion within the physician leadership community should not be surprising and further reinforces that CMS is wise to ask for feedback on this sensitive topic. ACPE strongly believes any financial data related to physicians and reported to the public must be accurate, reliable, valid, relevant, meaningful and usable. In addition, ACPE is a member organization of the National Quality Forum (NQF) and supports the core premise that any form of measurement of health care performance by physicians should optimally be done through the use of NQF-endorsed measures.

Health care, like most other industries, has clearly entered an era where measurement and reporting are increasingly important. As physicians, our clinical practices have historically been built upon research and education—both of which rely on data that is derived from metrics, measurement, unbiased evaluation and reporting. In order to collect valid financial data that will be used in public reporting, there clearly needs to be a solid platform of metrics, measurement and evaluation. ACPE affirms that any move toward increased financial transparency should therefore be accomplished with the goal of creating financial data built upon valid and reliable metrics that result in development of evidence-based standards – standards that will subsequently lead to the creation of best practices. As the credibility of a new physician financial data reporting strategy by CMS improves, buy-in from physician leaders will likewise continue to grow.

With this context, ACPE presents the following suggestions:

1). In regard to CMS's first question about whether physicians have a privacy interest in information concerning payments they receive from Medicare, results of the ACPE survey show there is recognition among many physician leaders that increased transparency has potential value. Example comments by ACPE members in support of releasing Medicare payment information include:

- The public has a right to know how their taxpayer dollars are being spent.
- As consumers continue to demand increased access to health care data, the move to greater transparency will only grow stronger and it doesn't make sense to fight it.
- Lobbying to keep the information private will make physicians appear overly secretive.

However, as our survey results show, not all ACPE members are in favor of making this data public and fear it may lead to unintended consequences. Among their primary concerns:

- The data is too easily misinterpreted by the public and could be used to portray physicians in a negative and unfair light.
- Reimbursement is complicated by a number of factors, including (but not limited to) geographic location, types of procedures performed and costs of medications.
- The time and effort it would take to translate the data might be better spent on other resources that might more directly affect patient safety and care.

Additionally, there is a feeling among many physician leaders that their collective voice has not historically been presented or heard in a balanced fashion when new federal policies are created that potentially impact their professional lives and careers. While ACPE understands the needs of patients take precedence, we would ask CMS to take extra steps to better understand the potential impact on the physician workforce before creating any new policy. Historically, ACPE has been in favor of increasing transparency in order to create a more open and accessible system for all. However, the concerns of our physician leaders are not without merit. Due to the complexities inherent in the Medicare reimbursement system, there is huge potential for misinterpretation of this data by the public. We would ask CMS to anticipate this response and be sensitive to the potential impact on the physician community and the public. The data cannot be distributed in a vacuum; the public will need education and guidance in order to interpret the numbers in a way that is fair and meaningful.

2). As for the specific policies CMS should consider with respect to the disclosure of individual physician data, ACPE believes immediate steps are necessary to further reduce any waste, fraud and abuse in CMS

programs. We recognize that further efforts toward transparency represent a powerful tool in the ongoing struggle to decrease these problems and ACPE strongly supports these initiatives.

However, there is increasing concern among the payer and provider communities in regard to recently disclosed inequities with Medicare pricing. This ongoing inequity has the potential to create additional confusion in the marketplace as it relates to any public disclosure of individual physician reimbursement from Medicare. There is a growing consensus that the time is right politically to eliminate the outdated and flawed SGR funding formula. As new payment models evolve, ACPE urges CMS to take steps to ensure there is greater equity in pricing. In this respect, we echo the recommendation recently put forward by leaders of the Bipartisan Policy Center, who suggest replacing the SGR formula for physician reimbursement and offering all Medicare providers financial incentives to participate in new payment models.[1]

3). Regarding the form in which CMS should release information, ACPE does not have specific recommendations at this time but would once again stress the need for validated, accurate, reliable data that are fair, relevant and easily understandable to all parties so that meaningful and usable improvements in the health care delivery system result.

Lastly, we ask CMS to consider the nine essential elements ACPE has identified as necessary for creating meaningful change in health care. We believe any policy change must be:

1. Quality-centered
2. Safe for all
3. Streamlined and efficient
4. Measurement-based
5. Evidence-based
6. Value-driven
7. Innovative
8. Fair and equitable
9. Physician-led

[1] Daschle, T., Domenici, P., Frist, W., & Rivlin, A. Prescription for patient-centered care and cost containment. *The New England Journal of Medicine* (369:5), p. 471.

Thank you for the opportunity to offer our comments on this important and timely issue. ACPE and its 11,000-plus physician leader members stand ready to assist as you move forward.

Sincerely,

Peter Angood, MD
ACPE - CEO

Mark Werner, MD
ACPE - President

September 5, 2013

Department of Health and Human Services
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

The undersigned organizations appreciate the opportunity to provide our views concerning the Centers for Medicare and Medicaid Services' (CMS) request for public comment on the potential release of Medicare physician claims data. We welcome the opportunity to work with CMS to improve meaningful and appropriate access to this information, and recognize the potential value and importance of Medicare physician claims data. If used correctly, this data can provide accurate and meaningful information to patients, physicians, and other stakeholders that can improve quality at the point of care. We therefore support the appropriate use of Medicare claims data to inform and improve our health care system.

With these goals in mind, we encourage CMS to partner with physicians to develop policies that will promote the reliable and effective use of this information. We urge CMS to carefully consider how use of this data may change over time, and the role it may play in an evolving Medicare system. Our goal is to promote efforts focused on improving the quality of patient care while safeguarding against potential abuses that could negatively impact health care outcomes or diminish the privacy of Medicare physicians and patients. It is from this perspective that we offer the following comments responding to specific questions listed in the CMS request for public comment.

- *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?*

The public's interest in disclosure of claims and payment data resulting from government health care programs must be balanced against the confidentiality and personal privacy interests of physicians, their practice entities, and patients, who may be adversely impacted by disclosures. Steps must be taken to ensure that the release of data does not mislead the public into making inappropriate and potentially harmful health care treatment decisions. **In light of these considerations, the release of raw data regarding physician claims for providing medical services should be limited for specific purposes and with appropriate safeguards.**

In particular, reports, analyses, or other publications that incorporate Medicare claims data must include appropriate disclosures and/or explanatory statements as to the limitations and potential misinterpretations of the data. Such misinterpretation can result from data limitations that do not include the costs of providing care such as specialty, location, patient mix and demographics, drug and supply costs, hospital and service costs, professional liability coverage, support staff,

and other practice costs, as well as the potential for mistakes and errors in the data or its attribution. It is important to note that individual Medicare payment information should be presented together with quality (i.e., clinical) information, encouraging and facilitating value-based decision making by consumers. If quality information is not available, cost and price information should be presented in a context that raises the importance of considering quality in decisions about providers, treatments, and health care services.

In addition, Medicare data is used primarily to pay claims and therefore includes confidential and sensitive information about patients and their treatments. Under current law, when CMS releases such data (e.g., under a data use agreement) the agency must ensure that disclosure complies with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy laws. **Given the potential for security breaches, hackers, or efforts to re-identify information, we urge CMS to consider the potential impact of any data release on patient privacy and engage with experienced data statisticians, physician organizations, and other relevant stakeholders on ways to further protect such data.**

While we recognize the significant privacy interests for both physicians and patients, we also acknowledge the potential benefits of physician claims data. As noted in the request for comments, Medicare has experienced significant changes prompting stakeholder interest in the information. We believe that CMS has and continues to respond appropriately to these new demands by expanding access to the data while protecting its integrity. In particular, we recognize that, since 2010, CMS has released an unprecedented amount of aggregated data, including offering providers Quality and Resource Use Reports and working to provide Accountable Care Organizations with monthly claim feeds for approximately three million beneficiaries. CMS has also allowed beneficiaries full and open access to their Medicare claims data through the Blue Button Initiative that permits beneficiaries to download data in a simple format and then share this information with providers and caregivers.

We believe these efforts to release Medicare physician data are appropriate, recognizing that they serve to enhance the quality of our health care system and include safeguards. The unfettered release of raw data, however, could easily result in inaccurate and misleading information that could ultimately undermine the quality of care for patients. Publication of reimbursement information for any purpose and without appropriate safeguards would move toward an opposite extreme—it would categorically dismiss significant privacy interests and would fail to ensure that the data can be used in a truly effective manner. Such broad, indiscriminate disclosure of personal financial information would undermine the careful balance which presently exists in existing laws and regulations that recognize the interests between public disclosure and the privacy of physicians and patients.

In particular, Congress recognized these competing principles when it enacted legislation to improve access to Medicare claims data through the Qualified Entity (QE) program included as part of the Affordable Care Act. This legislation creates a structure through which experienced entities can receive Medicare claims data and publish public reports for quality improvement purposes. However, it also preserves the privacy interest in the data by ensuring the information being used for quality improvement is appropriately risk-adjusted and allows physicians an opportunity to correct their information. **We therefore support the protections that are**

currently available under the Affordable Care Act and the implementing regulations ensuring disclosures are appropriate and include certain procedural safeguards. Such programs may be expanded, allowing for greater flexibility and innovation, while recognizing the benefit and importance of appropriate safeguards.

- *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?*

If not approached thoughtfully, release of individual physician payment data to anyone for any purpose can have unintentional, adverse consequences for patients, providers, and the health care system. For any data release program, safeguards must be in place to ensure that neither false nor misleading conclusions are derived from this information. We therefore urge CMS to consider adopting the following policies: (i) focus on release efforts that seek to improve health care quality; (ii) ensure accuracy of the data by educating those accessing the information and allowing physicians to review and correct any errors; and (iii) follow existing safeguards, including appropriate risk-adjustment and attribution methods, for any public reports that utilize the information.

Focus on improving care quality

As an initial matter, we fundamentally support efforts that increase knowledge about the quality of care and the efficient use of resources in the delivery of health care services. We recognize that greater access to Medicare data may be necessary to expand new delivery models and transform the existing Medicare payment system. Consequently, we urge CMS to engage with physicians and focus on care quality given that obstacles to this data may be blocking improvements to our health care system.

CMS should concentrate efforts aimed at improving the quality of health care services. Multiple federal agencies already have broad access to Medicare claims data, in addition to a range of other health care information, and tremendous financial resources provided by taxpayers to support their investigations into program integrity matters. Allowing other, untrained entities that lack knowledge about the Medicare program to attempt to detect fraud and abuse is likely to bring false or incorrect accusations without due process that ultimately undermine federal investigator efforts and result in wasted finite resources. In addition, a focus on fraud and abuse may spur meritless medical liability lawsuits that manipulate the data to paint a false and misleading picture of the standard of care. **As explicitly provided for in the Affordable Care Act, any release of this data should not be subject to discovery or admitted into evidence without the identified physician's consent. This should include all analyses or reports derived from this data.**

Meaningful efforts to ensure data accuracy

Medicare data is highly susceptible to misleading conclusions. CMS should undertake a detailed educational program to explain any Medicare data release program and openly address its limitations, including that the data may take into account only a small fraction of a physician's patient population or may be outdated. **We also encourage providing greater access to entities that demonstrate prior experience in handling Medicare data to ensure this information is used in a manner that is safe and protects patient privacy. To further guarantee accuracy of this data, physicians must have the opportunity to review and correct their information in a timely manner.**

Necessary safeguards when publicly reporting Medicare data

CMS must not only monitor the release of the data, but also any public reporting of this information. As noted by CMS Deputy Administrator Director Jonathan Blum, claims data are complex and often require sophisticated interpretations to obtain useful, meaningful, and understandable information about the quality of care.[1] Without statistically valid sample sizes and standardized risk-adjustment and attribution methods, multiple and conflicting reports could be published for the same physician. Ultimately, this will undermine the usefulness of this data and could lead to misleading and inaccurate information about health care quality. Attribution and risk adjustment methodologies should also be assessed on a condition-specific basis, be based on physician and other expert input, and transparent to all stakeholders.

Likewise, public release of information in the media or on the Internet, without safeguards and due process, can jeopardize the professional reputations of innocent physicians and threaten their ability to practice medicine. Indeed, there is a well-documented history of private insurers misusing claims data to profile physicians, deny them reasonable reimbursement, or subject patients to higher out-of-pocket costs. To avoid these abuses, physicians must have the opportunity to request their data for review and comment prior to use in publications. Providers must also be permitted to review and appeal any conclusions that are part of a public report.

We urge CMS to keep existing safeguards intact for the public reporting of Medicare data. We also encourage CMS to consider ways to increase flexibility for non-public or internal uses that pose fewer privacy and reputational risks. One example includes allowing QEs more flexible access to Medicare data for use in enhancing *internal* quality performance reporting for quality improvement activities.

- *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).*

Entities are seeking access to Medicare physician data for a variety of different purposes, all of which will influence the most appropriate way in which to release and present the data. Currently, entities like the Research Data Assistance Center (ResDAC) assist in navigating

[1] *See Repealing the SGR and the Path Forward: A View from CMS*, Hearing before the Senate Committee on Finance, United States Senate, 113th Cong. (Jun 10, 2013).

Medicare data so that researchers can readily access the most relevant information. Maintaining this approach, as opposed to developing a new public database, improves the usefulness of the material and allows for monitoring and safeguarding the release of information. In contrast, a public database, while easy to access, is cumbersome to search and would require the agency to devote significant new resources in order to create a workable system.

In regard to the data elements, CMS should consider whether certain information is more likely to confuse than assist in providing meaningful and accurate information about the quality of care. For example, while procedure codes and physician charges may be useful to those with significant experience with Medicare data, patients may need access to more general, synthesized information that can simply convey the types of services and treatment offered by a specific physician. **We recommend that CMS protect the privacy of patient and physician identifiable information, such as the National Provider Identifier, which may be susceptible to fraud and misuse.**

In addition, raw Medicare claims data is a crude metric for assessing the quality of medical care. When used in isolation this data ignores the more important clinical factors that affect patients, including case mix, co-morbidities, and other patient characteristics. These deficiencies are exacerbated by the fact that Medicare claims constitute only a portion of services performed by many physicians. **For these reasons, we discourage public reporting of claims data without any relevant quality information or the inclusion of other payer sources. CMS must safeguard attempts to mischaracterize the data or emphasize volume as an indicator of quality.**

If not approached thoughtfully, public release of Medicare claims data can have unintentional adverse consequences for patients. Patient de-selection can occur for individuals at higher-risk for illness due to age, diagnosis, severity of illness, multiple co-morbidities, or economic and cultural characteristics that make them less adherent to established protocols. Further, physicians and patients must be able to easily understand and act upon the information made available through the use of Medicare claims data, and not have to decipher conflicting reports that present opposing and inaccurate conclusions about physicians or the quality of care.

In conclusion, we are at a critical juncture with respect to expanding access to physician Medicare data that can help promote meaningful, accurate, and innovative ways to improve the overall quality of patient care. We look forward to working alongside CMS to establish appropriate ways to utilize this data to advance our health care system and improve health care quality, delivery, and access.

We appreciate the opportunity to comment on this important matter.

Sincerely,

American Medical Association
AMDA - Dedicated to Long Term Care Medicine
American Academy of Dermatology Association
American Academy of Family Physicians

American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Association of Allergy, Asthma, and Immunology
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Allergy, Asthma, and Immunology
American College of Emergency Physicians
American College of Gastroenterology
American College of Medical Quality
American College of Mohs Surgery
American College of Osteopathic Internists
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Hematology
American Society of Plastic Surgeons
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
Infectious Diseases Society of America
International Spine Intervention Society
Joint Council of Allergy, Asthma, and Immunology
Medical Group Management Association
North American Spine Society
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery

Society of Hospital Medicine
Society of Nuclear Medicine and Molecular Imaging
The Society of Thoracic Surgeons

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association

Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society
Wyoming Medical Society

September 5, 2013

Department of Health Human Services
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

On behalf of the American Medical Group Association (AMGA), we thank you for the opportunity to provide written comments on the potential release of Medicare physician data. As you may know, AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA represents 430 medical groups in 49 states that employ nearly 125,000 physicians who treat over 130 million patients. Our member medical groups are working diligently to provide innovative, patient-centered medical care and support transparency of health care data, both within their health care organizations in order to improve care and to drive down the overall cost of care, and externally to wider audiences. We offer comments on the questions posed by the Centers for Medicare and Medicaid Services (CMS) resulting from the May 31, 2013, Florida federal district court decision to lift a permanent injunction that prohibited the agency from disclosing annual Medicare reimbursement information at an individual physician-level.

The first question asks 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. AMGA recognizes the tension between the public benefit inherent in disclosure of Medicare reimbursement data and the confidentiality of physicians, and we believe that with an individual physician and claim-level of disclosure, there are significant privacy concerns. We would urge the agency to take steps to make sure that data are not presented in a misleading way that could be harmful to physicians, but at the same time, be useful to members of the public in making health care decisions.

A common scenario could involve a well-known surgeon, renowned for their success in performing certain surgical procedures. Because of their expertise, they receive a number of highly appropriate referrals for surgery, for which Medicare provides reimbursement. Let's assume this surgeon is also a salaried employee and practices with a certified physician assistant, so the surgeon can spend more time in the operating room. This is typical in many larger AMGA member medical groups. Depending on how the information on this physician was presented, a potential beneficiary could look at this surgeon's reimbursement data and conclude that (1) this surgeon performs surgery on nearly every patient they see, and (2) they earn more money than they actually do. It is therefore extremely important that physician reimbursement data be presented with the appropriate explanation and context, which is a

very complex undertaking. This type of complex evaluation, while extremely valuable, requires advanced training to conduct and to interpret the findings.

It should be noted that publication of detailed data may also abridge the privacy rights of patients, even in the absence of any specific details about individual patients. Certain practices can be limited in the number and scope of beneficiaries served, e.g. mostly celebrities, making physician-level data too direct to protect the privacy of the physician-patient relationship.

Larger multi-specialty medical groups and other integrated systems are typically organized around a team-based model of care, as in the example above involving the surgeon and the physician assistant. CMS should also consider providing physician data at the system, or medical group level, rather than at an individual physician-level. The emphasis on individual physician-level data is a relic of an outdated care model and a fragmented health care delivery system that is rapidly transitioning toward more efficient models of care delivery. Individual physician-level reimbursement data, in the wrong hands, could also be used to target physicians in any number of ways, from something as harmless as unwanted marketing attempts, to being the target of criminal activity.

CMS must also be mindful of the potential variability in state laws that may require limitations on disclosure of reimbursement data related to certain diagnoses, and of any other state laws that may govern the disclosure of physician data. It should be noted that varied state laws impeding the full disclosure of certain diagnoses may significantly compromise risk adjustment in many instances.

CMS also asks what specific policies the agency 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.

AMGA supports the disclosure of physician payment data to enhance the quality and value of health care, among other laudable goals. However, individual physician claims data, in its raw form, does not supply meaningful information to individuals who are not knowledgeable about evaluating and interpreting those data. Identifiable physician claims data must be carefully risk-adjusted and aggregated, in order to draw valid inferences or meaningful comparisons. Furthermore, providing broad access to physician-identifiable claims data without providing additional data regarding the underlying patient population could confound and distort potentially meaningful results. As noted above, data presented at the physician group level could mitigate some of the potential negative consequences of disclosing individual physician-level data. Physician practices can also vary greatly in terms of services that are billed in conjunction with other professional services, and this must be taken into account in order to produce data that are useful for comparative purposes.

Moreover, several larger medical group practices furnish health care to the majority of their Medicare beneficiaries through Medicare Advantage plans. CMS will therefore need to carefully consider how to meaningfully compare data derived from Medicare Advantage claims with data derived from Original Medicare claims, since physicians may receive differential reimbursement through Medicare Advantage plans.

Lastly, CMS must consider how to make meaningful comparisons of claims data with respect to its varied rates of reimbursement as a result of Geographic Practice Cost Indices so that there is no unintentional misrepresentation of this data.

CMS also asks for input on the form in which the agency should release information about individual physician payment, should the decision be made to release this information. As suggested above, only risk-adjusted, aggregated, professional services claims data would be comparable across similar medical practices, notwithstanding varied state laws that may impede full disclosure of certain diagnoses. Additionally, it would be important to also provide characteristics of the underlying patient population (e.g., demographics, comorbidities, health care utilization, and insurance status). Further, physician reimbursement data contained in claims should be normalized to remove variations in CMS reimbursement due to geographic disparities or type of Medicare plan.

As an alternative to broad release of detailed data, CMS may wish to consider releasing aggregated data in a form such as the *Dartmouth Atlas,* which demonstrates geographic variability, or commissioning reputable health services researchers or research organizations to answer specific policy questions.

With the Research Data Assistance Center (ResDAC), CMS has developed a mechanism to release detailed data to qualified health services researchers and to offer extensive training to enable these researchers, who typically come with graduate-level training in statistics, to understand the limitations of the data and potential biases, in order to carry out valid analyses. Without expertise and effort in risk adjustment of aggregate claims data for a given physician, as well as one knowing how to relate claims data across specialties, the data cannot be accurately utilized for any comparative purpose. ResDAC is a responsible approach which has added a great deal to our understanding of the health care delivery system. With the growing interest in "data-driven" investigative journalism, responsible news organizations are following suit, recognizing the training and careful analysis required to draw valid inferences. Simply releasing detailed data without the controls and training that ResDAC provides would be a step backward.

In conclusion, great care must be taken to prevent misrepresentation of reimbursement data that could have an adverse impact on physicians, or their patients. Such concerns must be carefully balanced with the public benefit of disclosing this information. In addition, CMS must take great care to ensure that data disclosures comply with the safeguards provided in current laws and regulations, including the Health Insurance Portability and Accountability Act and the Qualified Entity program enacted in the Affordable Care Act, which creates a means for experienced entities to receive Medicare claims data and publish public reports for the purpose of quality improvement.

Thank you for your careful consideration of our comments.

Sincerely,

Donald W. Fisher, Ph.D.
President and CEO

American Optometric Association
1505 Prince Street, Alexandria, VA 22314•(800) 365-2219
FAX: (703) 739-9497

September 5, 2013

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

Re: Physician Data Comments

Administrator Tavenner,

The American Optometric Association (AOA) represents approximately 36,000 doctors of optometry, optometry students and paraoptometric assistants and technicians. Optometrists serve patients in nearly 6,500 communities across the country, and in 3,500 of those communities are the only eye doctors. Doctors of optometry provide more than two-thirds of all primary eye and vision health care in the United States. Approximately 34,000 optometrists are enrolled as physicians to serve the Medicare program with their professional services (medical eye care), and approximately 14,000 optometrists are enrolled as suppliers serving the Medicare program with prosthetics (primarily covered eyeglasses following cataract surgery). The AOA appreciates the opportunity to respond to the issues raised in the CMS request for comments regarding the potential release of Medicare payment data. Please find the AOA's responses to the questions posed below.

CMS sought comments and input with regard to:

(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;

Physicians, as well as patients, have a privacy interest in payments physicians receive from Medicare. The AOA has significant concerns that releasing raw data could infringe on the doctor-patient relationship and jeopardize patient privacy. While CMS acknowledges that the agency does not intend to disclose any information that could directly or indirectly reveal patient-identifiable information, the AOA is concerned that the risk of indirectly revealing patient identifiable information is high. Physician-identifiable payment data, combined with the large volume of public information already available, could be used to further chip away at physician and patient privacy. A loss of privacy could cause physicians and patients to avoid Medicare, reducing the number of people receiving needed care.

Earlier this year, when CMS released detailed hospital billing data, much of the press coverage focused on the variances in payments from one hospital to the next. These variances on the

surface seem shocking, however the majority of the differences can be explained by policies that CMS itself has put into place to pay hospitals. These payment variances do not provide the public with any information regarding the value or benefit of the services provided, nor do they reveal fraud and abuse. The same issues will present if CMS moves forward with releasing physician payment data. Variances will again be noted in services provided by a physician in Baltimore, Maryland and a physician in Mobile, Alabama. These variances are due to the fact that Medicare adjusts payment rates based on geographic location and other factors such as whether a doctor is practicing in a Health Professional Shortage Area. Much of the public is unaware of these payment policies and could easily misconstrue physician payment data.

When hospital billing data was released this year, press coverage also noted that the Department of Health and Human Services "hopes researchers will repackage its data."[1] If the Department is ill-equipped to release physician payment data in a manner that is useful and comprehensible to the general public, the Department should reconsider whether it is really valuable to release this information. The AOA is concerned that releasing a huge amount of raw data with the hope that another organization will make this information useable by the public is irresponsible and does little to improve quality of health care.

(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

The claim that releasing Medicare payment information can help combat fraud and abuse is questionable. Presumably, CMS would release payment information on claims that were processed and paid by CMS. As such, the payments would have been made for services that the doctor, patient, and CMS viewed as reasonable and necessary. CMS has always had access to payment data and this information was previously used to identify unusual billing patterns when CMS was operating under the "pay and chase" approach to reducing fraud and abuse. As demonstrated by the success of recent CMS efforts to focus on pre-payment fraud and abuse prevention, efforts to stop fraud and abuse after payments have been made are more costly and less effective. Making payment data public will likely do little to prevent fraud and abuse, and only gives the appearance of transparency.

One of AOA's major concerns with publically releasing payment data is that the data would be released in a vacuum without the proper context. If one looks solely at payment data, concerns could be raised if a doctor bills for a service with more frequency than his or her peers. However, this kind of billing pattern can easily be explained if one understands that some doctors provide a certain covered service more frequently than others because of patient demographics and practice specialty. The AOA is concerned that without any real context, the predominant information that public fee disclosure will reveal is utilization. Without context, utilization rates are meaningless at best and misleading at worst.

Furthermore, utilization rates also tell us little about quality or value. CMS has other initiatives underway that better address these important issues. The public can learn about a doctor's

[1] http://money.cnn.com/2013/05/08/news/economy/hospital-bills/index.html?iid=EL

participation and performance in the Physician Quality Reporting System (PQRS) through the Physician Compare website. If CMS follows its proposed plans, Physician Compare will also soon include information on Maintenance of Certification efforts. The Value Based Modifier Program is also in its early stages. This program provides more reliable data on cost and quality performance and the equations used to compare and contrast providers is far more statistically sound than simply releasing raw payment data. To improve quality and value, CMS should rely on the programs already in place that were developed explicitly with these goals in mind.

(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).

The AOA has significant concerns with the overall concept of releasing individual physician payment data, either in line item or aggregate form. Releasing line item claim details raises concerns not only for physician privacy, but also patient privacy. The AOA strongly recommends against this approach. Aggregated data at the individual physician level may better protect patients, but the value and use of this information is questionable. Almost as important as the form in which data is released, is the context and packaging that the data comes in. If previous data releases are any indication of how CMS will proceed, it seems that there would be little attention paid to these additional critical factors.

The AOA appreciates this opportunity to provide feedback regarding this important issue. Please contact Rodney Peele, Esq., Assistant Director for Regulatory Policy and Outreach at rpeele@aoa.org or (703)837-1348, if you have any questions or need additional information.

Sincerely,

Mitchell T. Munson, O.D.
President
American Optometric Association

AMERICAN OSTEOPATHIC ASSOCIATION

1090 Vermont Ave., NW, Suite 500, Washington, D.C. 20005-4949 ph (202) 414-0140 | (800) 962-9008 | www.osteopathic.org

September 5, 2013

Administrator Marilyn Tavenner
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: Physician Data Comments
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

RE: Release of Physician Data

Dear Administrator Tavenner:

Thank you for the opportunity to provide public comment about the most appropriate policy for the agency to follow regarding the public release of Medicare physician payment data.

The American Osteopathic Association (AOA) represents its professional family of more than 104,000 osteopathic physicians (DOs) and osteopathic medical students nationwide. Approximately 65 percent of practicing osteopathic physicians specialize in primary care areas such as pediatrics, family medicine, obstetrics and gynecology, and internal medicine. Many DOs fill a critical need for patients by practicing in rural and other medically underserved communities.

In addition, the AOA promotes public health; encourages scientific research; serves as the primary certifying body for DOs; is the accrediting agency for osteopathic medical schools; and has federal authority to accredit hospitals and other health care facilities. More information on DOs/osteopathic medicine can be found at www.osteopathic.org.

The AOA understands the agency's commitment to improving data transparency. As CMS has noted, the agency now receives multiple requests from various stakeholders for physician payment and reimbursement data.

The AOA believes access to timely and meaningful data is vital to empowering physicians to improve patient care. We appreciate that CMS' wealth of data may have significant value in improving the quality of health care and bringing spending to more sustainable levels.

The agency specifically asks the following questions:

- 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;
- 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; and
- 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).

Medical professional organizations are making considerable investments in the development of clinical guidelines, quality measurement sets, and other research in order to engage in multiple quality improvement initiatives in the public and private sector. Like the federal government, medical professional societies have finite resources available for these activities; therefore, determining which clinical areas would have the greatest potential to improve health outcomes is essential. By combining Medicare claims data with other sources of clinical data, we can better understand treatment patterns and gaps in care, which will enable us to direct resources where they are most warranted.

While there is value to using claims for internal quality improvement purposes, less is known about the value of providing the public with such data, especially when presented at a granular level. Therefore, the AOA believes releasing individual physician data should be delayed until such time as:

- Satisfactory technology and adequate statistical models have been developed and widely adopted to ensure the accuracy of such data;
- Research has shown that such data are not only meaningful and valuable, but are actually used by consumers for health care decision-making;
- Health care transparency requirements and requests do not add further cost and administrative burden to physician practices; and
- Physicians have the opportunity to review their data before it is published and that they are permitted to attach comments to any reports produced with the data.

While the AOA recognizes the value of involving consumers in their care as partners, we urge CMS to exercise caution when considering the release of individual level physician payment data. When raw data are presented to the public, they can very easily lead to false conclusions and greater confusion, which seems to contradict CMS' intent to empower the public through education. Payment data are particularly confusing since various complex factors contribute to their variability. Public disclosure of such data should not occur until it has been proven that such data are actually of value to the public, and that the public can and will use that data in meaningful manner.

We also question how helpful public availability of this information would be to improving patient care or reducing waste, fraud, and abuse. CMS already has access to this data and is much better equipped to draw conclusions about fraud and abuse than the public. If CMS does eventually proceed with the release of individual physician payment data, we urge incorporating safeguards so that the sharing of data does not compromise the security of confidential information about patients, erode the patient-physician relationship, or exacerbate the practice of defensive medicine to the ultimate detriment to patients.

In addition, any public reporting of individual physician data should be complete and continuously updated. Physicians should be allowed ample opportunity to review and dispute the information before it is disseminated. It also must be made clear to the public that Medicare payment data are just that and do not necessarily reflect the quality or competency of the physician. If raw specific physician data involving claims and payment are released to the public, explanatory statements should be included to address the limitations of the information that could lead to misinterpretations.

In conclusion, the AOA supports efforts to promote transparency in health care and to better engage consumers in health care decision-making. However, we remain concerned that raw Medicare claims data do not provide patients with meaningful information regarding quality of care or treatment options, and that the public dissemination of such data can be misleading and in some cases harmful to both patients and physicians. We encourage CMS to strongly consider the impact and unintended consequences this policy might have for physicians and their patients.

Thank you for the opportunity to provide comments. We look forward to working with CMS on this and other issues of importance to the osteopathic medical community.

Sincerely,

Norman E. Vinn, DO
President

APMA
American Podiatric Medical Association

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October 22, 2013

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: *Physician Data Comments*
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via Physician_Data_Comments@cms.hhs.gov

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

Dear Sir / Madam:

On behalf of the members of the American Podiatric Medical Association, Inc. (APMA), the national organization representing the vast majority of America's foot and ankle physicians and surgeons, I welcome the opportunity to submit comments regarding the Centers for Medicare and Medicaid Services' (CMS) request for public comment on the potential release of Medicare physician claims data, published August 6, 2013.

APMA commends CMS for soliciting public comments, especially from the Medicare physician provider community, on the release of Medicare physician claims data. The physician point of view provides valuable input that will result in the improvement of the health care system.

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?

Physicians do have a privacy interest in the information concerning payments they receive from Medicare. This privacy interest should be fairly and equitably balanced against the public's interest in the disclosure of Medicare payment information, especially with respect to physician-identifiable reimbursement data. If CMS chooses to disclose Medicare payment information, the development, adoption and implementation of explanations, disclaimers and safeguards are necessary to deter the loss, misinterpretation and misuse of this payment information, resulting in unintended adverse effects for Medicare beneficiaries and physicians. The clinical context in which Medicare beneficiaries are treated, as well as the ultimate use of the data, must be considered when reporting and presenting this payment information as well.

Also, we strongly urge that the data not be misused for purposes of identifying outliers, or potentially for identifying contracted physicians for adverse actions. Please consider that reimbursement data is significantly influenced by the volume of Medicare patients seen, type of care and services provided, place of service, and other factors. While obvious public good can come of sharing this data (to be seen later), these considerations must be weighed against the potential harm to Medicare physicians and their beneficiaries. Similarly, we ask that you consider the comparative value of the data by specialty and relative to Medicare commercial durable medical equipment (DME) suppliers.

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?

Medicare physician claims data should be utilized with the intent of improving the quality and value of care provided to the patient population. If this data is disclosed, CMS should encourage all individuals and entities that have access to this data to use it for these purposes and present the data in a manner that facilitates this type of usage. CMS should be a resource for these individuals and entities to provide the context and limitations of this data.

To ensure that the Medicare physician claims data is accurate, CMS should give physicians the opportunity to review and dispute the information disclosed pertaining to them. If resolution cannot be reached, this data should be flagged as disputed (similar to the OPEN PAYMENTS program). Likewise, physicians should be given the opportunity to comment on the use of data attributed to them prior to its inclusion in any publication.

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).

CMS should consider what Medicare physician claim data is truly necessary to inform the users of this data about the delivery of care to Medicare beneficiaries, and would not confuse or create opportunities for these users to misuse or misconstrue this data. It should also provide clinical quality data that is required to provide the context for the care provided to Medicare beneficiaries, and anticipate and explain how the data should not be characterized.

To make the data available of the most use to the public need, CMS should consider how the information is linked and provided. For instance, CMS may consider aggregating data in a manner that shows not only total billing for a particular service, but also then allow for that data to be broken down by specialty providing the service. This information could be potentially helpful in doing research on particular services provided by Medicare physicians. Also, CMS

should consider linking data to both ICD (9 and 10) codes as well as to CPT codes to further provide for stratification of the data based on particular conditions.

We would like to take this opportunity to comment on another CMS transparency initiative, the Physician Payment Sunshine Act (OPEN PAYMENTS), specifically the exemption for indirect payments made to speakers at accredited or certified continuing medical education programs from reporting requirements codified at 42 CFR § 403.904(g)(1). We strongly disagree with the decision of the CMS to omit arbitrarily the Council on Podiatric Medical Education (CPME) as an accrediting or certifying entity under this regulation. Also, we believe that CMS failed to provide proper notice and opportunity to comment on this exemption. We believe that the opportunity to address this inequitable decision still exists and must be taken. CMS has the authority to and should change its position concerning the inclusion of CPME under this regulation.

Thank you for the opportunity to provide input on CMS' request for public comment on the potential release of Medicare physician claims data, and we hope the above comments are helpful. If you have any questions regarding our comments or need more information, please contact Scott Haag, JD, MSPH, Director of APMA's Center for Professional Advocacy & Health Policy & Practice, at 301-581-9233 or via e-mail at slhaag@apma.org.

Sincerely,

Matthew G. Garoufalis, DPM
President, APMA

September 4, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1590-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850
Submitted Electronically: Physician_Data_Comments@cms.hhs.gov

Request for Public Comments on the Potential Release of Medicare Physician Data

Dear Administrator Tavenner:

The American Society for Radiation Oncology (ASTRO) appreciates the opportunity to provide a written response to the "Request for Public Comments on the Potential Release of Medicare Physician Data," posted on the Centers for Medicare and Medicaid Services' (CMS's) website on August 6, 2013.

ASTRO is the largest radiation oncology society in the world, with 10,000 members who specialize in treating patients with radiation therapies. As the leading organization in radiation oncology, biology, and physics, the Society is dedicated to the advancement of the practice of radiation oncology by promoting excellence in patient care, providing opportunities for educational and professional development, promoting research and disseminating research results, and representing radiation oncology in a rapidly evolving healthcare environment.

On May 31, 2013, a Florida federal district court lifted a permanent injunction originally issued in 1979 that prohibited the Department of Health, Education, and Welfare (as HHS was then known) from disclosing annual Medicare reimbursement payments to individual physicians or in a manner that could identify individual physicians. In light of this recent legal development, CMS seeks public input on the most appropriate policies with respect to disclosure of individual physician payment data.

ASTRO supports the agency's efforts to make the Medicare program more patient-centered, transparent, and competitive. We believe that accurate, reliable, and relevant data provides a window into the efficacy of the Medicare program and the quality of care delivered to Medicare beneficiaries. This commitment to using data to improve the Medicare program is reflected in the significant resources ASTRO has expended in recent years in the development of registry reporting programs and our accreditation program that is expected to be launched in 2014.

While ASTRO shares the agency's commitment to transparency and quality improvement, we caution it to be circumspect as it lifts the exemption on the release of individual physician

payment data. There is inherent complexity and significant limitations to Medicare claims data. This creates significant challenges to interpreting its meaning when it is not integrated with clinical data at an individual physician level.

As a specialty that effectively utilizes highly advanced, sophisticated technology, we also have concerns that the claims data alone will offer a distorted view of the revenue generated by radiation oncology practices, as the reimbursement data will not reflect the substantial expenses associated with operating a radiation oncology clinic. In addition to its use of expensive technology, high quality radiation oncology care can only be provided through a well-trained and specialized team, including medical physicists, dosimetrists, radiation therapy techs, nurses, and other health professionals like dieticians and social workers. As a specialty with unique costs – both non-physician staff and equipment – we are concerned that claims data alone will provide an unfairly skewed picture.

In these comments, ASTRO responds directly to the questions raised by CMS in this RFI. We also share our vision of how to best utilize administrative and clinical data to support the Medicare program, beneficiaries, and providers.

Questions Posed by CMS in the RFI

(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 the privacy interest and the public interest in disclosure of Medicare payment information, including physician-identifiable reimbursement data?

Balancing Public Interest and Physician Privacy Rights

This question is vitally important and represents the heart of the dilemma. The agency must balance the public's interest in disclosure of claims and payment data resulting from government healthcare programs against the confidentiality and privacy interests of physicians, their practices, and patients who may be adversely impacted by disclosure. Proponents of releasing data say it could help identify patterns of waste and fraud, as well as help identify physicians who deliver the most efficient and highest quality of care.

For instance, access to claims data helped a *Wall Street Journal* investigation identify inappropriate and wasteful treatment of prostate cancer patients at urology-owned radiation therapy centers. More recently, the Government Accountability Office found similar overutilization among self-referring urology-owned radiation therapy centers in its ground breaking report, "Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrants Scrutiny." This report recommended that the agency identify and monitor self-referral of IMRT services. While ASTRO continues to recommend that Congress remove radiation therapy from the self-referral law's in-office ancillary services exception, CMS should consider implementing an enhanced version of GAO's recommendations by requiring all physicians who self-refer for radiation therapy services to provide to CMS all financial relationship information, whether direct or indirect, related to the group practice that is furnishing these services. Specifically, the group practice should disclose all direct or indirect ownership and compensation relationships (including, but not limited to, all employment and lease arrangements) it has with

physicians and any other individual or entity. This information can be captured in the CMS enrollment system and should be updated every time there is a modification of a direct or indirect ownership or compensation relationship with the group practice. CMS also should post on its website a report of all direct or indirect financial relationships of self-referring group practices and update this information at least once yearly. In addition, CMS should require self-referring group practices to fully disclose to patients that the referring physicians have a direct or indirect financial interest in the service that is being self-referred. Further, CMS should require that the physicians fully notify patients that there may be alternative locations to receive the service and that there may be other treatment options available to the patient. Information about self-referral will make the claims data that is released more meaningful. This information will help patients understand that in these instances, the physician stands to financially gain from their treatment.

On the other side of the argument, there is a real and legitimate concern that if not approached thoughtfully, release of individual physician payment data to anyone for any purpose can have unintentional, adverse consequences for patients, providers, and the healthcare system. In order to balance these two sides, CMS must consider the risks and benefits of releasing physician-level claims data. Medicare claims data lacks detailed clinical information about a patient's disease state or treatment. We believe that on its own, claims data is limited in use and function. In contrast, linking claims data with clinical data through a registry can provide a wealth of information. Media outlets and other interested parties will need to make Freedom of Information Act requests to access Medicare claims data, and HHS should still have the option to deny the requests it finds inappropriate. When considering these requests, CMS must consider the intention of the request and if the data requested will be able to serve the stated purpose.

These limitations and risks compel CMS to include appropriate disclosures and/or explanatory statements as to the limitation and potential misinterpretation of the data.

ASTRO recommends that, in light of these considerations, the release of raw data regarding physician claims for providing medical services should be limited for specific purposes and with appropriate safeguards. ASTRO urges CMS to include appropriate disclosures and/or explanatory statements as to the limitation and potential misinterpretation of the data.

Ensuring Patient Privacy

The HIPAA Privacy Rule protects patient-identifiable health information, often referred to as "protected health information" or PHI. Medicare claims data includes a considerable amount of data that would fall under the PHI category. Under current law, when CMS releases such data (e.g., under a data user agreement) the agency must ensure the disclosure complies with HIPAA and other applicable privacy laws.

Patients trust that their health information will remain safe and secure. The potential release of physician-level data will require CMS to be even more diligent about these issues. When dealing with a specialist, such as a radiation oncologist, who may see a much smaller pool of patients than a typical general internist, ensuring patient privacy becomes more challenging. Moreover, a radiation oncologist who has a very specialized practice or treats rare types of cancer may have an even smaller and more easily identifiable patient pool.

For these reasons, ASTRO urges CMS that any established procedures take into account the variety of circumstances that may exist in various specialties and practices, including relatively small patient volumes, to ensure that patient privacy is not breached.

(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?

As noted previously, the GAO has recommended that there should be close scrutiny of self-referral practices for services, such as IMRT for prostate cancer, and CMS has the opportunity to play an important role in promoting transparency in this setting so that patients may be informed about possible conflicts of interest when physicians hold an ownership stake in health care facilities. Again, ASTRO supports closing the self-referral loophole for radiation therapy, but, as an interim step, suggests that CMS implement ASTRO's recommendations for self-referral disclosure outlined above.

In May 2013, Medicare released publically for the first time chargemaster data or the list prices for the most common hospital procedures. Chargemaster plays a complex role in how hospitals negotiate prices, but on its own provides little insight into what patients or payors might actually pay to have the services performed. This example illustrates that in the complex world of healthcare reimbursement, one piece of data out of context is not as helpful as data released in conjunction with other clinical information to make it more meaningful. Claims data or payment data at the individual physician level, unaccompanied by clinical data or the application of appropriate statistical analysis, such as risk adjustment, can be misleading.

If not approached thoughtfully, the indiscriminate release of individual physician payment data can have adverse consequences for patients, providers, and the healthcare system. Medicare must put in place program safeguards to ensure that neither false nor misleading conclusions can be reached.

Potential Models to Consider
One model to consider is the Qualified Entity (QE) program of the Affordable Care Act (ACA). This legislation creates a structure through which experienced entities can receive Medicare claims data and publish public reports for quality improvement purposes. However, it also preserves privacy interests by ensuring the information being used for quality improvement is appropriately risk-adjusted and allows physicians an opportunity to correct their information.

Another model to consider is the Physician Payments Sunshine Act (Sunshine Act), which requires manufacturers of drugs, medical devices, and biologicals that participate in U.S. federal healthcare programs to report certain payments and items of value given to physicians and teaching hospitals. Manufacturers are required to collect and track payment, transfer and ownership information beginning August 1, 2013**.** Manufacturers will submit the reports to CMS on an annual basis. In addition, manufacturers and group purchasing organizations (GPOs) must report certain ownership interests held by physicians and their immediate family members.

The majority of the information contained in the reports will be available on a public, searchable website. A key and important feature of this program is that physicians have the right to review their reports and challenge reports that are false, inaccurate, or misleading. A mechanism that allows for physicians to address inaccuracies in the data, or conclusions reached from the data subsequently published in a report or other publication, would help ensure the accuracy of the data.

Working with the Physician Community on Quality Measurement
In recent years, Medicare has significantly increased efforts to use data to improve the quality of care provided to Medicare beneficiaries. During this same time, physician specialties, including radiation oncology, have worked very hard to improve the knowledge base of quality improvement within their individual specialty. As a result, the number of measures available over the past few years has increased significantly. There are numerous examples of CMS working closely with the physician community to develop methodologies to measure and improve the quality of care provided to Medicare beneficiaries.

The practice of medicine is extraordinarily diverse. Even within a single specialty there is great diversity depending on specialization, patient population, or even diversity driven by geography. Physician involvement by specialty societies in the development of measures and quality improvement efforts provides a way for the heterogeneity of physician practices to be integrated and accounted for within various quality improvement efforts.

ASTRO urges CMS to continue and build upon previous collaborations with the physician community as it considers the most effective way to release Medicare claims data to enhance the quality of care provided to Medicare beneficiaries.

Addressing Fraud, Waste and Abuse
Entities requesting access to Medicare claims data will be doing so for a variety of reasons. While measuring quality of care provided to beneficiaries might be one reason, identifying fraud and abuse is potentially another area of interest.

Fraud, waste, and abuse cost taxpayers billions of dollars each year and put beneficiaries' health and welfare at risk. The Affordable Care Act enhanced the healthcare oversight and enforcement activities of the Office of Inspector General (OIG). In pursuing the reduction of fraud and abuse, the OIG follows a comprehensive five-principle strategy to ensure the integrity of their work. While entities targeted by OIG investigations may not agree with the findings, there is an understanding and transparency to their methodologies.

ASTRO believes that absent a clear and transparent methodology, the public release of claims data for fraud and abuse purposes is as vulnerable to misinterpretation as when the data is used for quality measurement.

ASTRO recommends that regardless if whether the request for data is made for quality measurement or fraud and abuse purposes, the same level of rigorous procedures in vetting the requests should be established.

(3) In what form should CMS release information about individual physician payment, should CMS choose to release it (e.g., line item claims details, aggregated data at the individual physician level)?

Maintaining the Structure of ResDAC to Distribute Data
Entities are seeking access to Medicare physician data for a variety of different purposes, all of which will influence the most appropriate way in which to release and present the data. Currently, entities like the Research Data Assistance Center (ResDAC) assist in navigating Medicare data so that researchers can readily access the most relevant information. Maintaining this approach, as opposed to developing a new public database, improves the usefulness of the material and allows for monitoring and safeguarding the release of information. In contrast, a public database, while easy to access, is cumbersome to search and would require the agency to devote significant new resources in order to create a workable system.

ASTRO supports the continued use of ResDAC in navigating Medicare data.

Limit Release of NPI Data
In regard to the data elements, CMS should consider, and work with relevant physician specialty organizations, to determine whether certain information is more likely to confuse than assist in providing meaningful and accurate information about the quality of care. CMS should also consider if there is any sensitivity around any of the data. For example, unauthorized use of a provider's National Provider Identifier (NPI) exposes a provider to identity theft and billing fraud.

ASTRO recommends that CMS protect the privacy of patient and physician identifiable information, such as NPI data, which may be susceptible to fraud and misuse.

In addition, raw Medicare claims data is a crude metric for assessing the quality of medical care. When used in isolation, this data ignores the important clinical factors that affect patients, including case mix, co-morbidities, and other patient characteristics. For example, when trying to understand costs associated with cancer care, the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute (NCI) is essential. SEER is an authoritative source of information on cancer incidence and survival in the United States. The SEER program collects information about cancer site, stage, and histology for persons newly diagnosed with cancer who reside in one of the SEER geographic areas. SEER registries cover approximately 28 percent of the US population. The SEER-Medicare data is an example of the linkage of two large population-based sources of data that provide detailed information about Medicare beneficiaries with cancer, allowing a more nuanced contextual understanding of Medicare payments as a function of stage and type of cancer. While clearly not the only method of enhancing claims data with clinical data, it is one method. It also helps illustrate the limitations of solely using claims data for quality measurement.

If not approached thoughtfully, public release of Medicare claims data can have unintentional adverse consequences for patients. Patient de-selection can occur for individuals at higher-risk

for illness due to age, diagnosis, severity of illness, multiple co-morbidities, or economic and cultural characteristics that make them less adherent to established protocols. Further, physicians and patients must be able to easily understand and act upon the information made available through the use of Medicare claims data, and not have to decipher conflicting reports that present opposing and inaccurate conclusions about physicians or the quality of care.

For these reasons, we discourage public reporting of claims data without the relevant quality information. CMS must safeguard attempts to mischaracterize the data or draw inappropriate conclusions about quality.

ASTRO's Vision of the Use of Data to Improve the Medicare Program, Support Beneficiaries, and to Measure and Improve the Quality of Care

ASTRO's mission is to advance the practice of radiation oncology is driven by administrative and clinical data. In recent years, ASTRO has initiated multiple programs to promote the quality of radiation oncology care. We believe these models exemplify the appropriate use of data to enhance patient care. Three examples are described below.

National Radiation Oncology Registry

ASTRO supports CMS's efforts in using Medicare claims data to improve the quality and value of healthcare and the efficient use of resources in the delivery of healthcare services. However as previously mentioned, the use of claims data, by itself, will not be effective. ASTRO believes that it is critical to link the claims data with quality measure data to derive the most utility for quality improvement purposes. Further, this is a task that should be entrusted to qualified entities with experience and a concrete understanding of Medicare – not left to those who are untrained or inexperienced in the Medicare program. ASTRO believes that qualified clinical data registries will be such entities. Qualified clinical data registries have the potential for being quality improvement tools that support provider performance assessment and comparative effectiveness studies.

ASTRO, in partnership with our foundation -- the Radiation Oncology Institute (ROI) – is developing the National Radiation Oncology Registry (NROR), the first of its kind for radiation oncology. The intent of the registry is to improve the care of cancer patients by capturing real-time, real-world, reliable information on radiation treatment delivery and health outcomes through a prospective electronic registry infrastructure. The pilot project for this registry is beginning this fall and will be focused on radiation oncology treatments for patients with localized prostate cancer.

ASTRO's Practice Accreditation Program

ASTRO's practice accreditation program establishes standards of performance derived from evidence-based guidelines and consensus statements on practice for radiation oncology. The new accreditation program will launch in early 2014 and will be comprehensive, objective, and transparent. The practice accreditation program will provide an objective peer review of essential functions and processes of radiation oncology practices. ASTRO is confident that radiation oncology clinics accredited under the program will have an underlying culture

committed to quality and safety, as well as the policies, procedures, and quality improvement infrastructure to ensure that patients receive high quality of care.

ASTRO's SEER-Medicare RFP
A little over a year ago, ASTRO launched a payment reform initiative. One component of this important project is to develop alternatives to the traditional fee-for-service payment model. ASTRO released an RFP for technical assistance in the initial steps of this effort to identify the costs of cancer care for Medicare patients by various treatment methods. ASTRO has sought proposals that will provide an exploratory analysis of the SEER-Medicare dataset. ASTRO believes that to truly understand trends and be able to correctly understand Medicare spending in cancer care, you must link administrative data with clinical data such as SEER. ASTRO will select an awardee to this RFP later this fall.

Thank you for the opportunity to comment on this important issue. We look forward to continued dialogue with CMS officials. Should you have any questions on the items addressed in this comment letter, please contact Sheila Madhani, Assistant Director of Medicare Policy at (703) 839-7372 or sheilam@astro.org.

Respectfully,

Laura I. Thevenot
Chief Executive Officer

Association of Health Care Journalists
Center for Excellence in Health Care Journalism
Better coverage. Better health.

10 Neff Hall
Missouri School of Journalism
Columbia, MO 65211
573-884-5606

September 3, 2013

To Whom It May Concern:

Thank you for your request for public comment on the potential release of Medicare physician data. I write on behalf of the board of the Association of Health Care Journalists, a group which represents nearly 1,500 health journalists from around the country and the world. We are an independent, nonprofit organization dedicated to advancing public understanding of health care issues. Our mission is to improve the quality, accuracy and visibility of health care reporting, writing and editing.

We strongly encourage CMS to release physician-level utilization and payment data. This information can inform patients, their caregivers and the public about the services physicians deliver in the Medicare program and the costs of those services. It also will lay the foundation for physician quality reporting programs. The value of such information to the public far outweighs any privacy claims of physicians. As long as patient confidentiality is protected, we see no reason why taxpayers should not know how individual physicians are spending public dollars.

The release of Part B utilization and payment data is long overdue. The U.S. District Court was correct in lifting the 1979 injunction in response to dramatic changes in the health care landscape over the past three decades. Beyond that, we believe an informed public makes better health care decisions.

Journalists, researchers and public interest organizations have skillfully utilized large and complex Medicare data sets to produce stories and reports in the public interest, but they have been stymied by the inability to identify individual physicians. *The Wall Street Journal*, for example, used Part B data to identify surgeons who may have performed unneeded operations (though it was prohibited, in most cases, from identifying those physicians in its reports). Likewise, The Center for Public Integrity used Medicare data to raise important questions about whether the transition to electronic medical records has resulted in upcoding by physicians and facilities to obtain higher payments from the program. These reports would have had greater impact if the physicians involved could have been identified, enabling members of the public to research their own providers.

We recommend that CMS:

- Offer a menu of disclosure options that protect the identities of patients but answer the differing needs of those requesting information. For example, some people may be interested only in the number of patients a specific provider treated in a given year and the amount billed; others may want specifics on the procedures performed and the diagnoses of patients that underwent them. Data should be available in aggregate

and for individual claims (taking steps to protect patient privacy).

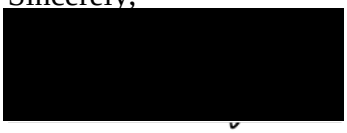
- Charge reasonable fees to ensure that information can be made widely available.
- Refrain from restrictions that would hinder the sharing of data.
- Make the data available in machine-readable format.
- Create a pathway for custom requests.

We commend CMS for releasing the data on provider referral relationships, provider prescribing patterns within the Part D program and hospital charge data. We also support CMS' ongoing effort to ensure that data provided under the Physician Payment Sunshine Act is useful and meaningful for the public.

The release of Medicare physician data with identifying information will be an important next step.

We look forward to working with CMS on data releases in the future, and our board of directors stands ready to offer additional guidance on the best format in which to release this data.

Sincerely,



Len Bruzzese
Executive Director

athenahealth

September 4, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attn: *Physician Data Comments*
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically to Physician_Data_Comments@cms.hhs.gov

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

athenahealth, inc. ("athenahealth") appreciates the opportunity to provide comments in response to the request for comment on the release of Medicare physician payment data.

We provide practice management, electronic health record, data analytics, patient communication, care coordination and related services to physician practices, working with a network of over 40,000 healthcare professionals nationwide. All of our providers access our services on the same instance of continuously-updated, cloud-based software. Our cloud platform affords us and our clients a significant advantage over traditional, static software-based health information technology products as we work to realize our company vision of a national information backbone enabling healthcare to work as it should. Much of that advantage depends precisely upon our unique access to real-time data that simply cannot be accessed, much less leveraged, without a cloud platform. Accordingly, we are very pleased to offer the following comments for your consideration on the crucially important issue of access to Medicare physician data.

General Remarks

> *For no compelling reason, a commanding tool for trying to contain health care costs is lying unused. That sidelined powerhouse is the Medicare claims database, which holds a record of all payments from taxpayers to physicians and other providers for seniors' health care*. – Sen. Chuck Grassley and Sen. Ron Wyden, "Give the public access to the Medicare database," Politico, Jul 28 2013.[1]

There is universal agreement among politicians and policymakers that the current trajectory of health care spending in this country is unsustainable; we must contain costs while improving the quality of health care to avoid bankrupting the nation.

Medicare paid claims data are the key to unlocking much needed price transparency in the health care industry. Physicians are increasingly held accountable for the cost and

[1] http://www.politico.com/story/2013/07/wyden-grassley-health-care-medicare-database-94840.html#ixzz2dSu9GPip

quality of care through programs such as Medicare Shared Savings, but we have a long way to go before "shopping" for affordable care options becomes routine for physicians and their patients. Releasing Medicare claims data to the public is a necessary step towards that goal.

But the potential benefits of Medicare 'data liberation' to individuals are only a small part of the rationale for revising current policy to allow for dissemination of this data. The real value of public Medicare data will be realized through the innovation that it catalyzes. Technology developers and researchers are the more likely initial consumers of this data than patients and physicians. Release by CMS of the Medicare claims data will trigger a proliferation of new technological tools to help physicians and patients make well-educated care decisions, such as apps that show patients' cost responsibility at various care providers or analytics built into health IT workflows that show complete downstream care costs. These technologies, already common in nearly every other sector of our data-driven economy, are desperately needed in health care.

Response to Questions for Public Comment

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

In its request for comments, HHS acknowledged that "a number of changes have occurred related to physicians' privacy interests in maintaining the confidentiality of their Medicare payments and the public interest in disclosure of such amounts." We agree. In addition to the changes highlighted in the request for comments, three other significant trends that have emerged that further support the argument that health care has indeed changed since 1979 in ways that militate in favor of data liberation:

a. New value-based, accountable reimbursement models are increasingly replacing the fee-for-service model that prevailed in the 1970s. In the Medicare program alone, there are currently over 250 participating accountable care organizations ("ACOs"). There are 41 different innovation demonstration models overseen by the Innovation Center at CMS. The success of these organizations and models depend on their ability to monitor and control the cost of care, which in turn depends on increased claims data availability and transparency. As payment models continue to make the much needed transition away from fee-for-service, the broad public interest in releasing paid claims data must increasingly outweigh the narrow and mitigable privacy interests of physicians.

b. Physician employment is increasingly on the rise. Numerous media outlets and academic journals have recently highlighted the rapid pace of physician employment over the past decade, finding that the rate of employment has tripled since 2000.[2] Sources estimate that between 50 and 70 percent of physicians in this

[2] Hayden Bush, *Hospital Statistics Chart Rise in Physician Employment*, Hospitals and Health Networks Daily, Jan 6 2012.

country are now employed.[3] While paid claims data may have allowed the public to easily calculate the income of their physician friends and neighbors in 1979, the reality in 2013 is that the majority of physicians are paid a salary that has no relationship to the claims reimbursement sought by their employers.

Interestingly, for the minority of physicians whose income still does have a relationship to their reimbursement data, public disclosure of that data has the potential to help them maintain their independence from large health systems, by empowering the kind of analysis and coordination that heretofore has been possible only for large organizations with commensurately expansive technological and administrative capabilities. As explained above, these physicians must be able to thrive in new value-based models to survive, and their ability to do so depends on access to comprehensive claims data for their patients.

c. Technology has evolved enormously since the 1970s. When the injunction was issued in 1979, sophisticated data analytics technology barely existed, and it was certainly not widely available to business and consumers. Therefore, at that time, if the data was publicly available, its usefulness was limited to detecting fraud and ascertaining the income of physicians. Today, however, every physician and patient regularly holds in the palm of their hand a smart phone or tablet capable of turning raw paid claims data into actionable insights to improve care quality. This increase in computing power greatly expands the potential of and the public interest in paid claims data. Further, the same expansion of technology creates new ways to safeguard legitimate privacy interests with protective measures far short of the current policy of simply locking down all paid claims data.

2. <u>What specific policies should CMS 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?</u>

In releasing claims data to fuel innovation, it is important that CMS not draw arbitrary distinctions with respect to types of entities that are eligible to access paid claims data. The Qualified Entity program under Section 10332 of the Affordable Care Act is a positive first step toward greater data transparency, but it contains a fatal flaw in that disallows any use of CMS paid claims data other than for the provision of free public reports on cost and quality. This is a *de facto* prohibition on for-profit entities building a business model around paid claims data, a huge deterrent to the very innovation that has the potential to control costs in health care. In contemplating the release of paid claims data, CMS should reverse this policy and determine the best way to ensure that all entities—public or private, for-profit or not—can access the data in service of their patient and physician clients, with appropriate safeguards against and penalties for abuse of data access.

[3] Accenture, *Clinical Transformation: New Business Models for a New Era in Healthcare*, 2012; HSC Community Tracking Study Physician Survey, http://www.hschange.org/index.cgi?data=11.

CMS should also not be overly reliant on programs such as the Medicare Shared Savings Program or Innovation Center demonstrations to release claims data for the purpose of promoting value-based care. While Medicare ACOs and other physician groups in certain demonstration programs currently get access to the claims data for attributed beneficiaries, limiting access to these groups excludes other providers—largely independently practicing physicians—from participating in the transition away from fee-for-service reimbursement. If paid claims data was available to the consultants, health IT providers, or other third parties that work on behalf of such physicians, these third party entities could act like virtual ACOs, using claims data to provide care coordination and utilization management services that today are completely out of reach to many solo physicians and small practices that still provide care to much of the nation's underserved populations.

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

CMS should recognize that practice patterns, not price, drive cost in Medicare because of the standardization of payment amounts for physician services. Data that merely reveals the price paid by CMS for various services has limited uses and could even be misleading to patients given the complexity of reimbursement. For patients and physicians alike, it is the ability to understand the comprehensive cost picture, including downstream costs, that holds the potential to transform health care.

With respect to the form of the data, as noted above, the primary consumers of CMS paid claims data are likely to be researchers and developers that will be able to work with data in any machine-readable format. The timeliness and completeness of released data are more important than the specific format.

The ideal for any data scientist is to receive claims data in real time. However, aside from being technically unrealistic, real time data also requires too great a trade-off between data liberation and protection of privacy by not allowing adequate time for privacy control measures. Therefore, CMS should aim to streamline its process for preparing data (as it does today to provide claims data to Medicare ACOs) to enable daily or weekly releases.

CMS should also aim to release a complete data set without limiting its source data more than is necessary to ensure patient privacy, where appropriate. If CMS substantially limits a data set before release, not only would this negatively impact timeliness, but the resulting data set is often harder for data experts to work with than if they were given a larger data set that they had to cull themselves. It would be a more efficient use of government resources and result in a better data set to provide comprehensive and detailed claims data and rely on the public to limit that data to meet specific needs.

Conclusion

athenahealth strongly supports the ongoing data liberation efforts within HHS and appreciates the opportunity to provide feedback on how to best include paid claims data in those efforts. Data transparency is and has always been at the core of our business. We look forward to working with HHS, and CMS specifically, in the future on these very important initiatives.

Sincerely,

Dan Haley
VP, Government and Regulatory Affairs
athenahealth, Inc.

300 New Jersey Avenue, NW
Suite 800
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Telephone 202.872.1260
Facsimile 202.466.3509
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September 6, 2013

BY EMAIL: Physician_Data_Comments@cms.hhs.gov

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: Physician Data Comments
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Dear Sir or Madam:

Business Roundtable is an association of chief executive officers of leading U.S. companies. Together, our member companies employ more than 16 million individuals and provide health care coverage to nearly 40 million workers, retirees, and their families. As a significant source of private health care coverage, Business Roundtable is invested in addressing both the quality and costs of our health care system.

Business Roundtable appreciates the opportunity to respond to the Request for Public Comments (dated 8/6/13) on the potential release of Medicare physician data. We are long-time supporters of the release of this data to foster the availability and use of health care information to drive innovations to improve health care.

Since 2006, Business Roundtable CEOs have advocated for making Medicare claims data available so that payers may aggregate their own claims data with Medicare claims data. This will enable consumers to have a broader and more reliable measure of the quality of care rendered by health care providers and their relative performance in treating important medical conditions. Combining Medicare claims data with claims data from other sources will provide a new opportunity for consumers to evaluate the performance of providers and also enable consumers and employers to select higher-quality, more efficient physicians, hospitals, and other health care providers.

Business Roundtable is very supportive of the new provisions in the Affordable Care Act relating to the sharing of Medicare claims data. The availability of information on prices and quality of health services will unleash greater opportunities for consumers to make appropriate decisions about the value and the need for services. We are also mindful of the protections that need to be in place to ensure the data is accurate and personal health information is secure.

We commend CMS for reviewing these important legal and policy questions regarding the release of the Medicare Part B claims data. Business Roundtable CEOs believe there will be ample rewards in providing more transparent information to consumers including greater information, choice, and competition and we strongly support these efforts.

Sincerely,

Gary Loveman
Chairman, Chief Executive Officer and President
Caesars Entertainment Corporation
Chair, Health and Retirement Committee
Business Roundtable

GL/mg

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

Attention: Physician Data Comments

Dear Ms. Tavenner,

This letter is in response to the request for comment on the potential release of Medicare physician data.

I am the CEO and co-founder of Castlight Health, a company that provides health care cost and quality information to enable consumers to make informed health care decisions. We strongly support CMS' commitment to greater data transparency, and we applaud the historic steps that you have already taken to disclose cost information for hospital inpatient and outpatient procedures.[1]

CMS has the most comprehensive health care dataset ever created. However, the data released to date represent only part of the picture. The release of the Medicare physician payment data would continue the important progress you have begun, and it would significantly advance the goals outlined in the August 6 request for comment: "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."[2]

[1] "Medicare Provider Charge Data," Centers for Medicare and Medicaid Services, last modified August 15, 2013, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/; "Medicare Provider Charge Data: Outpatient," Centers for Medicare and Medicaid Services, last modified June 2, 2013, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Outpatient.html

[2] "Request for Public Comments on the Potential Release of Medicare Physician Data," Centers for Medicare and Medicaid Services, last modified August 6, 2013, http://downloads.cms.gov/files/Request-for-Public-Comment-rePhysician-Data-8-6-2013.pdf

Access to Medicare physician claims data is in the public interest

The disclosure of Medicare physician payment information, including physician-identifiable reimbursement data, is in the clear public interest. Releasing this information will help millions of Americans get better health care and save money; continuing to keep it confidential will prevent patients across the country from making effective, responsible decisions about their own care.

Health care spending is rising for individuals, businesses, and the government. However, a longstanding lack of transparency in health care pricing and quality has made it virtually impossible for American consumers to factor these considerations into their decision-making processes about health care. This results in higher costs and lower quality for them, higher health care expenses and reduced productivity for their employers, and an unsustainable health care cost growth rate for the country.

Physician costs account for approximately 25 percent of total national health care spending. The Medicare physician payment and claims information will provide a unique window into the variation in cost, resource utilization, practice patterns, and quality of care that millions of Americans receive from providers where they seek medical treatment. As the largest payer in the market by far, Medicare has more information about specific physicians and hospitals than any other source. Just like with other types of statistical analyses, increasing the number of data points increases the reliability of the analysis – making it feasible to draw conclusions about physician practice patterns and variations in quality of care.

When combined with the previously-released hospital data and information from private insurers, the physician data will have a positive impact on helping companies, individuals, and the government to curb health care spending and improve outcomes.

Detailed information for professional, institutional, and pharmacy claims is essential

It is essential that full claims data are released regularly and in a timely manner. Partial claims data or summaries of claims will not allow the level of analysis required to identify true variation in care delivered by providers that patients need to make informed decisions.

To be useful, released data sets need to include a unique provider identifier (NPI), dates of service, place of service, reason for care (diagnoses), services provided, and payments for all care delivered. Many standard quality measures endorsed by the National Quality Forum (NQF) require this level of detail to be appropriated applied.

Through the work of the CMS-sponsored Better Quality Information for Medicare Beneficiaries (BQI) pilots, the value of combining Medicare claims data with commercial claims was well

demonstrated allowing for a richer set of measures to be applied across a broader set of providers and identifying significant variation in the practice of evidence-based medicine.

For example, in the Los Angeles metropolitan statistical area, an in-network, first time visit with a cardiologist can range in price from $149 to $272.[3] Yet, as studies have shown, there is no correlation between higher prices and better quality care.[4] Continuing to obscure this kind of information from patients does not serve the public interest.

Transparency leads to cost savings

Our research has shown that increased transparency has a direct benefit on consumers' health care decisions, financial circumstances, and health outcomes. With access to transparent price and quality information, individuals are able to make better-informed choices about their health care providers. An average patient who chooses a lower-cost, higher-quality clinician is able to save upwards of 15 to 20 percent on their out of pocket spending.[5]

This savings also benefits employers. A typical small business with 500 employees who each make informed health care choices could save approximately $672,000 every year in health costs.[6] One national grocery retailer who started using Castlight saw a 44 percent increase in the number of "high-spender" employees making proactive choices about health providers – and 66 percent of those employees selected services that cost less than the reference price. This led to a 9 percent reduction in projected health care spending for that business.[7]

Across the companies that Castlight currently serves, access to this data could create a potential savings of 5% in health care costs by helping employees choose better providers with lower prices – resulting in over $1.2 billion worth of savings per year.[8] If all American employers use these data to capture value, $59 billion could be saved annually, and the market would encourage more expensive (or lower-value) providers to improve their cost and quality, leading to further price reductions.[9]

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[3] Data from Castlight Health.
[4] Rattray et al., "Quality implications of efficiency-based clinician profiling," CareVariance LLC, 2004 – Based on Regence Blue Shield data
[5] Based on Castlight Health's analysis of average savings when shifting to health care services priced at overall median.
[6] Calculation: 500 (avg. # of small business employees; www.sba.gov) X $8,402 / year (annual health care spend per capita; Kaiser Family Foundation; www.kff.org) X 80% (assume 20% employee co-insurance) X 20% (employee engagement with value-based purchasing).
[7] Data from Castlight Health.
[8] Assumes 3 million lives covered at $8,402 health care spend per capita (Kaiser Family Foundation; www.kff.org).
[9] Assumes 140 million lives covered by employer-based plans (http://www.census.gov/prod/2013pubs/p70-134.pdf) x $8,402 health care spend per capita (Kaiser Family Foundation; www.kff.org) x 5% savings.

Conversely, if patients are unable to make proactive decisions about their health care based on price and quality, they could face both higher costs and a higher rate of adverse consequences, such as hospital acquired infections or other complications. Across a workforce population of 10,000 employees, the cost of failing to provide consumers with data about the quality of care could be an additional $1,000,000.[10]

Provider payment data will help reduce federal and state health care spending

Separate from the benefits that the provider payment data will offer to consumers and businesses, the release of this information will also help curb the growth of government health care spending. We have a clear national interest in seeing a more competitive health care sector in which market forces drive value up, reduce the rate of health care cost growth, and lessen the burden of health care spending on state and federal budgets.

Consider one of the most severe cost-drivers in our system: the overuse of medically unnecessary tests and procedures. The fee-for-service health care reimbursement system in the United States provides incentives for health care providers to deliver care based on volume, not outcomes. For instance, evidence suggests that most back pain is resolved with rest, physical therapy or other conservative treatment and does not require MRI's or other advanced testing or treatments.[11] Yet among low back pain patients in the United States, nearly a third of MRI's are for patients who had not first tried other potentially effective treatments.[12] Such unnecessary MRI's create significant financial costs. Better informed health care purchasers will help bend the health care cost growth curve down, saving the nation billions of dollars.

The net benefits of transparency – for our economy, consumers, and employers – outweigh the costs of continued and unwarranted secrecy.

Addressing privacy concerns

When considering the release of any data, privacy must be considered – and this is no exception. That is why the release of provider payment data should be paired with tough penalties for misuse of the information. Similarly, while access to data should be as broad as possible, it should only available to entities that have demonstrated that they have the appropriate privacy and security processes in place.

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[10] Calculator used from Leapfrog Group's "The Hidden Surcharge Americans Pay for Hospital Errors"; http://www.leapfroggroup.org/HiddenSurchargeCalculator; Following values used for calculation: (1) 10% of employees admitted annually = 1000, (2) 100% of admission assumed in "A" hospitals to calculate extra surcharge for utilizing "B", "C", "D", and "F" rated hospitals

[11] Pham HH, Landon BE, Reschovsky JD, Wu B, and Schrag D, "High-Value, Cost-Conscious Health Care: Concepts for Clinicians to Evaluate the Benefits, Harms, and Costs of Medical Interventions," *Annals of Internal Medicine* 154 (2011):181-189.

[12] Pham HH et al.,"Rapidity and modality of imaging for acute low back pain in elderly patients," *Archives of Internal Medicine* 169 (2009):972-81.

There is also clear precedent for the release of other kinds of federal payment data to businesses and individuals, including disclosure of farm subsidies and payments to defense contractors. In those cases, adequate controls have been put in place to protect individual privacy, and it was judged that the public interest in transparency outweighed the concerns of the entities receiving taxpayer money.

Ultimately, releasing the data will bring transparency and competition to health care so that the health care system can deliver better value to consumers. As Drs. Ezekiel Emanuel and Robert Kocher, a member of our board of directors, recently wrote, we need to embrace a "transparency imperative: All data on price, utilization, and quality of health care should be made available to the public unless there is a compelling reason not to do so."[13] In this case, we believe that there is no compelling reason to continue to keep this data secret – and there are multiple, clear reasons to make it public.

Sincerely,
Giovanni Colella, MD
CEO and Co-Founder
Castlight Health

[13]Robert P. Kocher and Ezekiel J. Emanuel, "The Transparency Imperative," *The Annals of Internal Medicine* (2013), doi: 10.7326/0003-4819-159-4-201308200-00666.

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Submitted via Physician_Data_Comments@cms.hhs.gov

September 5, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services,
Attention: *Physician Data Comments*
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for public comments on the potential release of Medicare physician data

Dear Ms. Tavenner,

Catholic Health Initiatives (CHI) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) on the request for public comments on the potential release of Medicare physician data. CHI is a national, nonprofit health organization with headquarters in Englewood, Colo. As one of the nation's largest Catholic health care systems, CHI operates in 18 states and encompasses 86 hospitals (including 23 critical access hospitals); 40 long-term care, assisted- and residential-living facilities; two community health-services organizations; two accredited nursing colleges; and numerous home health agencies.

In May 2013, a federal district court lifted a permanent injunction originally issued in 1979 that prohibited the predecessor agency to HHS from disclosing annual Medicare reimbursement payments to individual physicians or in a manner that could identify individual physicians. In light of this new legal development, CMS seeks public input about what would be the most appropriate policy regarding release of physician payment data.

CHI appreciates the opportunity to comment on this timely issue. We believe that transparency is essential to improving the overall health care system. However, we also believe that the intent behind releasing physician payment data is an important consideration.

If the intent is to uncover potential fraud and abuse, then physician payment data alone are not sufficient to draw any conclusions. While the information may be useful to news media or research organizations, it will require significant expertise to distill from the data critical information necessary to uncover illegal activity. For the average person who will also have access to the information if it is made public, physician payment data

alone will cause more confusion than clarity. For example, higher-volume providers, who may have higher volume due to factors like quality and reputation, also will have higher total payments. The data do not take into account medical necessity, the acuity of the patient population, or the desired trends (such as increased volumes in certain service lines like primary care). While releasing physician payment data in aggregate may lead to some raised flags that then lead to further investigation for fraud and abuse, CMS and other agencies already have access to these data. Therefore, releasing data to the public would add little to the efforts to combat fraud and abuse.

If the intent is to improve value, then physician quality data should be made available at the same time and location as physician payment data so that they can be viewed together. Physician payment data alone are not adequate if the goal is to assess value. CHI believes that health systems and other groups could use quality and payment data together to enhance their analytics and develop programs to make the health care delivery system more efficient. But we also believe the implications of misinterpretation and misuse of the data can be significant, including arbitrary exclusion from payer networks and provider organizations. If used by the public, we urge CMS to provide substantial assistance with interpreting physician payment data.

Overall, physician payment data are too complex to release en masse without significant structure, explanation, and interpretation. While health systems, news outlets, government agencies, and other major health care players may be able to find useful information in physician payment data, the general public will not. We urge CMS to ensure any data release is accompanied by sufficient structure such that the intent of the dissemination is clear and easily accomplished.

Thank you for the opportunity to present our views on this important issue. Please contact me at 720-874-1423 if you have questions or need additional information.

Sincerely,

Manoj Pawar, MD
Vice President, Clinical Operations and Physician Leadership Development

Attention: Physician Data Comments
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue SW
Washington, DC 20201

September 4, 2014

Dear Secretary Sebelius, Ms. Tavenner, and Mr. Brennan,

On behalf of the Center for Data Innovation (www.datainnovation.org), I am pleased to submit these comments in response to the Centers for Medicare & Medicaid Services (CMS) request for public comment on the potential release of Medicare physician data.[1]

The Center for Data Innovation at the Information Technology and Innovation Foundation, a non-profit, non-partisan, Washington-DC based think tank, conducts high-quality, independent research and educational activities on the impact of the increased use of information on the economy and society. In addition, the Center formulates and promotes pragmatic public policies designed to enable data-driven innovation in the public and private sectors, create new economic opportunities, and improve quality of life.

The recent ruling by a federal district court to vacate a 1979 injunction barring the Department of Health and Human Services (HHS) from disclosing Medicare claims data for physicians is a welcome step forward in the path towards more transparency in government and data-driven innovation in health care. This ruling has freed HHS to modify its current policy (adopted in 1980), which states that "the public interest in the individually identified payment amounts is not sufficient to compel disclosure in view of the privacy interests of the physicians." As it stands, the current policy is incongruent with the recent Presidential Executive Order mandating that government information be open and machine readable by default, as well as the great strides HHS has taken to be a leader in open data initiatives in the federal government.[2]

In this request for public comment, CMS seeks responses to the following three questions:

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[1] Centers for Medicare & Medicaid Services. "Request for Public Comments on the Potential Release of Medicare Physician Data." August 6, 2013. http://downloads.cms.gov/files/Request-for-Public-Comment-rePhysician-Data-8-6-2013.pdf (Accessed September 3, 2013).
[2] White House. *Executive Order -- Making Open and Machine Readable the New Default for Government Information* (Washington, D.C., 2013). http://www.whitehouse.gov/the-press-office/2013/05/09/executive-order-making-open-and-machine-readable-new-default-government (Accessed September 3, 2013).

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;

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; and

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).

Each question is addressed in turn below.

PHYSICIANS DO NOT HAVE A PRIVACY INTEREST IN MEDICARE PAYMENT INFORMATION

The information that CMS is considering releasing is not personally identifiable information about patients but rather information about the payments sent from the government to physicians. CMS is likely to receive some resistance from the American Medical Association (AMA) for releasing this information given the AMA's past public statements on the topic; however, physicians do not have a privacy interest in Medicare payment information.[3] Numerous court cases have found that privacy consideration should not be used to restrict disclosure of this type of information. In addition, professionals do not have a right to privacy for information about their professional activities.[4] The government should also not restrict individuals from publishing lawfully obtained, truthful information about a matter of public concern.[5] Finally, individuals do

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[3] Fiegl, Charles. American Medical News. "CMS mulls how to unseal Medicare doctor pay data." August 19, 2013. www.amednews.com/article/20130819/government/130819958/4/ (Accessed September 3, 2013).
[4] Organization for a Better Austin v. Keefe, 402 U.S. 415 (1971) http://caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=us&vol=402&invol=415 (Accessed September 3, 2013).
[5] Bartnicki v. Vopper, 532 U.S. 514 (2001). http://www.scholar.google.com/scholar_case?case=2171346211086974391&hl=en&as_sdt=2&as_vis=1&oi=scholarr (Accessed September 3, 2013), The Florida Star v. B. J. F., 491 U.S. 524 (1989). http://www.caselaw.lp.findlaw.com/scripts/getcase.pl?court=us&vol=491&invol=524 (Accessed September 3, 2013), Smith v. Daily Mail Publishing Co., 443 U.S. 97 (1979). http://www.caselaw.lp.findlaw.com/scripts/getcase.pl?court=us&vol=443&invol=97 (Accessed September 3, 2013), and Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 (1975). http://www.caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=420&invol=469 Accessed September 3, 2013).

not have Fourth Amendment protections for personal information in records maintained by third-parties, such as businesses or the government.[6]

Moreover, previous attempts at the state-level specifically aimed at restricting disclosure of information about the professional practices of physicians under the guise of protecting physician privacy have been rejected. The Supreme Court ruled in *Sorrell v. IMS Health* that a Vermont state law that restricted the disclosure of the prescribing practices of individual physicians was unconstitutional.[7] Specifically, the majority found:

> "...the State cannot engage in content-based discrimination to advance its own side of a debate. If Vermont's statute provided that prescriber-identifying information could not be sold or disclosed except in narrow circumstances then the State might have a stronger position. Here, however, the State gives possessors of the information broad discretion and wide latitude in disclosing the information, while at the same time restricting the information's use by some speakers and for some purposes, even while the State itself can use the information to counter the speech it seeks to suppress. Privacy is a concept too integral to the person and a right too essential to freedom to allow its manipulation to support just those ideas the government prefers."[8]

While (as with all comparisons) there are obvious differences with the *Sorrell* case, many of the broad lessons still apply. Most notably, detailed Medicare payment information is already being shared with a subset of entities, such as through CMS claims feeds to Accountable Care Organizations and through the Blue Button Initiative.[9]

CMS SHOULD MAKE TIMELY, ACCURATE DISCLOSURES OF PHYSICIAN PAYMENT DATA

Patients benefit when timely, accurate information is made available to them whether this information is about their personal health records or the overall functioning of the health care system. As HHS has found from its projects such as the Health Datapalooza conference, the demand for high quality health care data is strong across the public, research and private sectors.

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[6] California Bankers Assn. v. Shultz, 416 U.S. 21 (1974). http://www.caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=us&vol=416&invol=21 (Accessed September 3, 2013).
[7] Sorrell v. IMS Health Inc., No. 10-779 131 S.Ct. 2653 (2011). www.supremecourt.gov/opinions/10pdf/10-779.pdf (Accessed September 3, 2013).
[8] Ibid.
[9] Tavenner, Marilyn and Niall Brennan. HHS.gov Digital Strategy. "CMS Progress Towards Greater Data Transparency." August 6, 2013. www.hhs.gov/digitalstrategy/blog/2013/08/cms-data-transparency.html (Accessed September 3, 2013).

Health Datapalooza has seen rapid growth since its inaugural event in 2010, with over 1,900 attendees in 2013. Eighty organizations offered demonstrations of their data-driven applications this year, including several that used CMS data to enable financial and other business analytical tools. Granular paid claims data would be a crucial asset to such applications and would enable the development of more patient- and provider-facing analytical tools in the future.

CMS's own recent efforts have also received enthusiastic responses. The 2012 Blue Button initiative, which allows Medicare beneficiaries to access and download their personal health data on a website or mobile device, has already spurred patient-facing app creation, and was the focus of a recent app contest on the federal crowdsourcing platform Challenge.gov.[10]

Granular paid claims data would lend itself to a broad range of use cases, including efficiency and performance measurement beyond what has been implemented among qualified entities and Accountable Care Organizations.[11] The ability to compare providers along paid claims could also be a valuable addition to care coordination schemes, both for patients and health systems.[12]

In addition, the data could be used to inform physician recommendations in the Health Insurance Marketplace, a resource for individuals seeking health care under the Affordable Care Act.[13]

To these ends, CMS should streamline its internal formatting and reconciliation processes to facilitate daily or weekly public releases. It should strive for completeness by default, and avoid releasing only subsets of data to the extent possible, in order to maximize the versatility of the data for use in future applications. Making complete data available publicly in a machine-readable format and in a timely manner will allow for reuse by businesses, researchers, non-profit organizations, and citizens.

Releasing this information will also allow citizens to become more involved in identifying fraud, waste and abuse in CMS programs. A 2012 special communication in the Journal of the American Medical Association estimated the cost of fraud and abuse in Medicare and Medicaid to be as high as $98 billion in

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[10] Brennan, Niall. HealthData.Gov. "Medicare Blue Button, More Data Than Ever Before!" June 22, 2012. www.healthdata.gov/blog/medicare-blue-button-more-data-ever (Accessed September 3, 2013).
[11] "CMS Progress Towards Greater Data Transparency."
[12] athenahealth, Inc. Making Care Coordination Work: A Sustainable Model to Benefit the Whole Community. February 2012. www.athenahealth.com/_doc/pdf/whitepapers/Making_Care_Coordination.pdf (Accessed September 3, 2013).
[13] HealthCare.gov. "What is the Health Insurance Marketplace? https://www.healthcare.gov/what-is-the-health-insurance-marketplace/ (Accessed September 3, 2013).

2011.[14] The HHS Office of the Inspector General has identified Medicare and Medicaid fraud as one of its top management and performance challenges, and has noted that data mining solutions to automated fraud detection are an area of increased focus. The public release of granular paid claims data could foster savings through greater involvement of data-driven private sector firms in solving these problems.[15]

The value of the data for fraud detection could be maximized in a number of ways. For one, CMS has proposed to modify the reward structure of the Medicare Incentive Reward Program which would encourage greater engagement with this data.[16] A similar reward increase to the IRS Incentive Reward Program has been a considerable success, with $592 million in collections attributed to whistleblowers in 2012, up from $61 million in 2003.[17]

Another approach to fostering automated efforts to detect fraud and abuse with this data could be realized through engaging existing civic hackathons and other app contests. In health care, these vary in size and scope from the Robert Wood Johnson Foundation's highly targeted Hospital Price Transparency Challenge to the Knight Foundation's broadly focused Knight News Challenge: Health.[18] Such contests are often designed to derive value from specific data sets, and could serve to accelerate the adoption of granular claims data in a variety of contexts, quickly putting the data to use in some applications and identifying potential future uses in others.

CMS SHOULD RELEASE DETAILED CLAIMS DATA

Under its new rule, CMS should endeavor to release granular physician claims data in a widely-accepted, non-proprietary file format. Details should include the amount paid to each unique health care provider, the items or services provided, and the location of the provider. In addition to the line item claim details, each entry should be accompanied by the provider's unique identifier (i.e. the National Provider Identifier).

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[14] Berwick, Donald and Andrew D. Hackbarth. "Eliminating Waste in US Health Care." *Journal of the American Medical Association* 307 (2012): 1513-1516. doi:10.1001/jama.2012.362 (Accessed September 3, 2013).
[15] Office of Inspector General, U.S. Department of Health and Human Services. "Management Issue 3: Preventing and Detecting Medicare and Medicaid Fraud." https://oig.hhs.gov/reports-and-publications/top-challenges/2012/issue03.asp (Accessed September 3, 2013).
[16] "Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment." Federal Register. https://www.federalregister.gov/articles/2013/04/29/2013-09991/medicare-program-requirements-for-the-medicare-incentive-reward-program-and-provider-enrollment (Accessed September 3, 2013).
[17] Internal Revenue Service. "Fiscal Year 2012 Report to the Congress on the Use of Section 7623." www.whistleblowers.org/storage/whistleblowers/docs/BlogDocs/2012%20irs%20report.pdf (Accessed September 3, 2013).
[18] "RWJF Hospital Price Transparency Challenge." Health 2.0 Developer Challenge. www.health2con.com/devchallenge/rwjf-hospital-price-transparency-challenge/ (Accessed September 3, 2013).
Knight Foundation. "How can we harness data and information for the health of communities." https://www.newschallenge.org/challenge/healthdata/brief.html (Accessed September 3, 2013).

Data should be released in a machine-readable format and be accessible to the public in a searchable online database at no cost.

CONCLUSION

CMS has an enormous opportunity to unlock a valuable data set for public benefit. To maximize the public benefit of releasing data, CMS should adhere to the principles of accuracy, completeness and timeliness. Ongoing efforts to release health care claims data and health care quality data have the potential to unleash new patient-friendly tools to make it easier for consumers to shop for health care and stimulate price competition among health care providers. In addition, releasing physician claims data may be particularly useful for fostering citizen-led efforts at combatting fraud, waste, and abuse within Medicare and Medicaid. Finally, releasing detailed physician claim data will help provide additional information for use by researchers, policymakers, and the private sector.

Sincerely,

Daniel Castro

Director, Center for Data Innovation

1101 K Street NW, Suite 610
Washington, DC 20005

dcastro@datainnovation.org

September 5, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Office 341D-05
Washington, D.C. 20201

Via e-mail: Physician_Data_Comments@cms.hhs.gov

Attn: *Physician Data Comments*

Dear Ms. Tavenner:

We respectfully submit this letter, on behalf of CDT and the signatories below, in response to the Centers for Medicare and Medicaid Services (CMS)' request for public comments on the release of Medicare physician data.

The Center for Democracy & Technology ("CDT") is a non-profit Internet and technology advocacy organization that promotes public policies that preserve privacy and enhance civil liberties in the digital age. As information technology is increasingly used to support the exchange of medical records and other health information, CDT, through its Health Privacy Project, champions comprehensive privacy and security policies to protect health data. CDT promotes its positions through public policy advocacy, public education and litigation, as well as through the development of industry best practices and technology standards. Recognizing that a networked health care system can lead to improved health care quality, reduced costs, and empowered consumers, CDT is using its experience to shape workable privacy solutions for a health care system characterized by electronic health information exchange.

CDT is frequently relied on for sound policy advice regarding the challenges to health privacy and security presented by health information technology (health IT) initiatives. We have testified before the U.S. Congress five times since 2008 on the privacy and security issues raised by health IT, and we chair the privacy

and security policy working group of the federal Health IT Policy Committee (called the "Tiger Team").

We support CMS' efforts to make Medicare data available to serve the public interest; our comments below address the privacy and security issues raised in the Request for Comment.

Physician Privacy Interest

In *Florida Medical Ass'n Inc. v. Department of Health, Educ. & Welfare,*[1] a Florida federal district court lifted the 1979 injunction prohibiting the Department of Health, Education and Welfare – now the Department of Health and Human Services (HHS) – from releasing physician-level Medicare payment data. However, the vacatur of the injunction does not mean this information is now automatically available to anyone who requests it. Instead, the Centers for Medicare and Medicaid Services (CMS) must establish policies to determine the circumstances when the public interest in this information outweighs any interests the physicians may have in preventing disclosure of this information.

We support CMS' efforts to establish policies and a process for determining when this information will be released. We urge HHS to continue to evaluate requests for this information based on whether the information will be used to further the public's interest. Consumers and patients suffer the most from a health care system that costs too much and too frequently delivers poor-to-mediocre quality care. Medicare data can be key to gaining a better understanding of these trends and how to reverse them. Taxes from consumers and patients substantially fund the Medicare program; consequently, data generated by this program should be available for uses that have the potential to serve their interests. For example, CMS should view favorably requests for Medicare payment data where the recipient commits to sharing analyses of payment data with the general public.

CMS should take care not to overstate the "privacy" interests of physicians. The behavior of physicians and other health care professionals is routinely scrutinized by federal and state regulators, accrediting organizations, licensing boards, and health care plans, among others. A broadly recognized privacy interest in physician-level Medicare data could have implications for multiple important initiatives, including quality measurement and public reporting, as well as comparative effectiveness research, which are critical to reform of our health care system. At the same time, we recognize that this data could be used to discriminate against professionals or in ways that have a negative impact on their operations. CMS does have an obligation to carefully review requests for this information, balancing the importance of advancing the interests of the public against the interests of physicians and other professionals in this data. We urge

[1] 2013 WL 2382270 (M.D. Fla. May 31, 2013)

CMS to make public all decisions made regarding requests to release claims data, as transparency about uses of health information is a key principle of Fair Information Practices.

In implementing a new process for reviewing requests for Medicare data, CMS must take care to apply review criteria consistently, and not establish per se barriers to access. In *Sorrell et al. v. IMS Health Inc. et al.,*[2] the Supreme Court struck down state limitations on health information access that barred access based on type of requester (pharmaceutical manufacturers) and the specific purpose of the request (marketing). The standards that CMS will apply to requests for Medicare data, and the process for requesting data, should be transparent to the public. Appeals of CMS decisions can proceed under the Administrative Procedure Act (APA).

Protecting Patient Privacy

We are pleased that CMS does not intend to disclose, "…any information that could directly or indirectly reveal patient-identifiable information." However, we urge CMS to be more clear about how it will protect Medicare claims data from revealing sensitive information about individuals or groups of patients.

CMS should ensure that any Medicare claims information released pursuant to a Freedom of Information Act request meets the HIPAA Privacy Rule standard for de-identification and has been de-identified pursuant to the Privacy Rule's statistician (or statistical) method. The statistical method requires that someone with "appropriate knowledge of and experience with generally accepted statistical principles" must determine that the "risk is very small that the information could be used, alone or in combination with other reasonably available information, by an intended recipient to identify an individual who is the subject of the information."[3] The statistical methodology, in contrast to the safe harbor, considers risk of re-identification based on whether the recipient of the data has the potential to reidentify, which yields a more particularized and accurate assessment of re-identification risk. Research has shown that the HIPAA statistical method of de-identification, if done appropriately, provides very strong protections for data while maximizing data utility.[4] In recent guidance on HIPAA de-identification, the HHS Office for Civil Rights also urges use of the statistical method.[5]

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[2] *Sorrell et al. v. IMS Health Inc. et al.*, 131 S. Ct. 2653. 2011.
[3] 45 CFR 164.514(b).
[4] Khaled El Emam, Guide to the De-Identification of Personal Health Information (CRC Press, 2013).
[5] http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html

However, de-identification – even using the statistical methodology – does not result in zero re-identification risk.[6] Consequently, we urge CMS to require recipients of Medicare claims data to execute written agreements prohibiting unauthorized re-identification.[7] Such agreements also can be vehicles for limiting the use of claims data to the agreed-upon purposes. Recipients of claims data found to have re-identified data without authorization, or to have used data in violation of the agreement, should be subject to administrative penalties, including, at minimum, being barred from future receipt of claims data.

CMS also should consider setting appropriate retention limits for data recipients (and requiring return or secure destruction of data at the end of the retention period), with the length of permitted retention dependent on the purpose for which the data is released. We also urge CMS to consider making claims data accessible without releasing the raw data, adopting an approach similar to that used by CMS in its Knowledge Discovery Initiative, currently being used to enable vendor access to data for internal CMS analytics purposes.[8]

As a final note, the risk to patient confidentiality does not just stem from unauthorized re-identification. Aggregate data about patients can be used to discriminate against, or otherwise harm, groups of patients. Breach of public trust in uses of Medicare data will jeopardize access to this data for important public purposes. It will be critical for CMS to carefully review requests for data and maintain sufficient oversight over proposed and actual data uses.

Conclusion

We are pleased to see that CMS has chosen to adopt a standard set of policies that will govern the disclosure of physician Medicare data. In light of the *Florida Medical Ass'n* court decision and CMS' commitment to transparency, we recommend the adoption of policies that will continue to evaluate FOIA requests for physician data based on whether the information will be used to further the public's interest as well as ensuring that patient privacy is protected through the use of statistical de-identification methods, appropriate data retention periods and carefully evaluating the use of aggregate data.

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[6] McGraw, "Building public trust in uses of Health Insurance Portability and Accountability Act de-identified data," J. Am. Med. Ass'n (2012), https://www.cdt.org/paper/building-public-trust-de-identified-health-data (open access).

[7] See Id.

[8] http://healthspottr.com/weeklydigest/34-5-reasons-to-like-the-cms-data-marketplace-initiative

We appreciate your consideration and thank you for the opportunity to provide comments and recommendations.

Sincerely,

Deven McGraw, Director, Health Privacy Project

Christopher Rasmussen, Policy Analyst, Health Privacy Project

On behalf of CDT and the following consumer organizations:
National Consumers League
National Partnership for Women and Families

September 5, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: Physician Data Comments
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201
Via email to Physician_Data_Comments@cms.hhs.gov

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

We, the undersigned organizations, dedicated to advancing government transparency and accountability, welcome the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS) request for public comments on the potential release of Medicare physician data. We urge CMS to uphold its stated commitment to transparency and adopt a policy to promptly disclose, in an open format, payment data, with as much detail as practicable while protecting patient privacy.[1]

Public interest in disclosure of payment data

There is a strong public interest in disclosure of Medicare payment information, including the amounts of payments made to particular medical providers.

The public has a fundamental right to know how government spends public funds.[i] Medicare expenditures represent a significant portion of the public funds spent each year by the federal government – an estimated $555 billion in 2012. The program also impacts many Americans – it covered more than 49 million beneficiaries in 2012.[ii]

Medicare spending has also attracted public attention due to concerns about fraud or waste in the program. Medicare reported improper payments estimated at more than $44 billion in 2012.[iii] Greater disclosure of Medicare spending could help deter fraud and waste and detect it when it occurs. In fact, the former chair of the Recovery Accountability and Transparency Board suggested that the increased transparency of payments under the American Recovery and Reinvestment Act of 2009[iv] deterred fraudsters from targeting recovery programs, specifically as compared to Medicare.[v] When the *Wall Street Journal* was able to access a subset of the Medicare payment data, it successfully demonstrated the ability of journalists to use the data to

[1] CMS should also revoke its previous policy, published at 45 F.R. 79172.

identify suspicious practices through its groundbreaking 2010 series[vi] – and was a finalist for a Pulitzer Prize as a result.[vii]

Additionally, disclosure could support public health and safety by enabling greater public understanding of medical practices. For instance, ProPublica and *The Washington Post* used Medicare data identifying providers for their groundbreaking series on prescription drugs,[viii] finding "hazardous prescribing practices."[ix] Furthermore, releasing payment data could inform discussions about the growing costs of health care, including disparate prices charged to different patients and insurance companies.[x]

Medical businesses do not have a privacy interest in Medicare payments

In our view, CMS is obligated to release payment data if requested under the Freedom of Information Act (FOIA).[xi] Recent developments support the position that payment data should not be considered exempt from disclosure under FOIA's Exemption 6.[xii]

Medicare payments are commercial transactions for services and goods rendered in a professional context. In its 2011 decision in *Federal Communications Commission v. AT&T*, the Supreme Court made clear that corporations do not have "personal privacy" for the purposes of FOIA's Exemption 7(C), which uses the same phrase as Exemption 6.[xiii] In that opinion, Chief Justice Roberts pointed to the distinction between commercial and personal interests, noting, "We often use the word 'personal' to mean precisely the *opposite* of business-related."[xiv] Because the amount that CMS pays to medical businesses is clearly "business-related," we suggest that there is likewise no personal privacy interest in the disclosure of such amounts. If that is the case, then Exemption 6 cannot be used to withhold such information, and CMS is required to release such information in response to FOIA requests. Moreover, even if any personal privacy interest did exist, it would be outweighed by the strong public interest in disclosure.[2]

Indeed, to treat such information as exempt would create a tremendous disparity among recipients of federal funds. Under the Federal Funding Accountability and Transparency Act of 2006, all expenditures of federal funds – including contracts, grants, purchases, and other forms of financial assistance – of $25,000 or more must be disclosed on a public website.[xv] All entities that receive federal funds are covered by such disclosure requirements, including sole proprietorships. While Congress did not specifically address Medicare payments under the law, we see no logic by which medical providers would have a privacy interest in the amount of federal funds received, while providers of non-medical services and goods would have no such interest.

[2] However, we agree that CMS should not publicly disclose information that would identify individual patients.

CMS should adopt a policy to disclose granular data in an open format

Given the strong public interest in disclosure and the fact that payment information should not be exempt under FOIA, we urge CMS to adopt a policy to promptly disclose, in an open format, payment data, with as much detail as practicable while protecting patient privacy.

Under FOIA, CMS is obligated to provide records in the format requested.[xvi] In addition, CMS should also, as resources allow, construct a publicly accessible database to proactively disclose payment data. Proactive disclosure, without waiting for FOIA requests, will make the data most accessible and avoid duplicative FOIA requests. CMS should release as much detail as practicable while protecting patient privacy, which will best facilitate investigation and research. Data should be disclosed in an open, machine-readable, and well-documented format, in compliance with the government-wide open data policy.[xvii]

Conclusion

We appreciate the opportunity to respond to CMS's request for public comments on the potential release of Medicare physician data. We appreciate you taking our recommendations into consideration. If you have questions about our comments or want to discuss the issues further, please feel free to contact us.

Sincerely,

Article 19
Cause of Action
Center for Effective Government (formerly OMB Watch)
Center for Public Integrity
Essential Information
Health Care for America Now
Liberty Coalition
National Priorities Project
OpenTheGovernment.org
Project On Government Oversight
Public Citizen
Society of Professional Journalists
Sunlight Foundation
Taxpayers for Common Sense

[i] *See* U.S. Senate, Committee on Homeland Security and Governmental Affairs, *Federal Funding Accountability and Transparency Act of 2006: Report Together with Additional Views to Require Full Disclosure of All Entities and Organizations Receiving Federal Funds* (to accompany S. 2590) (S.Rpt.109-329), Washington: Government Printing Office, 2006, p. 3 ("Greater transparency allows taxpayers to judge whether government funds are being used for purposes they consider valuable, or whether spending in certain areas is excessive or wasteful. It also allows the public to better understand, assess, and appreciate the scope and value of federal investments in their communities and to more fully participate in shaping priorities for Federal spending.").
[ii] Government Accountability Office, "GAO's 2013 High-Risk Update: Medicare and Medicaid," GAO-13-433T, Feb. 27, 2013, http://gao.gov/products/GAO-13-433T.
[iii] *Id*.
[iv] P.L. 111–5.
[v] Ed O'Keefe, "Set to retire, stimulus watchdog Earl Devaney tried to stay above the fray," *The Washington Post*, Dec. 11, 2011, http://articles.washingtonpost.com/2011-12-11/politics/35286129_1_recovery-accountability-transparency-board-stimulus, quoting Earl Devaney ("'I think this money was so transparent that guys that really commit big frauds and try to steal big money just stayed with the old tried-and-true fraud and waste like Medicare fraud and didn't come near this money,' he said.").
[vi] Dow Jones, "Secrets of the System," http://www.dowjones.com/pressroom/presskits/secrets/secretsofsystem.asp.
[vii] The Pulitzer Prizes, "Explanatory Reporting," http://www.pulitzer.org/bycat/Explanatory-Reporting.
[viii] Jennifer LaFleur, et al., "How We Analyzed Medicare's Drug Data," *ProPublica*, May 11, 2013, http://www.propublica.org/article/how-we-analyzed-medicares-drug-data-long-methodology.
[ix] Tracy Weber, et al., "Medicare Drug Program Fails to Monitor Prescribers, Putting Seniors and Disabled at Risk," *ProPublica*, May 11, 2013, http://www.propublica.org/article/part-d-prescriber-checkup-mainbar.
[x] Steven Brill, "An End to Medical-Billing Secrecy?," *Time*, May 8, 2013, http://swampland.time.com/2013/05/08/an-end-to-medical-billing-secrecy/.
[xi] 5 U.S.C. § 552.
[xii] 5 U.S.C. § 552(b)(6).
[xiii] *Federal Communications Commission v. AT&T Inc.*, 562 U.S. ___ (2011).
[xiv] *Id.*, slip op. at 5.
[xv] P.L. 109-282.
[xvi] 5 U.S.C. § 552(a)(3)(B).
[xvii] Sylvia M. Burwell, et al., "Open Data Policy–Managing Information as an Asset," Office of Management and Budget memorandum M-13-13, May 9, 2013, http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-13.pdf.

THE CENTER FOR
PUBLIC INTEGRITY

August 29, 2013

Physician Data Comments
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201.

Thank you for the opportunity to comment on the potential release of Medicare physician data by the Centers for Medicare and Medicaid Services.

The Center for Public Integrity, a non-profit investigative news organization, in partnership with the *Wall Street Journal,* filed a Freedom of Information Act request for Medicare billing data in June 2009. Our organizations also were partners in a subsequent FOIA lawsuit that led to limited disclosure of this data.

Since that time, we have analyzed the billing data for several investigative reporting projects that focused both on the cost and quality of Medicare services—matters of critical public importance as federal officials seek to restrain the health care plan's growing price tag. For instance, we showed how Medicare claims for digital mammography raised the cost of breast cancer screening by more than $350 million from 2003 to 2008 despite concern digital mammography is no more effective than film-based systems.

The Center for Public Integrity also documented some $1.9 billion in Medicare spending on common cancer screenings for people who were older than government recommended age limits, including more than $31 million spent on screening people in their 90s.

A third Center for Public Integrity article exposed questionable Medicare spending for surgical eyelid lift operations, which many experts consider cosmetic. These operations more than tripled over the past decade, costing Medicare $80 million in 2011.

Finally, our three-part series Cracking the Codes documented how thousands of medical professionals have steadily billed Medicare for more complex and costly health care over the past decade – adding $11 billion or more to their fees – despite little evidence elderly patients required more treatment.

910 17th Street, NW 7th Floor Washington, DC 20006 (202) 466-1300 Fax: (202) 466-1102 e-mail: contact@publicintegrity.org
http://www.publicintegrity.org

The billing data revealed 7,500 physicians who billed the two top paying codes for three out of four office visits in 2008, a sharp rise from the numbers of doctors who did so at the start of the decade. Federal officials said such changes in billing can signal overcharges occurring on a broad scale.

After the series was published, Department of Health and Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder warned hospital organizations they would ramp up oversight, including possible criminal prosecutions, of doctors and hospitals that "upcode" their charges to cheat Medicare.

Although our reporting has uncovered substantial potential Medicare fraud, waste or abuse, the settlement of our FOIA lawsuit has restricted our ability to publicly identify doctors with these suspicious billing patterns.

We argue that these restrictions should be lifted immediately. Full disclosure of physician payment data would further the government's stated goal of improving the quality and value of medical care, increase transparency and potentially reduce fraud abuse and waste. We also urge you to make this data available in formats that are both easy to understand and analyze.

These data will be most useful for researchers, journalists and the public at large if released at the individual claim level for physicians and any other medical providers in the data. Aggregated data can limit possibilities of further research and reporting not anticipated by those making decisions on how to aggregate the data. In a sense, data at the individual claim level puts HHS more in the role of wholesaler rather than retailer, that is, providing the raw materials for others to use for research and reporting purposes HHS may not anticipate.

To further enhance data usability, HHS should release these data in machine-readable electronic files with software neutral formats, such as comma separated value text files (.csv or .txt file formats). HHS should not anticipate what software users will select. Basic rectangular text files of less than 1 million claims or rows per file will ensure that the release will be open to as many researchers and citizens as possible. Such files can be read into off-the-shelf commercial programs, such as Microsoft Excel, or open source programs, such as the MySQL database manager.

Journalists and citizens should not be required to sue their government to obtain basic information about how their tax dollars are being spent, whether for a

construction project or medical care. Please note that we were not asking for patient names or other information that could reasonably be considered private.

Given the financial straits faced by Medicare, the more people who are able to examine and potentially evaluate Medicare spending, the better. Sunlight is not just a good disinfectant; it can also empower patients and the media to take a bigger role in helping our nation hold rising health costs in check.

Thank you again for considering our position on this important matter. We would be happy to provide you with answers to any follow up questions you may have.

Sincerely,

[redacted]

William E. Buzenberg
Executive Director

Cleveland Clinic

Kristen Morris
Chief Government and Community Relations Officer

September 5, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: Physician Data Comments
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

RE: Potential Release of Medicare Physician Data

Submitted Electronically to: Physician_Data_Comments@cms.hhs.gov

Cleveland Clinic (CC) is a not-for-profit integrated healthcare system dedicated to patient care, teaching and research. Our health system is comprised of a main campus, eight community hospitals, a children's hospital for rehabilitation, and 18 family health centers with over 3,000 salaried physicians and scientists. Last year, our system had nearly six million patient visits and over 165,000 hospital admissions. The following are the general comments of Cleveland Clinic as well as responses to the specific questions posed in the above captioned document.

General Comments

We believe Medicare data can help improve the quality of patient care, if it is used appropriately. As CMS states in its request for comments, the disclosure of payment information could help to expose Medicare fraud, waste and abuse. However, we believe that CMS already has sophisticated methods, auditing programs and data mining capabilities in place to successfully uncover fraud, waste and abuse. If CMS elects to release this Medicare data to third parties, it must be done in a way that ensures consistency and reliability of the data reporting.

Questions Posed in the Request for Public Comments

(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 that the potential disclosure of claims must be balanced against the confidentiality and privacy interests of patients, healthcare providers and health systems. CMS should develop a mechanism to ensure that the data is presented in a meaningful way that would be useful to the public rather than misleading and potentially harmful to patients and their healthcare.

Because of our group practice model, some Cleveland Clinic physicians may be singularly focused in one specialty area or on a specific procedure. If the Medicare data is taken out of context or not presented clearly, the release of this data could mislead the public about the physicians' practices and misrepresent the care they provide. Further, because Cleveland Clinic operates under a group practice model, our physicians receive a fixed salary rather than a payment per procedure. Physician billings are assigned to the health system and are not retained by individual physicians. We are concerned that billing information could be misconstrued or misinterpreted to indicate individual physician earnings and physicians and patients could potentially suffer unintended consequences as a result of the release of this data.

For all the reasons listed above, we believe that the data should be released for specific purposes that promote the effective and responsible use of the data. The data must be presented in a way that provides the full context of the provision of care and payment information must include explanations of the limitations of the data. CMS must also include appropriate safeguards, including providing physicians with the opportunity to correct their information. Misrepresentations or misinterpretations of the data could cause patients to be misinformed and make inappropriate decisions with respect to their health care.

In addition, to ensure our patients receive the privacy protections that they expect and are afforded under the law, the data should be aggregated so that it cannot be re-identified. Further, we encourage CMS to consider convening stakeholders such as hospitals and advocacy organizations, along with privacy and security experts, to develop practices that will protect patients, physicians and organizations.

(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.

We are concerned that unintended consequences for patients, physicians and organizations could arise if appropriate safeguards are not in place. While we support CMS in its efforts to improve the quality and value of care, we believe CMS must be diligent in developing processes to ensure that misleading information is not developed as a result of this program. Today, CMS and federal contractors, along with other agencies and experienced entities, have access to Medicare claims data. These entities access this information to ensure quality, appropriate payment and program integrity. We are concerned that untrained entities may not have the skills and sophisticated methodology necessary to understand the complexities of the Medicare data and, as a result, the data could be misunderstood or misused. Therefore, we urge CMS to develop minimum standards to ensure that data reporting is scientifically and statistically valid.

(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).

Like many large academic medical centers, patients seeking care from our physicians come from throughout the country and world. Our care includes treatment for sensitive, complex and/or rare diseases or conditions. Because the Cleveland Clinic campus is a large public environment, we have implemented a number of procedures to protect our patients' privacy. We are concerned that if a requestor is able to confine their dataset to a specific physician and a specific time period, re-identification of patients may be possible, particularly in cases of rare diseases, treatments or conditions. We urge CMS to aggregate any data it releases on an annual basis and to redact the dates of service and National Provider Identifier numbers from the data to protect our patients' and physicians' privacy.

In addition, since Medicare claims data does not provide the full context for the quality of patient care, it is crucial that the data include other relevant information. If the public is not presented with a complete and meaningful set of data, the release of Medicare data may lead to incorrect and harmful conclusions about the quality of physicians' care.

In conclusion, Cleveland Clinic supports the efforts of CMS to improve the quality of care through data analysis. We would welcome the opportunity to work with CMS to develop guidelines around which data could be released to the public to continue to improve the quality of healthcare for our patients.

Sincerely,

Kristen Morris
Chief Government and Community Relations Officer

The Cleveland Clinic Foundation
9500 Euclid Avenue /NA4
Cleveland, Ohio 44195
Tel 216 445-7445
Fax 216 444-2436
morrisk@ccf.org

Comments on Release of Medicare Physician Data

Submitted to CMS by Consumers' CHECKBOOK/Center for the Study of Services
1625 K Street, NW, Washington, DC 20006
September 5, 2013

Consumers' CHECKBOOK/Center for the Study of Services (CHECKBOOK/CSS) commends HHS for re-considering its policies and practices with regard to release of Medicare data on physicians. As a nonprofit organization whose mission is to inform and educate consumers to help them select and deal effectively with service providers, including health care service providers, we have devoted substantial effort over the years to encouraging the release of such data.

The Public Interest in Release of Such Data Greatly Outweighs Any Physician Privacy Interest

We agree with many others who have made the point that such data can have a powerful impact on improving health care delivery, quality, and efficiency of resource use. For example, the president of our organization, Robert Krughoff, joined with Michael Leavitt, who was Secretary of HHS in the previous Administration and has an especially deep perspective on the potential for such data to foster improvement, in arguing for the release of such data in a March 19, 2010, *Washington Post* op-ed piece, parts of which we quote below:

> "The release of Medicare data could have a powerful effect on the quality and cost of U.S. health care…
>
> "Releasing these physician-identified claims data (which, again, protect patient privacy) would make it possible for independent organizations -- including regional consumer, employer and provider health-care coalitions; government agencies; consumer organizations; and researchers -- to develop and produce rigorous measures and reports on the performance of physicians, medical groups and other providers, free of political or provider pressure.
>
> "Such reports could help consumers find the best providers, as well as give such providers public recognition; help public and private health insurers create rewards and other incentives for all providers to improve; and help reduce claims fraud.
>
> "Specifically, these reports could identify physicians who consistently ensure that their patients get the tests and treatments called for by evidence-based guidelines. The need to measure and improve on this front has been extensively documented. One widely cited 2003 New England Journal of Medicine study found that fewer than 60 percent of patients with a broad range of conditions received the recommended care.
>
> "Reports using these data could help identify physicians who consistently have better or worse risk-adjusted rates of patient death and complications in high-risk procedures.
>
> "For patients who need procedures in which the doctor's experience matters, reports based on the data would make it possible to know which doctors have appropriate levels of experience.
>
> "The data could make it possible to recognize and reward physicians who prescribe and deliver relatively low numbers of unnecessary or inappropriate procedures and services. Extensive research has shown that use of health-care resources is twice as high in some communities as in others without any significant difference in patient outcomes.
>
> "In addition, the data can be used to identify fraud, such as the tens of millions of dollars in claims that have been filed by "doctors" who are dead.

"Reports based on the data will require skilled, rigorous analysis, with the methods fully documented and subjected to public scrutiny. Efforts to prepare such reports using data from other sources are ongoing, but the Medicare data would make much better reports possible.

"Others that support releasing these data include AARP, Consumers Union, the AFL-CIO, the National Business Group on Health, Pacific Business Group on Health and the Business Roundtable."

The request for comments asks for comments on whether physicians have a privacy interest related to release of the data and, if so, how to weigh any such interest against the public interest in disclosure of the data. Since the claims data are collected as part of business transactions between the physicians and Medicare, it is appropriate to regard the physicians as "business entities" rather than as "individuals." "Business entities" do not have privacy rights in connection with governmental release of information. Even if there were such rights for business entities, they would not be a basis for failing to release information in which the physician had only a *de minimis* privacy interest, and that would be true the claims data. Physician organizations that have opposed release of the data have based their arguments on assertions that the data could be used to reach conclusions about a physician's income. This is not a valid concern since any such conclusions about income based only on Medicare claims information, would have to be based on gross income, rather than net income after other costs of practicing, and would not reflect physicians' other sources of income, including income from serving non-Medicare patients.

Even if physicians had a significant privacy interest in the data, the Freedom of Information Act would require release of the data because the public interest in release of the data would far outweigh any physician privacy interest. The many public beneficial uses of the data related to measuring physician performance, guiding consumer choice, giving physicians recognition, motivating and guiding physician improvement, creating high-quality networks and organizations, and other purposes are of enormous importance. And these purposes are at the heart of HHS's mission.

In the context of the FOIA, it is important to note that the release of *physician-identified* data will be critical to many strategies for public assessment of how well HHS is carrying out its mission and programs. Programs where HHS is (or is not but could be) evaluating physicians, providing financial and other incentives, seeking to change physician organizations, trying to educate physicians, trying to guide consumer choice, trying to prevent fraud, or using other strategies in its efforts to carry out its mission need to be evaluated and, to do that, it is essential to have the data to know how well physicians who are targeted or are not targeted by HHS's efforts are performing.

It is also important to note that HHS could quickly release the physician-identified data even if it, mistakenly we believe, were to conclude that such a release was not possible under FOIA alone. HHS can create a "routine use" for the data under the Privacy Act and publish notice of it in the Federal Register. Data can be released based on such a "routine use." Such a routine use would be substantially the same as existing routine uses of physician-identified but encrypted data except that the physician identifiers would not be encrypted. Such a use must be "compatible" with the reason for which the data were collected; if the current uses are compatible, there can be no question that the new uses (different only because the physician-practice identifiers are unencrypted) are also compatible.

HHS Should Have Data Release Policies That Will Securely Protect Patient Privacy But That Are Otherwise Flexible and Supportive of Widespread Data Use

Release of Hospital Data as an Illustration

HHS's history of release of hospital-identified data illustrates various points about how physician-identified data should be released. We will give you a little history of our own experience using and observing the use of the hospital data to provide some context for our recommendations on physician-identified data.

HHS first published hospital death rates for various diagnostic categories in 1986, based on data from Medicare claims and other sources. The reported measures were for deaths within 30 days of admission; HHS supplemented the claims data with data from the Social Security Administration on whether the patient had died within 30 days of the admission date. The reports showed, for each hospital, numbers of cases for each diagnostic category, actual mortality rates, and a range of predicted mortality rates so that the reader could see whether a the hospital's rate was outside the range of what would be predicted taking into account various patient characteristics (age, comorbidities, source of admission, etc.) and sampling error (good or bad luck). HHS included in its reports extensive explanations of its methods, additional references, and many caveats about the limitations of the information and the need for consumers to consider other indicators of quality.

Our organization which had, along with other organizations, encouraged HHS to make hospital data available (including through our membership in an Institute of Medicine committee on Access to Medical Review Data) was very pleased with HHS's release of these results. But as an independent consumer organization, we realized that the release only in a 7-volume, hard-copy publication at a price of $69 was not likely to get into the hands of many consumers. So we extracted the key results for the nearly 6,000 hospitals and published them in a single-volume *Consumers' Guide to Hospitals*. This Guide also included extensive explanation of the methods and limitations behind the death-rate data, many other factors to consider in choosing a hospital, and the need to consider other input, including a full discussion with one's physicians. Other organizations also disseminated the information and/or used the information in their own decision-making about hospitals.

HHS continued to publish hospital mortality information through the early 1990s and, taking into account much feedback from hospitals, researchers, consumers, and others, continued to refine its methods of risk adjustment and its methods of reporting—for example, starting to report for each hospital for each case type, the actual death rate, the risk-adjusted death rate, and trend information.

But HHS got much push-back and criticism from many hospitals, including legitimate comments on the imperfections of the measurement, and in 1993 decided to stop publishing its death rate reports. Our organization and many others were very disappointed with the Administration's decision that year and continue to believe that the field of provider quality measurement would have advanced much more rapidly if this reporting program had continued and continued to evolve. But we also recognize that pressure from providers weighs heavily on government, regardless of political party. And we recognize that having the government do measurement can be more difficult than having private entities do measurement because the government imprimatur may be interpreted by the public as giving the measurement more authority than it deserves.

Although HHS ceased to publish its own death rate reports, in the 1990s claims-based hospital data were available from CMS and could be used by other entities to calculate risk-adjusted death rates

and other measures. In 1998, our organization began to explore using these Medicare data to do its own calculations of hospital death rates and other measures. We identified one research organization that was doing such analyses and hired them to do risk-adjusted death rate reports on all U.S. acute care hospitals. When we got their results, checked them, and reviewed their methods, we concluded that we were not satisfied with their methods and decided not to use these bought-and-paid-for results. But we benefited from the fact that there were other research organizations we could turn to—a marketplace of ideas and methods—and we found Michael Pine and Associates (MPA), which provided us with well-documented methods based on sound research.

MPA had done much work on developing and refining its methods—for example, methods for distinguishing between present-on-admission comorbidities that should be used for risk-adjustment versus complications that occurred in the hospital, and which should not be adjusted for. (Diabetes is obviously not a complication but how about pneumonia?)

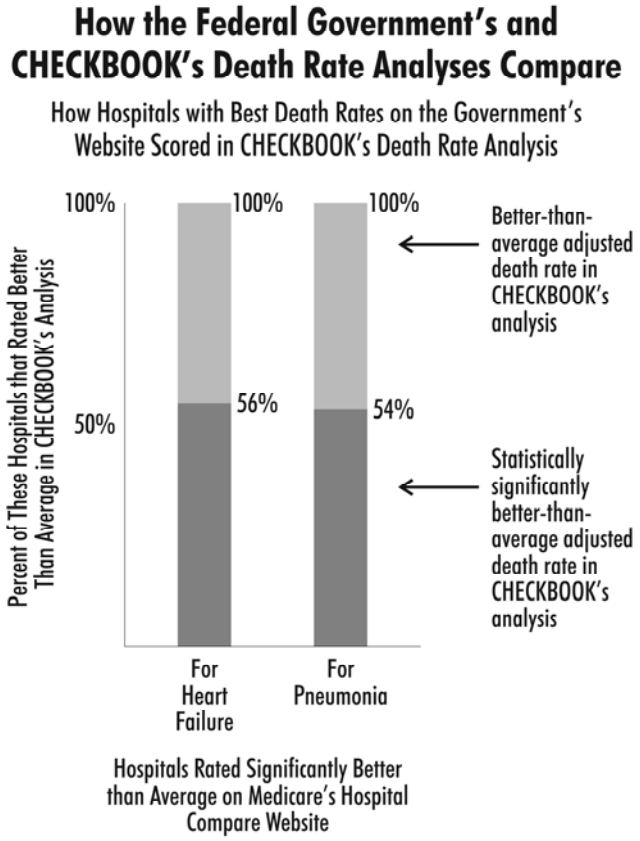
MPA also had a valuable approach for identifying adverse outcomes—a combined rate of complications and mortality, so we could report not only on mortality but also for other negative outcomes—including in types of cases where mortality is rare. MPA's approach includes concluding that a complication is likely to have occurred if a patient's length of stay was significantly higher than would be expected for the patient's procedure given the patient's characteristics and the hospital's usual pattern of lengths of stay in such cases. This was an approach that MPA developed as it and other entities with access to the data continually sought to improve the usefulness of information that could be produced.

Having the hospital data available to multiple users also meant that there would be many creative minds thinking about how HHS could improve the data it was providing. Michael Pine personally is an example of someone who has helped to bring advances on this front. He was a strong advocate for including present-on-admission coding into hospital claims to make it easier (though not fool-proof) to distinguish comorbidities from complications for purposes of risk-adjustment. Such coding is now required by Medicare. Pine has also done much analysis of the extent to which knowing laboratory values (for example, blood test results), in addition to the information on patient comorbidities and other characteristics that have generally been used in risk adjustment, can improve the validity of the risk adjustment models. And there are now government-funded efforts underway to bring lab values into the available databases.

We published a new addition of our *Consumers' Guide to Hospitals* in print and online in 2002 and have published similar results since, relying on analysis of Medicare hospital claims data as analyzed by MPA—and also using patient survey results, results of our own surveys asking physicians to evaluate each hospital, various measures from the Leapfrog Group, information about hospital medical school affiliations, and various other pieces of information. Our ratings have been used by AARP Magazine and other outlets. And many other organizations, including US News, HealthGrades, and recently Consumer Reports (which published adverse outcome rates calculated by MPA), have produced and disseminated hospital ratings.

In 2008, HHS resumed publishing its own risk-adjusted death rate data on hospitals—reported on the HospitalCompare website. This is a valuable step. And we would hope that HHS would use PhysicianCompare to make various types of measures available on physicians. But it is still useful to have other independent entities be able to analyze the disaggregated data. At least at the start, the reports on the HospitalCompare website identified very few hospitals as different from the average. And even

when we last did a comparison, we found that on the HospitalCompare website relatively few hospitals were singled for users as distinguishable from other hospitals. For example, for heart failure cases, only 193 of the roughly 4,000 hospitals were identified as having significantly better-than-predicted death rates and only 118 were identified as having significantly worse-than-predicted death rates. That compares to 305 and 426 hospitals, respectively, being identified as significantly (95 percent confidence interval) better or worse in our Guide's analysis. Yet our Guide's analysis (which used a somewhat different time period of data) had results that lined up well with the HospitalCompare results, as is shown in the figure below. For example, for heart failure cases, all hospitals identified by physician compare as significantly better than average were at least better (though not always significantly better) than average in our Guide and 56 percent were significantly better than average in our Guide.



A key element of our experience with hospital data is that getting the data has been easy and not too expensive, at about $3,500 per year the last time we ordered it. We requested the MEDPAR Limited Data Set file from CMS. The request for the data and the Data Use Agreement we signed briefly described what we would be doing with the data by way of analysis and reporting of results. But CMS did not pass judgment on those plans other than with respect to our protection of patient privacy. We had to give evidence that we could keep the data secure. And we had to promise not to report death rates or adverse outcome rates for types of cases where the hospital's number of patients was fewer than 11—to avoid risk that patients might be able to be indirectly identified.

Recommended Policies and Procedures on Physician-Identified Data Release

We believe that key elements of HHS's program on release of physician-identified data should be—

- The data should be available for analysis using whatever methods the user believes are sound and appropriate. CMS should rely on the "marketplace of ideas" to discipline the way the physician-identified data are analyzed and used. Whether the use is for consumer reporting, provider education, health plan decision-making, government intervention, or other purposes, as soon as the results have any visibility or impact, there will be opportunities to criticize the methods (or lack of disclosure of methods) and the results. Organizations with the interest and resources to use these large and complex databases are likely to be quite sensitive to such criticism—or even the potential for defamation lawsuits.
- Users should be required to make their methods fully transparent. With hospital data, there is no requirement to let each hospital review the results before publication, and doing so for physician data should not be required. But it would be good if HHS would set up a mechanism to allow the entities using the data efficiently to give physicians such a review opportunity—perhaps with a website where these entities could post notice of new performance measurement results and could let physicians get secure access to their own results using their NPI login identifiers or some other means.
- It should be possible to get all the Medicare claims data for a period of years or to let users who want less to request and get data files filtered in certain standard ways, such as by geography, procedure, chronic condition, or physician identifiers. The potential for scale is important here because it can lead to efficiencies and because measures that are reported nationally will have much more visibility and may support large-scale, uniformly applied programs. But there will be potential users that want to analyze a narrow issue or that function only in a limited geographic area or that want to test a program before going larger. HHS should make it easy for such users to meet their more limited needs.
- The government should set up systems to provide data files quickly in response to standard data requests, even for terabytes of data, at very low cost. The goal should be to encourage creative use of the data by multiple independent entities and to foster innovation in measurement of the kind demonstrated by MPA, as described above.
- CMS should put a high priority on improving the usability of the data. There will be opportunities to make improvements like the inclusion of data from the Social Security Administration on date of death after hospital admissions in the MEDPAR hospital data releases. And the systems that accumulate the raw data will be able to be improved similarly to the way hospital-identified data have been improved by the addition of present-on-admission coding. But release of the data should not be delayed at all to include such improvements. Much can be done with the physician-identified data now; improving the data might be slow, and as the data are used, more opportunities for improvement will become evident as was done in the documentation of the value of having lab results along with hospital claims data.
- There should be no requirement that a user provide, or demonstrate the ability to provide, any data other than the requested Medicare data. For some purposes, having additional data might be desirable, but that should be for the user to determine and should not be a bar to using the Medicare data. The situation is analogous to the situation with hospitals; it might be desirable to have claims data from private payers as well as Medicare, but many users, including CMS, have been able to provide meaningful death rate information without such non-Medicare data. On the other hand, there will be some types of analysis where even having data for every health care encounter in the nation for a long period of years would not be sufficient to produce meaningful measures. A requirement to have substantial amounts of non-Medicare claims data,

for example, for every part of the country would make using the Medicare data for national measures impossible for most potential users.

- HHS should not pass judgment on the types of measures to be produced. It is sufficient that a user believes that a measure will be valued. If there are problems with a measure, the policy should be, as it generally is with regard to release of information under the principles of the Freedom of Information Act and the general principles of free speech, that such problems will be exposed and addressed in the marketplace of ideas (or in extreme cases in courts of law). For example, there has not been broad interest at the National Quality Forum or other measurement endorsement organizations in reporting on the case volume of individual physicians with specific procedures even though there is sound research evidence that volume/experience matters for some procedures. If a user wants to do simple counts of volume by procedure for individual physicians using Medicare data (possibly inviting physicians to attest to their full combined Medicare and non-Medicare volume if they wish) such a user should have access to the data.
- There should full protection of patient privacy, with users having to show that they have strong systems in place to ensure such protection. For example, for some data requests that would include substantial encrypted patient identifier information, it might be appropriate to require that the requesting entity have a third party audit that tests the entity's privacy and data security systems (as a SOC Type-2 audit does). But the standard should be lower or higher depending on the nature of the data requested. For example, a user that wanted to have just the data elements needed to report physician volume by procedure would need no patient identifiers while a user intending to measure whether physicians were giving all guideline-recommended tests and treatments to diabetic patients might need to request encrypted patient identifiers.

The Data Should Be Available Physician-Identified In Fully Disaggregated Form

Some users may want only data aggregated by physician—for example, reports on a physician's average level of compliance with guidelines for care of diabetic patients. This might be especially true to the extent that HHS provides measures for direct consumer use on something like a PhysicianCompare website.

But the data should be available in disaggregated form. The data will have much greater value if they are disaggregated—for example, individual claims—so that they can be analyzed and combined by entities that wish to do so and that might produce more meaningful and usable measures than HHS would produce on its own.

Very important: the data must enable users to measure and report at the individual physician level since there is important performance variation among physicians within the same practice and consumers and other decision-makers have compelling reasons to want information at the individual physician level.

These comments are submitted by Consumers' CHECKBOOK/Center for the Study of Services

Signature: 

Robert Krughoff, President

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August 30, 2013

Marilyn Tavenner
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Attention: Physician Data Comments

Dear Ms. Tavenner:

On behalf of our 39 hospitals in Arizona, California and Nevada, and in support of the 590 contracted providers and over 1,600 employees that make up the Dignity Health Medical Foundation (MF), Dignity Health appreciates the opportunity to submit comments as CMS considers the most appropriate policy regarding release of individual physician Medicare payment data. Dignity Health MF provides multi-specialty medical services through non-profit, multi-specialty medical clinics located in various communities throughout California. Committed to our mission of providing quality affordable care to all, especially to the poor and disenfranchised, and partnering with others in the community to improve the quality of life throughout the communities we serve, Dignity Health MF is proud of our partnership with the government by providing care to many Medicare and Medicaid beneficiaries.

Dignity Health MF supports data transparency, as long as the data can be validated and is accurate and meaningful, and argues physician data already does and should inform program improvements in Medicare. However, the value of individual physician Medicare payment data – versus aggregated Medicare payment data – is unclear. Even with the appropriate controls in place to protect patient information, the collection of individual physician payment data can become complicated, based on the physician's locality, payor mix and patient population. It is also difficult – if not impossible – to report accurate *individual* Medicare payment data in a managed care environment, much less through a medical foundation model that provides payment and claims administration services to physicians. **As it develops standards for disclosure of individual**

physician data, Dignity Health urges CMS to consider the variety of payment models (fee-for-service vs. capitated) and physician alignment models and either exempt physicians that are part of a group or medical foundation from independent data reporting, or allow for the risk adjustment and aggregation of data for physicians in those circumstances.

Below is our response to the specific questions posed in the request for comments:

(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.

Dignity Health MF agrees independent physicians have a privacy interest concerning Medicare payment data. The availability of the data opens the possibility of inappropriate scrutiny of the independent physician's finances, business practices and may affect his/her ability to negotiate competitive contracts. In a medical foundation model, where individual physicians and medical groups contract with the medical foundation to provide administrative and other services, the privacy interest is diluted, but the data collection and reporting becomes more complicated if the data is specific to an individual physician. Further, current law already provides significant oversight of independent physician practices to identify fraud and abuse, and monitors physician performance on quality and efficiency through incentive programs. **Dignity Health MF urges CMS to maintain a level playing field for independent physicians while appropriately balancing public interest by allowing for the collection of physician claims data, which more accurately reflects a physician's patient population and clinical practices. If physician payment must be released, Dignity Health recommends CMS exempt physicians that are in group practice and/or allow for risk-adjusted aggregate data reporting.**

(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.

Existing law establishes programs to provide oversight, curb fraud and abuse, and improve the quality and value of care available to Medicare beneficiaries. In fact, the *Affordable Care Act (ACA)* provides for several quality improvement

initiatives for all providers, including physicians. Those programs require the submission of specific quality measures developed through national-accredited agencies. This way, CMS ensures comparisons are made on the same measures containing the same data points. **Instead of developing a new data reporting requirement that will not necessarily address quality or program improvement, Dignity Health MF encourages CMS to focus on refining such programs and develop best practice forums to improve the care available to Medicare beneficiaries. If it must move forward to disclosing individual physician payment data, Dignity Health MF urges CMS to apply risk adjustments and release only aggregated data.**

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

As noted above, Dignity Health MF has significant concerns about the collection and release of individual physician payment data. For Dignity Health MF, individual physicians are paid on a contracted basis by the medical foundation, which in turn contracts with Medicare Advantage plans for services to Medicare beneficiaries. Through this model, Dignity Health MF believes the individual physician payment data generated from our physicians will not provide a complete picture of the services and patient population our physicians serve. **Dignity Health urges CMS to apply a risk-adjustment to individual payment data and exempt physicians who are part of a group or medical foundation from individual payment data collection.**

Dignity Health MF appreciates the opportunity to comment on this important matter and hopes our comments are helpful. If you have any questions, please contact Clara Evans, Director of Public Policy & Fiscal Advocacy at clara.evans@dignityhealth.org or at 916.851.2007.

Sincerely,

[redacted]

Joseph Jasser, MD
President/Chief Executive Officer

The power of physician-level cost data to change the health care system cannot be overstated; it will forever change the power dynamics between the various players on the health care stage in these United States. The release of this data in a conscientious way will deliver profound benefits throughout the system, and the leadership position that CMS and HHS have taken is highly commendable.

As experts in engaging patients and providers, and facilitating better connections between those groups, Health Platforms [parent company of Doctor.com] will actively seek opportunities to integrate the data set with our existing data in order to bring price transparency to consumers.

However, there is another component which needs to be considered in order for the information to be actionable--- metrics on the quality of the care delivered. This is the most important and actionable metric for any type of patient, and it is the balance of the argument that most physicians will make against the release of the cost data. Cost and Quality, displayed together, create an educated consumer who is in control of their healthcare future, and the dissemination of these coupled metrics is our ultimate goal.

It is for this reason that individual claims, in their fullest entirety possible, need to be published in this data set, since it is the flow of the claims which can give indicators as to the clinical outcomes of the episodes of care. it is a leading indicator on the quality of care being given. This is the kind of information wouldn't be available if the data is aggregated in any way.

Thank you for considering our opinion in this matter, please reach out with any questions your team may have, we'd be happy to help in any way possible.

Reed Mollins

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September 5, 2013

VIA HAND DELIVERY and EMAIL
(Physician_Data_Comments@cms.hhs.gov)

Department of Health and Human Services
Centers for Medicare & Medicaid Services
Physician Data Comments
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Office 341D-05
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Comments of Dow Jones & Company on *Request for Public Comments on the Potential Release of Medicare Physician Data*

Dear Sir or Madam:

Dow Jones & Company ("Dow Jones"), publisher of the nationally distributed newspaper *The Wall Street Journal* and other publications, by counsel, hereby responds to the above-referenced *Request for Comments on the Potential Release of Medicare Physician Data* (the "Request for Comment") issued by the Centers for Medicare & Medicaid Services ("CMS").

Dow Jones submits that CMS should release individual physician Medicare payment data as broadly and granularly as possible. Such disclosure is supported – and, under the Freedom of Information Act, 5 U.S.C. § 552 ("FOIA"), is required upon request – in that the public interest in disclosure clearly outweighs physicians' privacy interests in how much public money they receive under what is one of our most vital and expensive federal programs. As that balance is the critical determinant for whether disclosure is permitted by the Privacy Act, 5 U.S.C. § 552a, and required by FOIA, *see*, *e.g.*, *ACLU v. DOJ*, 655 F.3d 1, 6 (D.C. Cir. 2011), CMS should immediately grant full access to its Medicare reimbursement data.[1]

[1] As the Request for Comment makes clear, it is important to note that public disclosure of information that could directly or indirectly reveal patient-identifying information is not at stake here. *See* Request for Comment at 2. Any release of Medicare reimbursement data advocated here can, and would, be patient-anonymized before release.

Dow Jones can attest first-hand to the public interest value that access to the data affords. As discussed in greater detail below, Dow Jones reporters at *The Wall Street Journal* were able to identify and report on a number of instances of Medicare waste, fraud and abuse, using only tightly constrained access to CMS Medicare data. The *Journal*'s *Secrets of the System* series, a 2011 Pulitzer Prize finalist, exposed suspicious billing activity by Medicare providers, and questioned whether the government effectively mines data at its disposal to prevent that kind of improper Medicare billing. Dow Jones stands ready to continue shining a public light on these issues, as its reporters such as John Carreyrou and Tom McGinty, once unshackled from limits on access to and use of Medicare data, can disseminate similar information through the *Journal* or similar publications, and online. Dow Jones's belief in the importance of this data is shared by other like-minded press and public interest entities as well. CMS should follow through on the promise of its Request for Comment by making that data as freely available as possible, as soon as possible.

INTRODUCTION

Dow Jones appreciates CMS's profession of a "strong commitment to greater transparency in recent years." Request for Comment at 1. That commitment is but the tip of an iceberg of sweeping change that occurred over the 30-plus years since the Department of Health and Human Services ("HHS") last formally examined its *Policy on Disclosure of Amounts Paid to Individual Physicians Under the Medicare Program*, 45 Fed. Reg. 79172 (1980). Since that time, the law has evolved, and technological innovation has strengthened the public's ability to analyze and gain insights from Medicare reimbursement data.

The last 33 years have seen public policy shift in favor of access. Courts and President Obama have made clear, for example, that FOIA "should be administered with a clear presumption: In the face of doubt, openness prevails." *Freedom of Information Act*, Memorandum for Heads of Executive Departments and Agencies, 74 Fed. Reg. 4683 (2009) ("*FOIA Department Heads Memo*"). Consistent with "the basic policy that disclosure, not secrecy, is the dominant objective," the Supreme Court has "repeatedly stated that the policy of [FOIA] requires that [its] disclosure requirements be construed broadly, the exemptions narrowly." *News-Press v. DHS*, 489 F.3d 1173, 1191 (11th Cir. 2007) (citations omitted).

For Medicare data specifically – including physician-identifying reimbursement amounts targeted by the Request for Comment – the need for openness, and the manner in which it contributes to public understanding of government operations and activities, was underscored by the Affordable Care Act becoming law, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA"), and by HHS's rules effectuating the ACA's data-access provisions. 42 C.F.R. § 401.701 *et seq*. The ACA's Medicare Data Performance Measurement provision and its implementing rules mandate the publication of Medicare reimbursement data of individually identified doctors to certain entities under certain circumstances – the very same data that the Request for Comment contemplates making even more publicly available. While the ACA is a step in the right direction, it is not, as discussed below, enough by itself to meet the public interest in widespread

access to individual physician Medicare payment data. Indeed, the importance of releasing such data was reinforced more recently by President Obama's issuance of Executive Order 13642, 78 Fed. Reg. 29559 (May 21, 2013), which recognized government-held data as a valuable resource and strategic asset that should be made more accessible, including the "thousands of Government data resources [involving] health and medicine," among others.[2] CMS should follow suit here.

THE BALANCE OF INTERESTS FAVORS FULL DISCLOSURE

As the Request for Comment correctly notes, CMS records, such as Medicare reimbursement data, may be released under the Privacy Act, and must be released under FOIA, unless the balancing of individual privacy interests against the public interest reveals that disclosure would constitute a *clearly unwarranted* invasion of personal privacy. Request for Comment at 2. *See also, e.g.*, *News-Press*, 489 F.3d at 1196-97; *ACLU v. DOJ*, 655 F.3d at 6; *FCC v. AT&T Inc.*, 131 S. Ct. 1177, 1184-85 (2011). And as the Request for Comment further notes, "a number of changes have occurred related to physicians' privacy interests in maintaining the confidentiality of their Medicare payments and [to] the public interest in disclosure," including that:

- The public's interest in the data is greater given the substantial growth in size of Medicare, which carries with it greater consequences of Medicare fraud, waste, and abuse.
- Disclosing payment information helps expose Medicare fraud, waste, and abuse.
- Medicare reimbursement has evolved toward greater standardization of payment amounts.
- The ACA furnishes qualified entities with Medicare claims data to generate public reports.

Request for Comment at 2.

These are among the points that Dow Jones made in successfully moving to vacate the injunction that barred CMS's release of physicians' individually identifiable Medicare reimbursement data prior to the decision in *Florida Medical Association, Inc. v. Department of Health, Education and Welfare*, 2013 WL 2382270 (M.D. Fla. May 31, 2013) ("*FMA v. HEW*"), which CMS cites as an impetus for the present inquiry. Request for Comment at 1 & nn.1-2. In intervening in *FMA v. HEW* and challenging the ongoing validity of the injunction entered in 1979, [3] Dow Jones filed pleadings with detailed showings why physician identifying Medicare reimbursement data held by CMS should be releasable under FOIA and the Privacy Act. The pleadings included affidavits and substantial evidence, as well as an expert declaration by Malcolm Sparrow, Professor of the Practice of Public Management at Harvard University's John

[2] Executive Order 13642, coupled with a new Open Data Policy concurrently issued by the Office of Science and Technology Policy and Office of Management and Budget, require all newly generated government data to be made available in open, machine-readable formats to enhance their accessibility and usefulness.

[3] *See FMA v. HEW*, 479 F. Supp. 1291 (M.D. Fla. 1979) (the "1979 Injunction").

F. Kennedy School of Government, reflecting more than a decade-and-a-half studying Medicare fraud. Professor Sparrow, a former detective with expertise in fraud investigations, and member of the Recovery Independent Advisory Panel appointed by President Obama to help protect the integrity of the economic stimulus package created by the American Recovery and Reinvestment Act of 2009, authored the seminal work, *License to Steal: How Fraud Bleeds America's Health Care System* (1st ed. 1996; 2d ed. 2000). Those pleadings and their exhibits are incorporated herein by reference and are attached as an Appendix, to which Dow Jones respectfully directs CMS's attention as answering the Request for Comment's questions, in the following respects.

The Significant Public Interest

In litigating *FMA v. HEW*, Dow Jones showed that a great many changes have occurred since the 1979 Injunction issued that both warranted vacating the injunction, and confirm that the public interest in access to physician-identifying Medicare reimbursement data outweighs the physicians' privacy interests. Dow Jones showed that Medicare's evolution over the ensuing decades is itself a factor warranting disclosure. In 1979, Medicare had existed for only 14 years and cost $26.5 billion, or just over 5% of total federal outlays – today it has grown twenty-fold in nominal dollars, and nearly three-fold as a percentage of total federal budget. App. 137, 169, 199. The sheer size of the modern Medicare program speaks to the interest in gaining insight into CMS's "performance of its statutory duties" so that the public can better understand what the "government is up to" in this regard.[4]

Dow Jones also showed that, with expansion of the program, Medicare fraud sky-rocketed, and along with it, the public's interest in knowing how the government is addressing that problem. Since 1979, Medicare fraud has become what former Attorney General Janet Reno

[4] *Consumers' Checkbook Center for the Study of Services v. HHS*, 554 F.3d 1046, 1053 (D.C. Cir. 2009) (citing *DOJ v. Reporters Comm. for Freedom of the Press*, 489 U.S. 749, 773 (1989)). Though *Consumers' Checkbook* ultimately did not order the release of the Medicare data sought in that case, it suggested that, where evidence showed that the data could be used to identify waste, fraud and abuse, and allow the public to monitor what the government is doing to prevent same, release would be proper. *Id*. at 1054-55; *id*. at 1062-63 (Rogers, J., concurring in part, dissenting in part). As we show below, Dow Jones has presented just such evidence, and incorporates it by reference here. *See infra* 6-7.

In addition, there are obviously further public interests that a general release of Medicare reimbursement data by CMS would serve, such as patients learning if their doctors perform an inordinate number of risky surgeries, medical boards being able to investigate allegations of impropriety, and doctors making sounder referrals. However, the interest under FOIA – the only interest before the *Consumers' Checkbook* court – focuses on shedding light on agencies' performance of their statutory duties. *See, e.g., Consumers' Checkbook*, 554 F.3d at 1053. We thus limit our discussion, except where otherwise noted (*e.g., infra* 5 n.6, 9, 10), primarily to how release of physician-identifying Medicare reimbursement data will serve the public interest in knowing "what [CMS] is up to" in administering and overseeing Medicare. *Reporters Comm.*, 489 U.S. at 773.

labeled the nation's second leading crime problem, with HHS estimating 8.6% of all spending to be illegitimate, including millions for services purportedly rendered by long-dead doctors, or to long-dead patients or beneficiaries who had already been deported or imprisoned. App. 131, 137-38, 165-68, 199. Indeed, since 1990, the General Accounting Office ("GAO") has considered Medicare at "high risk for fraud, waste, abuse, and mismanagement."[5] Doctor Donald M. Berwick, who led CMS until recently, estimated that 20-30% of health spending is "waste" that yields no benefit to patients. App. 179-80.

Further changes since 1979 underlie the increase in fraud, including principally the manner in which claims are processed. In 1979, claims were submitted on paper and reviewed by processing clerks, whereas now most claims are submitted electronically and processed without human scrutiny. App. 139, 161-62, 169-70; *cf. id*. 153-54. Medicare's fee-for-service program now pays more than $1 billion on 4.5 million claims every single work day, and must pay within 30 days of receipt. *Id*. 137, 169. This automated claims system enables large-scale "hit and run" billing schemes in which public funds are extremely unlikely ever to be recovered. *Id*. 157, 169-70.

Meanwhile, as Dow Jones showed, the same automated billing that facilitates Medicare fraud also means that current, high-quality data is now available for more sophisticated analysis. That timely, granular data, along with technological advancements, allow the public and press to see more clearly how Medicare allocates its resources and how effectively it polices waste, fraud, and abuse.[6] The data now at issue is itself different than that in 1979. Back then, the information before the court in *FMA v. HEW* consisted of bare lists identifying doctors and how much money each received in the aggregate annually from Medicare, whereas now there are terabytes of electronic data that are far richer, reflecting payments for specific procedures, reasons for each procedure, and the frequency and number of procedures performed, to name just a few details. App. 157-58, 187, 209. *See also id*. 31. This reveals much more than a gross total of taxpayer money a doctor receives from Medicare – rather, it allows the public to learn whether they are paying for unnecessary or improper procedures or procedures never performed, whether there have been unlawful or unethical kickbacks or self-dealing, and whether government is working effectively to prevent and pursue these and related problems.

Indeed, the government has embraced the value of "crowdsourcing" accountability by making payment data public, App. 143, 177-79, 202, with nearly every entity paid with taxpayer dollars other than Medicare service providers having their payment information posted on government-run, publicly available websites. *Id*. 143-44, 177-78, 198. This can be seen under the American Recovery and Reinvestment Act, which required creation of "recovery.gov," and the Federal Funding Accountability and Transparency Act, which created "USAspending.gov."

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[5] GAO, *High Risk Series* (Jan. 2009), available at www.gao.gov/new.items/d09271.pdf.

[6] App. 157-58; 169-70, 173-74. Also, though not expressly part of the public/privacy-interest balancing under FOIA, *see supra* note 4, the public interest also is served by a deterrent effect that should arise from knowledge that public oversight has increased, enabled by disclosure pursuant to action on the Request for Comment. App. 179-81.

Id. 143-44, 177-78. *See also id*. 115-16, 123-24, 144, 178 (discussing Medicare Data Access for Transparency and Accountability Act (S.756)). The ACA and its HHS rules discussed above, which anticipate availability of CMS data to "qualified entities" and public reports by them, also attest to how disclosure provides insight into CMS's carrying out of its statutory obligations. *Id*. 143, 152-53, 214-16.

Dow Jones showed in microcosm just how this can work. In submissions in *FMA v. HEW*, it recounted how reporters at *The Wall Street Journal* gained a sliver of CMS Medicare data, and used it to research and publish the *Secrets of the System* series described at the outset of these comments. App. 2-4, 7-15, 41-77, 96-106, 107-27, 139-42. The series raised, among other things, whether the government is effectively using the mass of data in its possession to sniff out, punish, and prevent improper Medicare billing, and whether regulatory loopholes and other economic incentives encourage some doctors to disregard their patients' best interests and instead pursue unnecessary or high-cost procedures. [7] And this kind of private scrutiny can spur government oversight, as Dow Jones detailed before the court. App. 15-16, 34. *See also id*. 157-58, 170-71, 179-80 (discussing how supplementation of government fraud detection by an outside watchdog like the *Journal* can bring a different set of methods to bear and devote considerable attention to non-traditional areas of inquiry). *Cf. id*. 171-73 (discussing limits on government investigation and enforcement).

Along with the Sparrow Declaration, Dow Jones' court filings included declarations by Michael Allen, the then-Deputy Page One Editor at *The Wall Street Journal* (now, Global Enterprise Editor); Maurice Tamman, then a news editor and investigative reporter at the

[7] The *Secrets of the System* series encompassed the following articles (App. 41-77): Barbara Martinez, *Home Care Yields Medical Bounty*, Wall Street J., Apr. 27, 2010, at A1; Mark Schoofs & Maurice Tamman, *In Medicare's Data Trove, Clues to Curing Cost Crisis*, Wall Street J., Oct. 26, 2010, at A1; Anna Wilde Mathews & Tom McGinty, *Physician Panel Prescribes the Fees Paid by Medicare*, Wall Street J., Oct. 27, 2010, at A1; John Carreyrou & Maurice Tamman, *A Device to Kill Cancer, Lift Revenue*, Wall Street J., Dec. 8, 2010, at A1; John Carreyrou & Tom McGinty, *Top Spine Surgeons Reap Royalties, Medicare Bounty*, Wall Street J., Dec. 20, 2010, at A1; Mark Schoofs & Maurice Tamman, *Confidentiality Cloaks Medicare Abuse*, Wall Street J., Dec. 22, 2010, at A1. *See also* Mark Schoofs, Maurice Tamman & Brent Kendall, *Medicare-Fraud Crackdown Corrals 114*, Wall Street J., Feb. 18, 2011, at A3; Mark Schoofs & Maurice Tamman, *Bills Push Medicare Data Access*, Wall Street J., Mar. 3, 2011, at A4; John Carreyrou & Tom McGinty, *Medicare Records Reveal Troubling Trail of Surgeries*, Wall Street J., Mar. 29, 2011, at A1; Mark Schoofs & Maurice Tamman, *Senators Push to Open Database on Medicare*, Wall Street J., Apr. 8, 2011, at A2; John Carreyrou & Tom McGinty, *Hospital Bars Surgeon From Operating Room*, Wall Street J., Apr. 13, 2011, at A8 (App. 111-27). Following the decision in *FMA v. HEW*, Dow Jones filed a FOIA request for access to various Research Identifiable Files maintained by CMS under Medicare. That information, and information provided as a result of disclosure in response to the Request for Comment, should be even more useful than the sliver of CMS data the *Journal* obtained for purposes of the *Secrets of the System* series.

Journal; and Mark Schoofs, then a *Journal* investigative reporter. These declarations detailed the investigation and reporting behind *Secrets of the System*, the significant evidence of Medicare waste, fraud and abuse on which the series reported, and the limits on what the *Journal* was able to find and report because its reporters and analysts were refused access to complete CMS files and were restricted in what they could disclose about individual providers of Medicare services under the now vacated 1979 Injunction. App. 2-4, 7-15, 41-77, 96-106, 107-27, 139-42.

Dow Jones also vividly illustrated why doctors' names are needed to inform investigators, referring doctors, and the public of wrongdoers revealed in CMS data, and how lack of access to identifying information hinders necessary follow-up. App. 36, 83-84, 95, 139-40, 157-58, 162, 169-71, 210-12. As explained, the "[i]nability to discuss specific doctors imposes a severe limitation on finding all but the most obvious violators." *Id*. 101-03. *See also id*. 210-12. Once these impediments can be lifted, *Journal* reporters like John Carreyrou and Tom McGinty – who wrote, for example, about a doctor performing seven spinal fusion surgeries on one patient in a two-year span, while receiving consulting fees from a spinal fusion device company[8] – are poised to carry on the kind of work that the *Secrets of the System* series typifies.

Further indicia of the public's interest in disclosure of physician-identifying Medicare data continued to mount, even after the record closed in *FMA v. HEW*. For example, President Obama issued Executive Order 13642, as noted above. *Supra* 3 & n.2. Shortly before that, GAO issued a report, which, in citing Medicaid as having "the second-highest estimated improper payments of any federal program," reaffirmed that access to data that identifies individual physicians is highly important in identifying waste, fraud and abuse. *See* GAO, *National Medicaid Audit Program* (June 2012), at "Highlights" and p.1 (available at http://www.gao.gov/products/GAO-12-627). In discussing audits of paid claims, GAO cited failings where "data do not include elements that can assist in audits, *such as ... names of providers*[.]"[9] Using such incomplete records can "result in many false leads, [if] the data do not contain critical audit elements, including provider identifiers," and lead to conclusions that can be "misleading." *Id*. at 14-15. GAO thus corroborated the reasons given by Professor Sparrow and *Journal* personnel for why access to Medicare data on an individually identifiable physicians is necessary. All told, the growth of the public's interest in gaining access to physician-identifying Medicare reimbursement data, and its overwhelming nature as it stands today, is plain to see.

The Diminished Privacy Interests

The interest of physicians in maintaining the secrecy of their payments from Medicare – if any – has dwindled at the same time the public interest in disclosure has grown, as Dow

[8] App. 125.

[9] *Id*. at 4-5 (emphasis added). *See also id*. at "Highlights" (audits were "less effective" because they used data "missing key elements, *such as provider names*") (emphasis added). This included a "unproductive audits" that had to be "discontinued [], had low or no findings [], or were put on hold." *Id*. at 13.

Jones's *FMA v. HEW* filings showed. First, fundamental changes in how Medicare providers are paid minimizes any privacy interest that may have existed, in that reimbursements no longer reflect how much an individual provider chooses to charge for procedures, as in 1979. Rather, standardized payment schedules are now set by the government and published under the Omnibus Budget Reconciliation Act of 1989, so payment data no longer sheds light on what providers may charge their non-Medicare patients. App. 133, 153, 195-96. *See also* www.cms.gov/apps/physician-fee-schedule. In addition, any secrecy physicians once enjoyed has fallen by the wayside with the expectation of disclosure under the ACA's Medicare Data Performance Measurement provision and implementing rules, under which qualified entities will obtain individual physician's reimbursement data and *must* generate public reports using it. App. 152-53, 194-95. The ACA thus diminishes expectations of privacy insofar as the statute and its implementing regulations *require* published reports that may, indeed, identify individual doctors, even if they object or claim reports are erroneous.[10]

Dow Jones also highlighted how changes in law have come to disfavor privacy claims by those receiving governmental benefits. App. 132-33, 149-51, 195. It explained how courts have clarified that such persons cannot expect to keep government payments secret, in light of the enormous public interest in knowing whether an agency is a good steward of (sometimes several billions in) taxpayer dollars. *Id*. 149-51 (quoting *News-Press*, 489 F.3d at 1191-92, 1196, 1202, 1206). Even where there may be some minimal privacy interest in information that pertains to business activities, it shrinks considerably when business is funded by the government.[11] This is true, Dow Jones showed, in the case of lawyers, payments to whom, when appointed by courts to represent the indigent, are public as well,[12] and the same should extend to other professionals, including doctors. Indeed, Judge Rogers, dissenting in *Consumers' Checkbook*, noted the "quasi-public function" carried out by medical practitioners who contract with the government to

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[10] App. 152-53, 193. Dow Jones also showed that physicians cannot claim a right to have any information withheld in reliance upon promises or expectations of its being kept secret, given the ACA's required disclosures. *See id.* 198 (quoting *Washington Post Co. v. HHS*, 690 F.2d 252, 263 (D.C. Cir. 1982). Of course, standing alone, the ACA and its implementing regulations are insufficient to serve the public interests discussed here. *See infra* 9-10.

[11] *Id*. (citing *Multi Ag Media LLC v. Department of Agric.*, 515 F.3d 1224 (D.C. Cir. 2008); *Washington Post Co. v. HHS*, 690 F.2d 252, 261 (D.C. Cir. 1982); *Washington Post Co. v. DOJ*, 863 F.2d 96, 100 (D.C. Cir. 1988); *Sims v. CIA*, 642 F.2d 562, 575 (D.D.C. 1980); *Washington Post Co. v. Department of Agric.*, 943 F. Supp. 31, 35-36 (D.D.C. 1996)). *See also* App. 155-57.

[12] *See* Administrative Office of the U.S. Courts, *Guidelines for the Administration of the CJA*, available at http://www.uscourts.gov/FederalCourts/AppointmentOfCounsel/CJAGuidelinesForms/vol7PartA/vol7PartAChapter5.aspx (noting that "as amended in 1998, [the Criminal Justice Act] mandates disclosure of amounts paid to court appointed attorneys upon the court's approval of the payment," and providing procedures for expeditious release of the information). *Cf. United States v. Suarez*, 880 F.2d 626, 630 (2d Cir. 1989) ("[T]here is an obvious legitimate public interest in how taxpayers' money is being spent, particularly when the amount is large.").

provide services in exchange for federal payments. 554 F.3d at 1057 (quoting *Public Citizen Health Research Group v. HEW*, 477 F. Supp. 595, 604 (D.D.C. 1979)).

In that regard, Dow Jones explained that *Consumers' Checkbook* did not directly decide how the public/privacy-interest balancing plays out under FOIA when there is evidence of waste, fraud and abuse such as Dow Jones presented in *FMA v. HEW*, *i.e.*, one of the issues underlying CMS's Request for Comment here. *See generally* App. 141, 156 n.10, 189-91. Specifically, the court in *Consumers' Checkbook* was not squarely presented with claims of how the information that the plaintiffs sought would shed light on agency conduct, including its efforts to prevent waste, fraud and abuse.[13] Rather, Medicare waste, fraud, and abuse was, at most, an after-thought in *Consumers' Checkbook*, where the public interests asserted in the district court involved assessing quality of care and the experience level of Medicare providers. App. 189-91, 200 (citing *Consumers' Checkbook*, 502 F. Supp. 2d 79, 84 (D.D.C. 2007)). Conversely, waste, fraud and abuse was first discussed on appeal – and thus rejected – as "an unsupported suggestion" unaccompanied by "any evidence of alleged fraud [that] the requested data would reveal." *Id*. (citing *Consumers' Checkbook*, 554 F.3d at 1054, 1055 n.5).

Dow Jones's showing, of course, has been quite different. As Judge Rogers pointed out, it is a "near undeniable fact" that, if supported by evidence (such as Dow Jones was later able to offer in *FMA v. HEW*, even using a small sample size), Medicare data would "assist" the public's "evaluation of how HHS is carrying out … its efforts to combat Medicare fraud and waste." *See Consumers' Checkbook*, 554 F.3d at 1058. Moreover, because the Request for Comment anticipates potential release of individual physician Medicare payment data generally, not simply when subject to a FOIA request, CMS can consider the broader ways that disclosure would serve the public interest, such as those advanced in *Consumers' Checkbook* (and, Dow Jones is sure, as will be advanced in other comments here). Indeed, Judge Rogers' dissenting opinion is dedicated in significant part to all the ways, even under the constraints of FOIA analysis, that releasing physician-identifying Medicare data can serve the public interest. *See* 554 F.3d at 1059-63. And Dow Jones's efforts post-dating *Consumers' Checkbook* show further changes that have occurred even in just the few years that have passed since that case reached finality.

In showing how physicians' claims to privacy in their Medicare reimbursement data has been diminished by the ACA and HHS's implementing rules, App. 214-16; *see also supra* 7-9, Dow Jones also explained that those measures are not a substitute for the kind of access that the Request for Comment contemplates. The ACA will not make available to the public the CMS data at issue here, but allows access only for "qualified entities." App. 215 (citing 76 Fed. Reg. 76542 (2011); 42 C.F.R. §§ 401.707-711). In this regard, the ACA cannot supplant broader public disclosure needs, such as that embodied, for example, by FOIA, as only explicit statements by Congress can have such a displacing effect. *Id*. (citing *Grasso v. IRS*, 785 F.2d 70, 75

[13] Though other public interest benefits were proffered, all the court was permitted to consider were those bearing on how the agency carries out its functions, given that the case arose on denial of a FOIA request. App. 189-91, 200 (discussing *Consumers' Checkbook*, 554 F.3d at 1054-55). *See also supra* note 4.

(3d Cir. 1986)). The ACA's relevance is not that there is already "some" disclosure occurring – rather, it is that the ACA reflects how the balance of privacy and public interests shifted as (i) the statute lowered expectations of privacy (by requiring published reports that may identify doctors, *id*. 216 (citing 42 U.S.C. §§ 1320a–1327h; 42 C.F.R. § 401.717)), and (ii) it underscored the increased public interest in and value of disclosing Medicare data. [14]

It is significant in this connection that the journalists and public interest organizations who stand to benefit from the release of information contemplated by the Request for Comment serve a different function than do the qualified entities that may obtain data under the ACA. Per the statute, qualified entities are those designated to use claims data to evaluate service providers on measures of quality, efficiency, effectiveness, and resource use, and they must operate under a variety of restrictions. They must, among other things, specify in advance what evaluation methodologies they will use, and must provide reports of findings to HHS, with release to the public occurring as specified by HHS, only after reports are provided to service providers to allow for appeal/error-correction. Reliance solely on the ACA's qualified entity approach would thus be inconsistent with, *e.g.*, FOIA, which reflects the judgment that citizens – and the press as their surrogate – must be trusted to understand the workings of the government themselves, without relying on government-designated middlemen.[15]

Journalists (for example) may conversely take whatever tack the information they gather suggests to them, and can reach out to sources and whistleblowers. They are not constrained to reporting findings to HHS before publication generally. The press and public interest groups also can move with greater speed than it would appear qualified entities can, given the confines the ACA places on them. By way of example, in late 2010, as part of its *Secrets of the System* series, the *Journal* reported on the role played in Medicare expenditure increases by urology

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[14] In follow-on litigation to *FMA v. HEW*, the American Medical Association ("AMA") has recently underscored that, even as the ACA potentially subjects to disclosure the reimbursement amounts of any physician providing Medicare services, the statute significantly constrains the recipients and uses of the data. *See* Opp. of Intervenor-Defendant American Medical Ass'n, *Alley v. HHS*, No. 1:07-CV-0096-KOB (N.D. Ala.), filed Aug. 12, 2013, at 15-16.

[15] *See, e.g.*, *FOIA Department Heads Memo*, 74 Fed. Reg. at 4683 (FOIA "is the most prominent expression of a profound national commitment to ensuring an open Government. At the heart of that commitment is the idea that accountability is in the interest of the Government and the citizenry alike."). *Cf. Public Citizen Health Research Group*, 477 F. Supp. at 603-04 (withholding under Exemption 6 not warranted even though privacy interest was implicated and "[d]isclosure of physician identities … raise[d] the prospect of misleading publicity, possibly unwarranted professional and public criticism, and damage to professional reputation"), *rev'd on other grounds*, 668 F.2d 537 (D.C. Cir. 1981); *see also Petroleum Info. Corp. v. Department of Interior*, 976 F.2d 1429, 1436 (D.C. Cir. 1992); *Morton-Norwich Prods., Inc. v. Mathews*, 415 F. Supp. 78, 81 (D.D.C. 1976) (cited App. 195); *ACLU v. DOJ*, 655 F.3d at 15 ("The fact that the public already has some information does not mean that more will not advance the public interest.").

groups who own intensity-modulated radiation therapy ("IMRT") equipment and self-refer their prostate cancer patients for therapies that use that equipment. App. 54-57. Meanwhile, *nearly three years later*, GAO issued a report finding that the number of Medicare prostate cancer-related IMRT services performed by self-referring groups has been increasing rapidly (while declining for non-self-referring groups), and that providers substantially increased the percentage of their prostate cancer patients they referred for IMRT after they began to self-refer.[16]

Finally, Dow Jones also completely deflated notions that physicians will stop accepting Medicare were the public to gain access to information on how much of its money physicians receive from the system, as being even more fanciful than the claim was in 1979. App. 154-55. At the outset, Dow Jones showed that this issue did not play a role even in the 1979 Injunction, issued under less disclosure-favorable FOIA and Privacy Act law. *Id*. And, in fact, a mass provider exodus is extremely unlikely given that Medicare accounted for 21% of total national health care spending in 2011, and 23% of total spending on physician services, and that participation among providers has steadily climbed to near universal participation, even in the face of repeated threats to substantially reduce Medicare payments.[17]

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[16] GAO, *Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrants Scrutiny* (July 2013), available at http://www.gao.gov/assets/660/656026.pdf. This led GAO to recommended that CMS identify and monitor self-referrals of IMRT services. *Id*. As Medicare providers generally are not required to disclose that they self-refer IMRT services, and HHS lacks authority to compel disclosure, GAO found Medicare beneficiaries may not be aware their providers have financial interests in recommending IMRT over alternative treatments that may be equally effective, have different risks/side effects, and/or are less expensive. *Id*.

[17] App. 154-55 (citing Kaiser Family Foundation, *Medicare Spending and Financing*, available at http://www.kff.org/medicare/upload/7305-06.pdf; Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, available at http://medpac.gov/documents/Mar11_EntireReport.pdf; CMS Data Compendium, Table VI.8, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011_Data_Compendium.html). *Cf. Consumers' Checkbook*, 554 F.3d at 1058 (Rogers, J. dissenting) ("Medicare reimbursements represent, on average, a quarter of a physician's income, and can account for a 'large percentage' of total income for some"). *See also* Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy*, available at http://www.medpac.gov/documents/Mar13_entirereport.pdf (containing data consistent in relevant part with that Dow Jones relied upon in 2011 Report). Significantly, when AMA was asked in discovery in *FMA v. HEW* to provide evidence of any such Medicare defections based on disclosure of CMS data, it was unable to provide any (nor was HHS). App. 165. Nor did AMA (or HHS) offer any survey evidence indicating defections in the event of broader disclosure of CMS data. *Id*. In fact, the most recent HHS data confirms Dow Jones' showing. *See* http://aspe.hhs.gov/health/reports/2013/PhysicianMedicare/ib_PhysicianMedicare.cfm.

CONCLUSION

Based on the foregoing discussion and the materials in the Appendix, Dow Jones submits that, whatever privacy interest physicians had in information concerning payments they receive from Medicare, it has been substantially reduced over the years. As such, and given the limited insight into personal matters that that information would reveal, its disclosure would not cause a "clearly unwarranted invasion of personal privacy." The public interest in disclosure, in the meantime, has grown substantially since entry of the 1979 Injunction in *FMA v. HEW*, such that no credible argument can be made but that the balance of interests plainly favors granting full access to CMS's Medicare data.

Accordingly, CMS should release individual physician payments under Medicare at the most granular level at which the agency maintains the records. For Dow Jones' part, it already has demonstrated the impediments that receiving only limited and/or aggregated data presents. However, as set forth above, access to even that limited data revealed that it can offer a window into Medicare waste, fraud and abuse. One can only imagine the number and depth of insights the public stands to gain from full access.

Dow Jones further submits that, even if CMS opts not to make physician identifying Medicare reimbursement data publicly available for inspection or purchase under, *e.g.*, 42 C.F.R. §§ 401.106-401.112 and/or 401.130-401.135, there is no doubt that, under the balancing of public and privacy interests set forth above, CMS must release the data in response to a properly lodged FOIA request. Upon receipt of such a proper request, CMS should thus release the requested information within the timeframes specified by the Act, *see* 5 U.S.C. § 552(a)(6).

Respectfully submitted,

[redacted]

Laura R. Handman

cc: Marilyn Tavenner, Administrator and COO, CMS
Peter Budetti, Deputy Administrator for Program Integrity, CMS
William B. Schultz, General Counsel, HHS
Dori Salcido, Acting Assistant Secretary for Public Affairs, HHS
Todd Park, Chief Technology Officer, White House
Miriam Nisbet, Director, Office of Government Information Services
Corinna Zarek, Office of Government Information Services

Federation of American Hospitals®

Charles N. Kahn III
President and CEO

September 4, 2013

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: Physician Data Comments
Hubert H. Humphrey Building, Room 341D-05
200 Independence Avenue SW
Washington, D.C. 20201

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

Dear Administrator Tavenner:

The Federation of American Hospitals ("FAH") is the national representative of nearly 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural parts of the United States, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services ("CMS") *Request for Public Comments on the Potential Release of Medicare Physician Data*.

The FAH recognizes that Medicare data transparency can be used to achieve important quality improvement goals and help transform our Medicare payment and delivery structure into a more efficient, care-coordinated, and value-driven system. Effective transparency is critical, however, so that the data that are released actually can aide consumers, hospitals, physicians and all stakeholders in making more effective choices, from comparing health plans and providers, to making smart health care choices, and to providing more effective and improved quality of care at the point of care.

The FAH supports efforts to promote transparency and provide quality and price information that enhances consumer choice. Releasing data in the name of "transparency" only, simply for the sake of releasing data, only confuses and can harm consumers and other stakeholders, who may make ill-conceived choices based on faulty or irrelevant data.

For example, earlier this year, CMS released hospital charge data for Medicare inpatient and outpatient procedures. The release of this information, though, missed the mark because true

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price transparency for consumers should list Medicare payments compared to costs, not charges. Unfortunately, the release of the charge data created confusion among consumers, and missed an opportunity to provide meaningful, useful information.

Inappropriate data release also creates unnecessary and costly administrative burdens for CMS and other stakeholders without any corresponding benefit. **In light of the foregoing potential adverse outcomes that can result from the release of Medicare data that is not relevant to consumers, providers and other stakeholders, the FAH urges CMS to implement the following principles when developing a mechanism to release physician data.**

Dissemination of Standardized, Meaningful and Actionable Data

As discussed above, public dissemination of raw Medicare data does not provide patients with helpful information about the quality of care or treatment options. It also can be misleading and in some cases harmful. Therefore, the FAH urges CMS to refrain from "raw data dumps" that have no value to consumers and other stakeholders. Instead, CMS must ensure that Medicare data are meaningful, actionable, and user-friendly, and released in a manner that promotes and improves quality of care and provides the ability to make smarter, more effective, patient-centered health care choices by consumers, providers and other stakeholders.

Further, in developing methodologies for disseminating data, CMS must take into account the various existing Medicare programs under which physician and other provider data is made public. CMS should align any dissemination of physician data with the data released under existing programs, and release the data in a standardized, easy-to-use format. Otherwise, there could be contradictory and misleading data reports that only will confuse providers and the public.

Safeguards to Ensure Meaningful and Actionable Medicare Data

The release of Medicare data should adhere to certain safeguards to help ensure improved transparency efforts result in accurate information that is useful to patients, providers and other stakeholders. To be useful, public data reports must be valid, reliable and actionable for patients, physicians, and all stakeholders. Safeguards to ensure that these goals are met are discussed below.

Correct Attribution and Verification of Services Provided

CMS must ensure that any data release is based on an effective methodology for attributing care to those physicians who actually provide the care to a specific patient. The attribution methodology should be transparent, assessed on a condition-specific basis, and based on the input of affected stakeholders. Physicians, consumers and stakeholders must be able to trust the data provided, and should not have to decipher confusing or conflicting reports based on inaccurate attribution, which would undermine the goal of public reports resulting in actionable decisions by patients, physicians and other stakeholders, as well as improved quality of care.

Further, physicians and other affected providers must have the ability to verify that the data relates to patients actually treated by the physician for the specific services identified in a data report. Physicians also must have the opportunity for prior review and comment, along with the right to appeal, with regard to any data or data use that is part of the public data release process. Such comments also should be included with any publicly reported data. This is necessary to give an accurate and complete picture of the data and patient care provided by the physician and other professionals or providers.

Understandable Description of Data Reports

Data reports should contain an understandable description of the data, including limitations and possible misinterpretations of the data as well as any quality measures used to analyze the data. Misinterpretations can result from incorrectly linking volume with assumptions about quality, as well as from lack of information about medical specialty, location, patient mix and demographics, drug and supply costs, hospital and service costs, professional liability coverage, support staff, and other practice costs. Full disclosure of the data limitations will help consumers and others properly assess the data.

Quality Information Should Accompany Data Reports

Data reports should be released with quality information about the data. Any quality measures that are used to analyze the data should be standardized and endorsed through the National Quality Forum, a multi-stakeholder, consensus-based organization that enables broad-based vetting and "buy-in" of quality measures which consumers and other stakeholders can trust. The measures and resulting data reports also must include reliable risk-adjustment methodologies.

Data Should not Be Subject to Discovery or Admitted as Evidence

Physician data that is released should be for quality improvement purposes and should not be used to promote or increase litigation. Specifically, the data should not be subject to discovery or admitted into evidence in any judicial or administrative proceeding without the consent of the provider or supplier. This safeguard has precedent, and is included in Section 10332 of the *Patient Protection and Affordable Care Act*, which requires CMS to provide certain Medicare physician data to qualified entities that produce public performance reports.

Other Considerations for Data Release

CMS also should consider other elements in releasing data reports. For example, data reports should be accurate, user-friendly, relevant, and helpful to consumers, patients, physicians and other stakeholders. In addition, the reports should not encourage patient de-selection for individuals at higher-risk for illness due to age, diagnosis, severity of illness, multiple co-morbidities, low literacy level, or economic and cultural characteristics that make them less adherent with established protocols. Finally, CMS also should consider whether there is adequate public interest in data that pre-dates a certain time period. Old data are not likely to

promote any public interest and can mislead and even harm patients. Thus, CMS should be careful not to release old data.

Preserving Privacy

The FAH urges CMS to consider all privacy interests involved when releasing physician data, including the privacy interests of patients, physicians and any other providers affected by a data report. CMS should ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and also should consider the potential for identity theft when releasing physician National Provider Identifiers (NPIs) to the public.

The FAH appreciates the opportunity to provide our views on these important issues affecting the transparency of Medicare data. We look forward to continuing our work with CMS to resolve these matters in a manner that improves the delivery of quality health care to our patients. If you have any questions, please contact me, Jeff Micklos, Jayne Hart Chambers or Katie Tenoever at (202) 624-1500.

Sincerely,

Florida Blue
An Independent Licensee of the
Blue Cross and Blue Shield Association

Florida Blue
4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

September 5, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: *Physician Data Comments*
Hubert H. Humphrey Building
Office 341D-05, 200 Independence Avenue, SW, Washington, DC 20201
Submitted via email to: Physician_Data_Comments@cms.hhs.gov.

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

Greetings,

Florida Blue, Florida's Blue Cross and Blue Shield company, is pleased to submit comments on the potential release of Medicare physician payment data. Florida Blue is a leader in Florida's health care industry. Our mission is to help people and communities achieve better health. Florida Blue has approximately 4 million health care members and serves 15.5 million people in 16 states through its affiliated companies. Florida Blue is a not-for-profit, policyholder-owned, tax-paying mutual company and an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. Our comments in response to the three questions presented by CMS on this topic are discussed 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?**

Florida Blue appreciates the opportunity to comment on the balance between the privacy interest of physicians and the public interest in disclosure of Medicare payment information. As a Medicare Advantage Organization (MAO) and a Medicare Supplement Plan, we understand the importance of using data meaningfully to the benefit of the member and the Medicare system at large.

We believe the privacy interest of our physician partners should be protected. Florida Blue stresses the importance of CMS providing physicians with adequate deference to prevent misinterpretation of payment data by the public. CMS should provide an opportunity for physicians to review their data prior to publication, so that errors and other discrepancies can be addressed.

The health care system creates, maintains, and analyzes voluminous amounts of data on medical costs, health care quality, scientific research, technological innovation, and patient safety. However, the picture is still incomplete. When made available, additional data are contemplated and used by health plans in an additive way to empower consumers and enhance their health care decision-making abilities. Health plans play an integral role in guiding members and giving them access to high quality, low-cost health solutions. Data analysis is a key tool utilized by health plans to facilitate access with the goal of achieving the highest and best health outcome for the member. As a health solutions company, we use data responsibly to present our members with accurate information that can improve the quality of care.

Florida Blue believes that CMS should take steps to encourage responsible use of the data and, to the extent possible, prevent the likelihood of misconceptions that might unduly harm the reputation of a provider. In the past, CMS has issued data via different mediums, providing raw data for use by health plans and similar stakeholders alongside of aggregate data for a broader audience, typically explained through a press release. CMS may consider a similar approach with respect to physician payment data.

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?**

Florida Blue believes that while there are various approaches toward achieving better health outcomes, it is clear that the availability of reliable data is an indispensable ingredient. Data necessary for conducting sound evaluations and generating meaningful conclusions must come from a variety of disparate sources. Moreover, the process employed must compile and analyze data based on sound methodologies resulting in reliable conclusions that are fed back into a systematic process of continued evaluation and accuracy refinement.

There are key challenges associated with every step of data use from collection, to aggregation, to analysis, and to conclusion. Integrated care and innovative payment models offer promising new ways to evaluate the effectiveness of care from a quality perspective, but present new challenges for including cost data in the equation. Some perceived challenges may lie in how an analysis accounts for bonuses associated with meaningful use and Physician Quality Reporting System (PQRS) incentives. Seemingly high levels of primary care might actually be an alternative to readmission in many cases rather than overuse. ACO participation, other shared-service-model payments, and the downstream agreements within and between integrated entities, may create barriers to accurate cost analysis.

Despite these associated challenges, the release of cost data will yield one more piece of the puzzle to support analyses focused on increasing the value and quality of care from a medical outcomes perspective. Florida Blue believes that CMS should act to encourage responsible and credible analyses of data, which take into account sample size, statistical meaningfulness, accuracy reasonability, risk adjustment, and the appropriateness of methodology. Health plans have a responsibility to provide their members with guidance and a means to decipher complex health information. Florida Blue strongly supports efforts to make available any additional data that, in an additive manner, will be used to better inform consumers about provider quality, procedure prices, and plan performance.

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)?**

Taking into account the principles elaborated within the first two sections of this letter, with respect to data that will be released to the general public, we believe that the following supplemental information would be helpful in establishing a greater context and thus understanding of payment data: paid claims, gross payment versus net payment, overhead, patient volumes, specialties, average practice costs, location, procedure codes, years in practice, and malpractice liability costs. This data will aid in the discovery of new physician practice patterns involving similar patient types or conditions, which would enhance the potential to improve health outcomes.

Concerns associated with the level of granularity are less severe when that data is used responsibly by a stakeholder with an appropriate means of analysis. Payment data at the most granular level may improve important analyses on quality and health outcomes that directly benefit the member. Individualized and line-item detail, if made available, will provide more value and control than higher-level, aggregate data to analyses focused on improving the quality of care for beneficiaries.

Thank you for the opportunity to provide comments on this initiative. We hope they are helpful. Questions on these comments may be directed to Ernest.Cook@FloridaBlue.com or by phone at (904) 905-6021.

Sincerely,

Ernest C. Cook, Jr., MD
Senior Medical Director of Medicare

HANYS Healthcare Association of New York State

Proud to serve New York State's Not-For-Profit Hospitals, Health Systems, and Continuing Care Providers

Dennis Whalen, President

September 5, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services

Attention: Physician Data Comments

RE: Potential Release of Medicare Physician Data

To Whom It Concerns:

The Healthcare Association of New York State (HANYS), on behalf of our 500 non-profit and public hospital, nursing home, home health agency, and other health care provider members, welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) request for public input on the potential release of Medicare physician data.

HANYS appreciates CMS' consideration of public input when developing a new policy regarding release of individual physician payment data. The recent court decision vacating the injunction that prohibited disclosure of individual physician payments provides an important opportunity to further the CMS goal of greater data transparency and advancing the transformation of the health care delivery system.

CMS notes that stakeholders have argued that physician data are an important part of the ongoing research, assessment, and evaluation of programs and services necessary to make improvements in the delivery, quality, and cost of care. HANYS and our members agree fully with the vital need for these data. Physician interaction is a key component to understanding and coordinating cost-effective, high-quality patient care. Researchers, policy-makers, and providers have had only limited access to data on care provided by physicians. This limitation has impeded progress toward the Triple Aim, as providers look to collaborate on improved care management.

It is vital that data on Medicare services provided by individual physicians be made publicly available. CMS should provide the full claims-level detail of care provided in the physician setting, including the physician's National Provider Identifier (NPI) and name. This will allow a full and complete dialogue among all caregivers and the information needed to create real incentives for effective care delivery.

Specifically, we recommend that the Standard Analytic File for physicians (the "Carrier file"), includes physicians' NPI and name. The Carrier file should be made available as both a 5% sample and 100% of claims, as is available for all other settings of care. This would provide the same level of detail for physician services that is currently available for other providers and would allow, for the first time, a comprehensive analysis of the services provided to Medicare beneficiaries across all settings.

HANYS appreciates the opportunity to comment on this issue. If you have any questions regarding our comments, please contact Stephen Harwell, Vice President, Economics, Finance, and Information, at (518) 431-7777.

Sincerely,

[redacted]

Dennis P. Whalen
President

DS:lw

HR POLICY ASSOCIATION®
The Association of Chief Human Resource Officers

September 5, 2013

Submitted Via Email: Physician_Data_Comments@cms.hhs.gov

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: Physician Data Comments
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Public Comments on the Potential Release of Medicare Physician Data

Dear Sir or Madam:

HR Policy Association ("HR Policy" or the "Association") welcomes the opportunity to comment on the "Request for Public Comments on the Potential Release of Medicare Physician Data"[1] posted by the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS).

HR Policy Association represents the chief human resource offices of more than 350 of the largest employers in the United States. Collectively, their companies employ more than 10 million employees in the United States, nearly nine percent of the private sector workforce. Together the member companies spend more than $80 billion annually providing health insurance to tens of millions of American employees, their dependents and retirees. As the senior human resource executive for their companies, HR Policy Association members play a lead role in health care strategy, design, and implementation of the health care plans their companies offer to their employees and retirees.

As concerns about the cost and quality of health care in the United States continue to grow and large employers explore innovative ways to manage their health care benefits in a rapidly changing environment, the need for greatly improved transparency is widely recognized as a key element to better managing the cost and quality of the U.S. health care system.

The recognition of the importance of health care transparency is not a new phenomenon. Both private purchasers and policymakers have long sought to make better information available to consumers regarding the relative cost and quality of care throughout the health care supply chain. However, in spite of decades of effort, the tools and information available in the market today fall far short of what is needed by both consumers and employers.

[1] Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Request for Public Comments on the Potential Release of Medicare Physician Data," posted August 6, 2013, available at: http://downloads.cms.gov/files/Request-for-Public-Comment-rePhysician-Data-8-6-2013.pdf.

Need for Robust Transparency is Growing

Faced with rising and unsustainable costs, varying quality, and the uncertainty surrounding the implementation and impact of the Affordable Care Act, the need for robust transparency is growing. First, the rapid adoption and growth of consumer directed health plans that encourage beneficiaries to choose providers and treatments based on relative cost and quality makes it even more critical that they have the information needed to compare health care alternatives. From 2006 to 2013, the percentage of large employers offering high deductible health plans with a savings option has jumped from 8 percent to 43 percent.[2]

Second, the movement towards public and private exchanges further exacerbates the need for vastly improved transparency in health care. The Affordable Care Act (ACA) is largely based on the premise that consumers will discipline the market, resulting in lower costs and improved quality. This simply cannot happen if consumers don't have the information to make educated and rational choices regarding providers and treatment alternatives.

HR Policy Strongly Supports CMS's Health Data Initiative, Recommends Physician Level Data be Released

The Association applauds the CMS Health Data Initiative that was launched by HHS in 2010 to promote transparency. Since 2010, CMS has released an unprecedented amount of aggregated data in machine-readable form. In May 2013, CMS released information on the average charges for the 100 most common inpatient services at more than 3,000 hospitals nationwide, followed in June 2013 with the release of average charges for 30 selected outpatient procedures. However, the ACA will not be as successful as it could be in controlling health care costs if consumers don't have the price data they need to make informed decisions regarding providers and alternative treatments. For this to occur, CMS and others must make individual provider-identifiable payment data publically available (*i.e.*, line item claim details without patient-identifiable information). HR Policy strongly recommends CMS take steps publicly release such data while protecting the privacy of Medicare beneficiaries.

Transparency for every element of the health care supply chain is essential. Policymakers and employers need to be aware of the relative price and performance of providers in both the public and private health care exchanges as the ACA is implemented. Employers, government and consumers all have a vested interest in the need to compare relative cost and quality when choosing hospitals, doctors and other caregivers.

Proper Balance Should Be In Favor of the Public Interest

Although it is arguable that physicians have a privacy interest in information concerning the payments they receive from Medicare, price transparency can be an important tool for health care providers too. Recent studies suggest that price transparency can help providers evaluate and identify the most appropriate and affordable care for their patients.[3] Moreover, there are

[2] Kaiser Family Foundation, Employer Health Benefits, 2013 Annual Survey, Exhibit 8.3.

[3] Feldman LS, Shihab HM, Thiemann D, Shihab M, Yeh HC, Ardolino M, Mandell S, and Brotman DJ. Impact of Providing Fee Data on Laboratory Test Ordering: A Controlled Clinical Trial. JAMA Intern Med. 2013;173(10):903-908.

some health care providers, particularly those with market power, who put into their contracts with health plans a prohibition on revealing to health care purchasers or consumers any information about payment amounts. These anti-competitive contract provisions may allow those providers with higher-than competitive prices to keep their high-prices obscured. Further, improving price transparency increases the likelihood that consumers will choose health care providers that deliver the most effective and cost-efficient care.[4] HR Policy believes these facts should tip the balance in favor of disclosing Medicare payment information, including physician-identifiable reimbursement data. All data on price, utilization, and quality of health care, stripped of patient-identifiable information, should be made available to the public unless.

What Specific Policies Should CMS Consider With Respect to Disclosure of Individual Physician Payment Data?

CMS could increase transparency in a number of ways. First, building on its recent release of hospital charge data, it could share charge, payment, and quality information for a much broader range of providers and services, at a more detailed level. Second, CMS could, through the federally-facilitated exchanges, insist on price transparency from qualified health plans. Third, CMS should relax its data restrictions on access to the Medicare data without compromising safeguards to protect privacy. Although "qualified entities" have access to Medicare data, the definition of "qualified entity" limits access to this exceptionally useful data.

In What Form Should CMS Disclose Individual Physician Payment Data?

In the request for public comments, CMS suggests it could release both line item claim details and aggregated data at the individual physician level. HR Policy strongly recommends that it do both, provided the privacy of Medicare beneficiaries is protected by removing patient-identifiable information from the line item claim detail. The information should be publically available on the Internet in a machine readable data set with appropriate documentation similar to how the Census Bureau releases its data.

* * *

We appreciate your consideration of the comments set forth above. If the Association can be of further assistance, please contact Mark Wilson at 202-315-5575 or mwilson@hrpolicy.org.

Sincerely,

[redacted]

Mark Wilson
Vice President, Health & Employment Policy
Chief Economist
HR Policy Association

[4] Hibbard JH, Greene J, Sofeaer S, and Firminger K. An Experiment Shows That A Well-Designed Report On Costs and Quality Can Help Consumers Choose High-Value Health Care. Health Affairs. March 2012.

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imshealth™
INTELLIGENCE APPLIED.

September 4, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Hubert Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Attention: Physician Data Comments

Dear Sir or Madam:

IMS Health respectfully submits comments to the Centers for Medicare and Medicaid Services in response to the agency's "Request for Public Comments on the Potential Release of Medicare Physicians Data".

As a global leader in information solutions, IMS Health is an international expert in health information stewardship — including privacy and data protection. We firmly believe that:

- Health information used wisely and responsibly advances healthcare globally and offers real value for patients, payers, and providers of healthcare;
- Patient privacy must be preserved and protected; and
- Data accuracy and validity are essential for provider level data to be useful, trusted, and lead to health care improvement.

As a company, we are patient privacy and data protection advocates AND leading experts in health information collection and analysis. Since our founding more than 50 years ago, IMS has pioneered practices to de-identify individual patients' sensitive data, while serving a broad array of health stakeholders, including the FDA and other agencies of the U.S. Department of Health and Human Services. IMS relies on a combination of resources, policies and practices to ensure the leadership and expertise necessary to manage information in a manner that balances vital societal values, including improved health care and patient privacy.

Kimberly S. Gray, Esq., CIPP/US
Chief Privacy Officer, Global
Work: 484 567 6045
KGray@us.imshealth.com
IMS Health® | One IMS Way | Plymouth Meeting Pa 19462

Overview:

IMS applauds and supports the work of CMS to improve health care quality, safety and costs for patients through improved data availability. We believe data transparency, if developed with excellent and routinely employed patient privacy, security, and data stewardship practices, can lead to important improvements in patient safety and quality of care and empower innovation. To accomplish the important objective of increased data transparency and availability, there must be a laser focus on the creation and development of data stewardship and data accuracy in conjunction with data availability.

We strongly recommend that CMS:

1. **Ensure patient privacy.** Review of data to be released in the context that it will be used for risk of identification is an essential element for good data stewardship. We urge CMS to set up and conduct bio-statistician expert review of data sets to be released in the context of the permitted use(s) of the data. This will ensure patient privacy is protected while also permitting the data to be used for important public good.

2. **Test and ascertain data accuracy and utility**. Review the data to be released for accuracy and utility, and then take action to establish databases and data for release that can be trusted and used for analyses that are in the public interest; and,

3. **Engage in constructive discussion with providers** to identify and resolve proprietary and accuracy concerns.

Specific Responses to Questions Posed by CMS:

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

Privacy is a personal concept and PERSONAL privacy is protected by law, regulation and through self-regulatory behaviors. Physicians in their professional capacity (operating a business of practice of medicine) do not have a privacy right or privacy interests under long standing and well recognized federal law.[i]

Rather, the public has a significant interest in physician professional conduct. Physicians are publicly regulated and licensed as a "learning profession," and state laws, in almost 50 states, provide public access to professional licensure information including physician name, business address and current licenses status. Further, Medicare payments are publicly funded and the public legitimately has a right to know that such

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funds are being handled and used in a manner that protects patient care and the financial interests of the public.

Physicians have a legitimate interest in ensuring that proprietary information of their business or corporate entities is protected and that information released about their business/practice is accurate. Release of information must be evaluated carefully to determine if it may contain proprietary information. Further, it should be evaluated to ensure that it is accurate. .

We suspect that Medicare payment data is unlikely to contain proprietary information, but it is vital to review the data to be released to ensure does not reveal proprietary information or information that undermines intellectual property. Also, it is vital to review any data to be released for accuracy, as any release of inaccurate information could lead to market imbalances.

To accomplish this, we recommend that CMS engage in constructive discussion with providers to determine proprietary and accuracy concerns and, if legitimate proprietary and accuracy concerns are identified, find a balanced approach to release important data and addresses these concerns

Question 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;

We urge CMS to review the data to be released for accuracy and for utility.

> Accuracy: It is vital that data being released for use is accurate and, if at the individual physician level CMS cannot ensure data accuracy (because the NPI system is not set up to support that level of accuracy or because the claims data does not require accurate identification of individual providers), it must aggregate the data to the level at which it can assure the public that the data is accurate.
>
> If aggregated data is what must be released because of accuracy issues, we urge CMS to develop and implement a plan to improve its data set accuracy to meet objective accuracy standards.
>
> Utility: We urge CMS to consider and provide the data in a format that can be used by the public and by researchers to analyze Medicare program operations and physician practices.

Question 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).

We urge CMS to release at the data at the most granular level at which it can assure patient privacy, accuracy and utility.

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Conclusion:

Health care information must be handled with the utmost care. Balancing patient privacy, data accuracy, proprietary concerns, and demand for transparency when creating data sets to be released and used by the public is a delicate, resource-intensive task. Yet it's a task that is at the heart of good data stewardship and that is required of entities engaged in the trusted exchange of health information.

We urge CMS to take the time and invest resources necessary to ensure that the important provider-level data it releases protects patient privacy, is accurate and useful, and respects propriety concerns. In the long run, proper data practices and excellent stewardship will lead to strong and long-standing data practices that will support and enhance patient care in this nation.

Respectfully submitted,

Kimberly S. Gray, Esq., CIPP/US
Chief Privacy Officer, Global
IMS Health

[i] From the Department of Justice, Overview of the Federal Privacy Act, accessed at:

http://www.justice.gov/opcl/privacyactoverview2012/1974definitions.htm#individual

> "Corporations and organizations also do not have any Privacy Act rights."
>
> "The OMB Guidelines suggest that an individual has no standing under the Privacy Act to challenge agency handling of records that pertain to him solely in his "entrepreneurial" capacity. OMB Guidelines, 40 Fed. Reg. at 28,951, available at http://www.whitehouse.gov/sites/default/files/omb/assets/omb/inforeg/implementation_guidelines.pdf"
>
> "Privacy Act rights are personal to the individual who is the subject of the record and cannot be asserted derivatively by others."

kyruus

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FAX: (855) 759-7887
www.kyruus.com

September 6, 2013

Attention: *Physician Data Comments*

Ms. Marilyn Tavenner
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

Dear Ms. Tavenner:

The leadership of the Centers for Medicare & Medicaid services ("CMS") have requested public comments to be filed with the Agency on issues pertaining to the potential release of Medicare Physician Data. CMS has not published a more formalized request in the Federal Register, but instead issued a notice on its website on August 6, 2013.[1] We thank the Agency for this opportunity to submit comments on behalf of Kyruus and appreciate the Agency's time and efforts in reviewing public comments from the industry.

Since 2010, the Department of Health and Human Services ("HHS") and CMS have released an unprecedented amount of aggregated data in machine-readable format as part of the Health Data Initiative. The release of these data have enabled software developers and companies like Kyruus to use the data to develop new applications that improve healthcare delivery in the United States and in turn make health information more actionable for patients, physicians and hospital administrators.

Kyruus is a Boston-based, Big Data company that focuses on improving healthcare delivery by making data-driven applications for use by physicians and other healthcare professionals. At present, Kyruus uses data to serve the needs of several

[1] *See* Request for Public Comments on the Potential Release of Medicare Physician Data, Dept. of Health and Human Services, Centers for Medicare and Medicaid Services, Aug. 6, 2013, available at: http://downloads.cms.gov/files/Request-for-Public-Comment-rePhysician-Data-8-6-2013.pdf

hospitals and health systems across the U.S. Kyruus aims to empower healthcare professionals with clinical information about the physicians to whom they refer patients for specialty care. The Medicare Physician Data is critical to better understanding the healthcare ecosystem, and would allow organizations like Kyruus to further augment applications that make healthcare more data-driven and transparent.

Physician Privacy and Reimbursement Data

According to the Congressional Budget Office ("CBO"), in 2012 alone enrollment in Medicare averaged approximately 50 million people, with gross federal spending (excluding administrative costs subject to appropriation) of $551 billion. CBO projects that Medicare enrollment and spending will continue to rise rapidly across the next decade. CMS has requested comment on whether physicians have a privacy interest in information concerning the payments they receive from Medicare in light of public disclosure of physician-identifiable reimbursement data. **Kyruus believes that the public interest in Physician Medicare Data outweighs the physicians' privacy interests given the changes in the technical, factual and data landscape over the past 30-plus years.**

The American Medical Association ("AMA") and other state medical societies contend that publication of data on individual physicians' earnings would violate physicians' privacy. The AMA has intervened in numerous legal matters regarding physicians' privacy rights[2], but more recently published a June 2013 letter to CMS supporting the "use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients, and is used to provide physician performance assessments."[3]

The recent court decision vacating the injunction against disclosure of physician-identifiable reimbursement data was based on a change in the law over the past 33 years, but the court also recognized other changes have occurred in the factual landscape.[4] **Kyruus believes the changed landscape of factors that weigh in favor of public disclosure include:**

i) more sophisticated technology and data analytics, which enable faster, easier and more accurate corrections to data;

ii) greater capabilities in data analytics allowing for greater insight into the data;

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2 *See Alley v. Dep't of HHS*, 590 F. 3d 1195 (11th Cir. 2009); *Consumers' Checkbook v. Dep't of HHS,* 554 F.3d 1046 (D.C. Cir. 2009); *see also Florida Medical Ass'n, Inc. v. Dep't of Health, Educ., & Welfare,* 479 F. Supp. 1291 (1979) vacated by *Florida Medical Ass'n, Inc. v. Dep't of Health, Educ., & Welfare,* 2013 WL 2382270 (M.D. Fl. May 31, 2013).

3 Madara, James L., MD, AMA Letter to CMS Patrick Conway, CMO, Jul. 17, 2013, available at: http://www.ama-assn.org/resources/doc/washington/physician-compare-redesign-17july2013.pdf

4 *See Florida Medical Ass'n, Inc. v. Dep't of Health, Educ., & Welfare,* 2013 WL 2382270 (M.D. Fl. May 31, 2013).

iii) more standardization of Medicare payment structures, which lessens the need to protect the privacy of physician price structures;

iv) increased growth of the Medicare program in terms of both overall annual expenditure and total number of enrollees;

v) previous release of the Medicare data to other private entities without objection by physicians or hospitals;[5]

vi) rampant rate of fraud and abuse within the Medicare program; and

vii) the establishment of the Qualified Entity program that permits disclosure of Medicare claims data.

As part of its demonstrated commitment to data transparency, CMS frequently fields requests for the disclosure of physician-identifiable information under the Freedom of Information Act. CMS has historically weighed whether the public interest in disclosure outweighs a physician's privacy interest in this information under the Privacy Act of 1974.[6] Sen. Charles Grassley (R-IA) and Sen. Ron Wyden (D-OR) have argued that taxpayers have been denied their right to such data, and that "virtually every other government program, including some defense spending, is more transparent than the Medicare Program."[7] Furthermore, in light of the approximate 3-10% of total healthcare expenditures attributed to fraud and abuse[8], release of Medicare Physician Data would help reign in wasted payments that drive up healthcare cost and reduce the overall quality of care.

Kyruus believes the release of the Medicare Physician Data would help deter wasteful practices and overbilling, and help drive innovations and programs that improve quality and access to medical care. We fully support U.S. District Judge Marcia Morales Howard's ruling, and believe that greater transparency in information concerning physician payments they receive from Medicare is in the public interest.

CMS Policies for the Disclosure of Individual Physician Payment Data

The current CMS Data Use Agreement[9] ("DUA") clearly stipulates that the agreement must be completed "prior to the release of, or access to, specified data files containing protected health information ("PHI") and individual identifiers."

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5 *See id.* (citing RTMD's brief acknowledging that they had received millions of claims data over a six year period without objection).

6 *See* 5 U.S.C. 552(b)(6).

7 "Introduction of the Medicare Data Access for Transparency and Accountability Act." Senator Chuck Grassley, available at: www.grassley.senate.gov.

8 Federal Bureau of Investigation, U.S. Attorney's Office, "Medicare Fraud Strike Force Charges 107 Individuals for Approximately $452 Million in False Billing", May 2, 2012, available at: http://www.fbi.gov/neworleans/news-and-outreach/press-room/2012.

9 HHS-CMS DUA Form CMS-R-0235, available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Data-Use-Agreement.pdf

Kyruus believes CMS should preserve its responsibility to protect PHI and uphold the privacy of Medicare beneficiaries. However, in light of the recent decision to vacate the 1979 injunction in *Florida Medical Ass'n, Inc. v. Dep't of Health, Educ., & Welfare*, CMS should revise its policy with respect to disclosure of individual physician payment data.

CMS should replace its current DUA form with an online User Agreement that would be presented to an End-User prior to being granted access to the database. Developing and implementing an electronic DUA would reduce the burden on CMS staff to review and approve the current DUA form process, and streamline public access to the data. To ensure the privacy of Medicare beneficiaries, CMS should mandate that any End-User abide by current DUA standards, particularly line item #9 which mandates that End-Users do not attempt to deduce an individual patient's identity or uncover PHI including, but not limited to, geographic location, age, sex, diagnosis, admission/discharge date(s), or date of death.

Under Section 10332 of the Affordable Care Act amending section 1874 of the Social Security Act, CMS is required to provide standardized extracts of Medicare claims data to "Qualified Entities"("QEs") for the purpose of evaluating the performance of providers and suppliers, and to generate public reports regarding such performance. As part of its commitment to provide information to QEs, CMS has established policies to ensure data security and privacy protection.

Kyruus believes CMS should adopt similar policies for the disclosure of Medicare Physician Data to include the following requirements on End-Users: (i) abide by CMS' Data Use guidelines; (ii) combine data from other sources other than Medicare with the Medicare data; (iii) use valid and reliable measures for evaluating the performance of providers and suppliers; and (iv) produce and make publicly available reports from the use of the Medicare Physician Data on individual providers and suppliers in aggregate form. Although such policies are important to maintain data security and privacy protections, CMS should carefully craft its Data Use policies for the Medicare Physician Data while taking into consideration that overly burdensome policies may create undue burdens or barriers that could in turn limit the effectiveness, usefulness and value of such a data asset.

Individual Physician Payment Data Form

In order to further CMS' stated 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 make publicly available the Medicare Physician Data in the form of line item claims.

In June 2013, Senators Grassley and Wyden reintroduced a bipartisan bill entitled, "Medicare Data Access for Transparency and Accountability Act,"[10] which would

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[10] *See* H.R. 2843 – 113th Congress: Medicare Data Access for Transparency and Accountability Act. www.GovTrack.us. 2013. August 22, 2013, available at: http://www.govtrack.us/congress/bills/113/hr2843/text.

require the Secretary of HHS to issue regulations to make Medicare claims and payment data available to the public, similar to other federal spending disclosed on www.USAspending.gov. The bill calls for the data to be released and available "to the public through a searchable database that the public can access at no cost…[and] that each provider of services or supplier in the database is identified by a unique identifier that is available to the public (such as the National Provider Identifier of the provider of services or suppler)."[11]

Kyruus believes CMS should release information about individual physician payments in the form of line item claim details with an assigned NPI number associated with each claim. These data should be released in a secure and publicly accessible database, with the ability to download the dataset at no cost using a CSV form for use by researchers, investigative reporters, the public interest and healthcare information companies like Kyruus. CMS should also consider a method of providing notice that data updates are available for review.

Based on the current CMS Form-1500[12], we have included in the Appendix below, an example pseudo-schema for CMS that outlines the specific fields the Agency should make available. We believe these fields should be updated on a semi-annual basis and provide the preceding six (6)-months worth of claims using a batch feed.

Conclusion

Since the 1979 injunction, which prohibited the Department of Health, Education, and Welfare from disclosing annual Medicare reimbursement payments to individual physicians, 30-plus years have passed and it is time for CMS to fulfill its commitment to greater data transparency. The Agency should proceed with its request for public comments, receive and review the comments due by September 6, 2013, and finalize its course of action for the dissemination of the Medicare Physician Data. In the event there happens to be a physician conflict with the release of these data, then that can be addressed at the appropriate time factually rather than hypothetically.

We thank the Agency for the opportunity to submit these comments. If the Agency has any questions or would like further information, please do not hesitate to contact us at mstuart@kyruus.com.

Respectfully submitted,

Michael J. Stuart
Manager of Business Development
Kyruus, Inc.

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[11] H.R. 2843 Sec. 2 – Public Availability of Medicare Claims Data.

[12] *See* CMS Form-1500 (OMB-09038-0999), available at: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500805.pdf

APPENDIX:

We propose the following data fields, based on current CMS Form-1500:

- All four (4) DX fields;
- All six (6) CPT / HCPCS fields;
- Prior Authorization Number;
- Name of Referring Provider or Other Source;
- NPI Number(s);
- ($) Charges;
- Place of Service / Facility Name; and
- Service Facility Location

September 5, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: *Physician Data Comments*
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington DC 20201

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

To Whom It May Concern:

On behalf of Lumeris, Inc. and its Accountable Delivery System Institute, we are pleased to provide written comments to the Department of Health and Human Services (HHS), including the Centers of Medicare and Medicaid Services (CMS), on their Request for Public Comments on the Potential Release of Medicare Physician Data.

We appreciate the strong commitment to greater data transparency that CMS has demonstrated in recent years, particularly that which fosters the availability and use of health care data to drive innovations that improve health and health care. Thank you for the opportunity to comment on this important topic.

Lumeris traces its roots to 1996 and the founding of Esse Health, a primary care group based in St. Louis. Esse Health expanded its care coordination, operational, and technical capabilities through a series of acquisitions and endeavors that enabled its focus on wellness and personal, patient-centered care. In 2004, Esse Health created its own health plan, Essence Healthcare, which led the industry in terms of innovative reimbursement, collaboration, and clinical informatics. The health plan provided its physicians with the incentives, technology, and training to share risk and effectively manage their patient population while controlling cost. It also provided consumers with comprehensive and affordable coverage and access to an integrated network of primary care physicians and a virtual integrated network of specialists. In 2008, Esse Health spun off on its own, and Essence Group Holdings Company (EGHC) was created.

In 2010, the technology that integrated clinical and financial data from Essence Healthcare and its provider groups (including Esse Health), became its own company, Lumeris. Based on more than 10 years of experience, Lumeris has evolved to become an accountable care delivery innovation company offering health systems, payers, and providers operational support, technology, and consulting services. The depth and breadth of Lumeris' solutions, along with its real-world application within accountable provider groups and an accountable health plan, make the company an ideal partner for any health care organization seeking the significant benefits of a better connected, aligned and informed accountable delivery system.

Lumeris' Accountable Delivery System Institute (ADSI) is the premier resource for hospitals, health plans, and large physician groups seeking proven solutions and practical guidance on establishing successful models of accountable care. ADSI is led by the seasoned experts who established one of the nation's first successful accountable delivery systems — long before "accountability" was an industry buzzword or there was an acronym to describe it. Through their efforts, they improved the management and delivery of health care by instituting rational economics, new operational processes, and innovative technology to enable value-driven health care decision-making throughout the enterprise. The result: improved revenue, lower per-capita costs, and better patient outcomes.

Please consider this letter as you weigh your final recommendations for moving forward on the potential release of Medicare physician data.

Sincerely,

Jim Hansen
Vice President, Health Policy
Lumeris, Inc.
13900 Riverport Drive
St. Louis, MO 63143

(1) Do physicians have a privacy interest in information concerning payments they receive from Medicare and, if so, how does one properly weigh the balance between that privacy interest and the public interest in disclosure of Medicare payment information, including physician-identifiable reimbursement data?
Physician-identifiable data is already being displayed in various venues, such as HealthGrades.com, Physician Compare via Medicare, and health plan-based websites; therefore, the privacy interest related to disclosure of such data has already been breached to some extent. Compared to Hospital Compare, the physician data available is sparse, focused solely on quality, and/or focused entirely on satisfaction. There is little to no information about the cost of care. Cost/price comparison is one important way to bend the cost curve of health care and data transparency is the mechanism by which to accomplish this. Additionally, since private insurance is increasingly tied to a percentage of Medicare reimbursement, making this data available would provide a higher level of transparency overall and move the health care industry forward toward more accountable care that achieves the Triple Aim of lower cost, higher quality, and better outcomes. Finally, physician-level disclosure of payments for HIT incentive programs was met with very little resistance; therefore, it is possible that disclosing physician-level payments from Medicare would be as well.

One point to strongly consider is that there could be a negative impact from providing physician-identified data in the wrong format. The potential for "misuse" of this data is high, as many conclusions can be drawn out of context. For instance, cost data by itself, without context such as panel size and risk adjustment, might not be useful, and in some cases might be counterproductive. Additionally, fee-for-service data is completely different from that of a managed population like Medicare Advantage. It is possible that the data can be just as useful if it is deidentified if presented in the right format. The approach to the formatting and distribution of such data should be carefully considered.

(2) What specific policies should CMS 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?
The release of physician Medicare data is a natural evolution from the current policy of providing 5% deidentified data for benchmarking purposes; therefore, a similar protocol should be followed. Data that are grouped together, such as quality and satisfaction, and the display of data from a statistical significance standpoint are two such examples. CMS should also consider following similar guidance as Hospital Compare, such as the ability to select a physician by geography and the ability to download the database. Quality, cost, and satisfaction should all be located in the same place, so as not to single out cost-related information, but rather the tradeoffs to care.

(3) In what form should CMS 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)?
Aggregated data will provide an overview of the physician practice; however, in order to analyze the data most effectively, line item detail is also needed. At the line level, cost can be identified and compared to quality and satisfaction levels. However, a cost/quality balance must be struck in order to identify "preferred providers" for a geography or for an organization. Target areas of improvement should also be identified.

MAYO
CLINIC

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September 5, 2013

Honorable Marilyn Tavenner
Administrator
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Centers for Medicare and Medicaid Services
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200 Independence Avenue, SW
Washington, DC 20201
Email: Physician_Data_Comments@cms.hhs.gov.

Re: Request for Public Comments on the Potential Release of Medicare Physician Data

Dear Administrator Tavenner;

Mayo Clinic appreciates the opportunity to respond to the agency's request for comment on the potential release of individual physician Medicare payment data. Mayo Clinic is a not-for-profit health care system dedicated to medical care, research and education. With more than 3,600 physicians and 60,000 employees, Mayo Clinic demonstrates a relentless and unwavering commitment to excellence which has spawned a rich history of health care innovation. Each year, more than one million people from all 50 states and 140 countries come to Mayo Clinic to receive the highest quality care at sites in Minnesota, Arizona and Florida. In addition, Mayo Clinic Health System, a family of clinics, hospitals and health care facilities, serves communities in Iowa, Georgia, Minnesota and Wisconsin.

We, like CMS, recognize the role data can play in achieving our shared national goal of better quality health care at lower costs. Indeed, Mayo Clinic supports the release of physician-specific payment data if presented and made available in a way that provides fair, accurate and meaningful information to patients, physicians, and other key stakeholders and which accurately describes physician effort, reflects statistically valid sample sizes and standardized risk-adjustment and attribution methods, includes quality information, and appropriately protects the privacy of patient and individual physician identifiable information, such as National Provider Identifier numbers.

There is increasing interest among purchasers of health care to better understand the factors associated with costs of care. One of the key areas of interest is to understand the payments for facilities and providers. CMS recently released the hospital-specific payment data for the Top 100 DRGs. The released data provides the charges by the hospital and the associated payment. Even this relatively straightforward data has led to misinterpretation of the data such that higher

payments were inappropriately associated with higher cost care. In this case, the higher payments were reflective of graduate medical education, outlier payments, and being a disproportionate share hospital.
Among the goals of releasing physician-specific payment data are improving transparency and reducing fraud. While these are laudable goals, there are a number of considerations in releasing physician-specific data such as the following;

- It would be important to understand the form in which these data will be released. Unlike the DRG codes used to release hospital-specific payment data, similar ways of classifying physician care is not available. This leads to a number of issues and challenges that make the interpretation of the data challenging.
- How will patients be risk-adjusted? If the physicians' data will be risk-adjusted what are the adverse consequences of this? Will some physicians' up-code while others will not, leading to inappropriate comparisons?
- Will the physician payments be considered at an aggregate-level for the physician or on a per-patient basis? A key adverse consequence of this may be that physicians opt-out of Medicare or focus their practices on commercial patients. This may be especially true of high demand, high quality providers and may lead to adverse consequences for Medicare beneficiaries including not being able to see these providers.
- Physician-specific data for clinicians who primarily take care of patients with chronic disease is particularly challenging to quantify. Unlike the hospital based costs and payments, the ambulatory utilization and costs are not only influenced by physicians, but also by patients. How will the patient-specific variability be taken into account?
- Will physicians have an opportunity to review and offer corrections to their data?

There is substantial literature showing that physician-level data often lead to poor interpretation or misclassification bias. A paper by Adams et. al showed that 59% of physician cost profiles had poor reliability http://www.nejm.org/doi/full/10.1056/nejmsa0906323#t=article <http://www.nejm.org/doi/full/10.1056/nejmsa0906323%23t=article>. This calls into question the actual value of providing physician-specific data. In addition, there is greater emphasis on moving from physician-based to team-based care as emphasized in this Institute of Medicine report (https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf), providing physician-specific data could possibly reverse the momentum.

In addition, physicians work in different types of practices (e.g. size and scope), have different financial incentives (e.g. salaried vs.productivity based pay), and work in communities with differing resources and needs. Without accounting for these factors, physician-specific data will have significant limitations. While there are many other issues to consider, given the previous research and significant challenges of making data meaningful the release of physician-specific data may have adverse consequences for Medicare beneficiaries.

The Mayo Clinic provides the following comments with respect to the following CMS questions;
(1) 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;

Individual Medicare payment information should be presented together with quality information, encouraging and facilitating value-based decision making by consumers. If quality information is not available, cost and price information should be presented in a context that raises the importance of considering quality in decisions about providers, treatments, and health care services.

(2) the form in which CMS should release information about individual physician payment, should CMS decide to do so (e.g., line item claim details, aggregated data at the individual physician level).

We recognize that in recent years CMS has begun to release certain aggregate data such as the Quality and Resource Use Reports (QRUR). Additional programs such as Value Based Purchasing (VBP) and the Physician Value Modifier will begin to utilize cost and quality measures to assess value of care provided. These programs are still in their infancy stages and do not yet reflect the true value of care provided. Releasing raw data could be misleading and undermine the quality of care for patients. CMS efforts to make claims, payment, and quality measures transparent should coincide with value of care delivered. Lastly, beneficiaries should not have to decipher conflicting reports that present opposing and inaccurate conclusions about physicians or quality of care.

In closing, Mayo Clinic is pleased that CMS is not considering public disclosure of any information that could directly or indirectly reveal patient-identifiable information but cautions that CMS must ensure that any information released is not potentially re-identifiable. CMS must establish safeguards on the public release of physician claims and reimbursement data to prevent such disclosures of personal health information. Importantly, the release of physician payment data must prevent adverse consequences for the health care delivery system. The Mayo Clinic looks forward to working with CMS to establish appropriate ways to utilize this data to improve quality, delivery, and access to patient care, and we hope to have an opportunity to provide further comment as CMS refines its approach to the potential release of individual physician Medicare payment data.

Thank you for the opportunity to comment. Please do not hesitate to contact me or Jennifer Mallard, Mayo Clinic Director of Federal Government Relations at 202.621.1850 or mallard.jennifer@mayo.edu.

Very truly yours,

[redacted]

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September 4, 2013

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

The Medical Industry Leadership Institute (MILI) is pleased to respond to the August 6 request for comment on the potential release of Medicare physician data. MILI is strongly in favor of the release of this information so that academics, policy makers and practitioners can have a more complete view of the scope of practice as well as the care rendered to patients. Since its creation, MILI has used Medicare physician claims data to advance health policy goals. We believe that wider availability of these data will vastly accelerate their contribution to science as well to as society at large. The data has the potential to dramatically advance both the quality and the efficiency of clinical care.

MILI represents over 3,000 students, affiliates, academics, medical entrepreneurs and business partners. Our national industry council includes some of the largest firms in the healthcare marketplace including The Mayo Clinic, McKesson, Medtronic, United Health Group, Pfizer, Merck, 3M, Accenture, and Blue Cross Blue Shield. We are the founding academic partner of The Morning Consult, a curated health policy daily blog with over 35,000 subscribers – many of whom are employees of HHS. MILI supported the development of the Medical Productivity Index (MPI), the first medical outcome and efficiency index of its kind to be published in peer-reviewed actuarial and clinical journals.[1] The index was developed with national samples of Medicare and commercial claims data. This experience informs our response to each of the areas of interest you posted in the request for comment below.

MILI's response had broad interest among health care economists and health services researchers and below my signature are the names of 54 such researchers who have signed on to the substance of MILI's response here.

[1] Parente, S. "Development of a Medical Productivity Index for Health Insurance Beneficiaries." Insurance Markets and Companies: Analyses and Actuarial Computations, Volume, Issue 3, 2011. and Parente, C. and Parente, S. "Comparing the Medical Productivity of Providers Treating Elderly Patients with and without Mental Illness. The Journal of Mental Health Policy and Economics, Volume 16 Supplement 1 (March 2013).

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;**

   There are strong public interests in disclosing these data. Researchers can make use of these data to identify best practices, to study the pattern and impacts of technological advances, and to examine how the organization of physician practices affects care, to list but a few promising research topics. As such, the public policy value of the information contained in the physician claims data outweighs privacy interests, which appear to be primarily motivated by providers' personal business objectives. Physicians who provide services to Medicare patients are in essence government contractors. Payments to government contractors are generally public information, unless there is a strong countervailing public interest in maintaining the privacy of such payments. If the contracting agency finds that transparency of contractor performance is in the public interest, it is incumbent upon the agency to release such data unless doing so would violate a statute or court order. We believe there are substantial public benefits to payment disclosure, so long as disclosure policies respect patients' personal information.

   With respect to physician identifiable reimbursement data, most of the reimbursement policies for Part B physician payment are formula-based and should not constitute a great revelation of private business practices. Revelation of physician-submitted charge information is relevant as a privacy concern only to the extent that it influences eventual provider payment. As long as submitted charges do not influence the RBRVS payment system, this concern is unfounded.

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; and**

   CMS should consider expanding its existing data policy to provide payment information to health care analytics firms (non-profit or for-profit) as it does to existing CMS contractors and academic institutions so long as demonstration of adequate security protocols for data recipients can be secured. These data have a value too great in the revelation of existing patterns of practice (good and sub-optimal) for a limited set of qualified individuals to work with the data.

   With respect to waste, fraud and abuse, only a comprehensive database with all physician claims would have the adequate statistical power and deterrence value to identify and minimize provider fraud. In a recent paper colleagues and I published (2012)[2], using data provided by CMS and with support from ASPE, we estimated that the potential fraud prevention return from the Part B physician component alone was $19 billion annually in 2009 dollars. This is far in excess of the current fraud recovery totals and demonstrates the value the data could provide to recover and prevent fraudulent payments in the Medicare program.

[2] Parente, S.T., Schulte, B., Jost, A., Sullivan, T., Klindworth, A. "Assessment of Predictive Modeling for Identifying Fraud within the Medicare Program." Health Management, and Policy Innovation. 1(2), 8-37, 2012.

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).**

   Since 1990 when CMS (then HCFA) made available the Common Working File and later the Standard Analytic File to non-government employees, the only data detail level with value for health economics and health policy research was line item detail. It is also the level of detail required for the fraud analysis described above. This level of detail provided the evidence for the first major peer-reviewed publication in JAMA focused on diabetes quality in Medicare patients using exclusively Medicare line item data.[3] Within four years of the appearance of that article the level of HBA1c testing in Medicare practices was nearly three times as large as the initial rate (19% of all seniors).

   An illustration of how physician claims can be used to compare Medicare provider practices cost and quality metrics within an accountable care organization framework relied on line item detail.[4] Countless studies since presented by health economists at the National Bureau of Economic Research, the Academy Health Annual Research meetings, or the American Economic Association meetings use line item detail.

   The line item detail level is required to complete the type of quality analysis that has been informing public policy makers and appeared in top peer-reviewed journals for over two decades since it was first available. Making only aggregate data available would significantly reduce the capabilities of health services research and health economics.

I hope the responses to these questions have provided some perspective and evidence of the value physician line item claims data provide. Restricting access to the data hinders the goal of developing evidence-based medicine, and in so doing endangers the lives of Medicare beneficiaries. Protecting the privacy of billing practices is an insufficient justification for withholding these data.

Sincerely,

Stephen T. Parente, PhD
Director, Medical Industry Leadership Institute

[3] Weiner, J., Parente, S.T., Garnick, D., Fowles,J., Lawthers, A., and Palmer, R. "Variation in Office-Based Quality: A Profile of Care Provided to Medicare Patients with Diabetes," JAMA (May 17, 1995).

[4] Parente, S.T., Weiner, J., Garnick, D., Fowles, J., Lawthers, A., and Palmer, R. "Profiling Medicare Beneficiary Resource Use by Primary Care Practices: Implications for a Managed Medicare," Health Care Financing Review (Summer 1996).

Researchers supporting this letter:

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September 5, 2013

Ms. Marilyn Tavenner
Administrator
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Hubert H. Humphrey Building
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200 Independence Avenue, SW
Washington, DC 20201

Sent via email to Physician_Data_Comments@cms.hhs.gov

Re: Request for Comments on the Potential Release of Medicare Physician Data

Dear Ms. Tavenner,

On behalf of the Minnesota Hospital Association (MHA) and our members, which include 144 hospitals and their health systems located throughout Minnesota, I am pleased to have the opportunity to respond to your agency's request for comments regarding new transparency and data availability in the Medicare program. The request for comments pertains specifically to Medicare physician data and some of the issues the Centers for Medicare and Medicaid Services (CMS) will need to address at it moves forward with a future rulemaking process.

At the outset, it is important to note that Minnesota's hospitals and health systems have long supported efforts to make Medicare data publicly available and transparent, especially for the purposes of research, and quality and patient safety improvement. In addition to all of the information available through Hospital Compare, Minnesota's hospitals and health systems provide transparent and publicly available information regarding their charges for the most common inpatient and outpatient services, occurrences of adverse health events, dozens of patient safety and quality measures, and a whole host of financial and utilization information.

Accordingly, Minnesota's hospitals and health systems have demonstrated our commitment to transparency of health care information and performance. Such transparency is a key component in driving continuous improvement in health care, either through direct comparisons of performance or through research and data analysis. But transparency in and of itself is not the end goal, but rather a necessary step toward the interrelated objectives of improving healthcare quality, slowing the pace of healthcare cost growth, and increasing population health.

MHA and our members' experience lead us to believe that efforts to make claims, payment, quality and other measures of health care delivery performance more transparent should be coupled with equally aggressive efforts to put those data in the appropriate context of the value of care delivered. Claims and payment data alone – whether the data pertain to hospitals, physicians or any other provider – fail to provide sufficient information to evaluate performance, allocate accountability, or differentiate payment amounts. Instead, the ultimate objective for CMS, policymakers, consumers, providers and other stakeholders should be transparency of the value of care delivered as measured by the quality of outcomes for the patient relative to the costs paid and/or resources used.

The hospital Value Based Purchasing program and the new physician Value Modifier are initial attempts by Medicare to begin to use cost and quality measures to assess overall value of care. However, these remain far too limited, incomplete and skewed to accurately reflect the value of care providers deliver or the variation in value that exists between providers. MHA encourages CMS to continue to develop, refine and enhance its efforts to better define, measure and report on total value of care as it considers how to release physician claims and payment data.

In the request for comments, CMS first asks whether physicians have a privacy interest in information concerning payments they receive from Medicare. MHA believes that physicians, like other government contractors and vendors, do not have a privacy interest in the claims, payments or other transactional data that are provided to, from or exchanged with the federal government.

As a general rule, Medicare and other federal programs should engage in the privacy analysis with a presumption that the data under consideration are public unless some other defined and significant privacy interests are at stake.

The Medicare program is an optional endeavor for physicians. By deciding to participate in Medicare, physicians understand that they will be required to provide certain information, abide by certain conditions and requirements, and deliver services within defined parameters. Thus, Medicare participation is a public, optional, and heavily regulated activity for physicians. Consequently, Medicare claims and payment data are not separate from or outside of a significant amount of government oversight and involvement. A claim to a privacy interest in such an activity is not a reasonable expectation for physicians, or other government contractors.

Moreover, unlike commercial health plans, the Medicare program does not negotiate payment rates with physicians. Disclosing Medicare reimbursements to physicians, therefore, will not reveal proprietary information or competitive pricing strategies. Instead, a physician's Medicare reimbursement amounts are calculated according to a federally defined formula and do not vary from another physicians in the area delivering the same service to a Medicare beneficiary.

It is important to emphasize that patients continue to have significant privacy interests in their individual health data. MHA encourages CMS to reiterate that the physician data that will be made public will not contain personal health information to allay any concerns that Medicare beneficiaries might have about their medical information becoming public. Also, MHA anticipates that CMS will need to establish safeguards on the public release of physician claims and reimbursement data to prevent any disclosure of personal health information, such as claims or reimbursement information on particularly rare services that could be used to identify a patient.

CMS also requested comments regarding the form in which physician data should be released. To leverage the greatest value from the data for purposes of improving the quality and cost of care, encouraging research and innovation, and reducing fraud, waste and abuse, CMS should strive to make the data available in as many forms as possible without undue cost or administrative burden. Multiple formats will make the information more readily available to and usable for research, but they will also enhance the ability of members of the public or users with less sophisticated computer/software resources to access the data.

Clearly, formats that allow researchers to sort, reorganize and restructure the data elements will be crucial.

Finally, MHA reiterates a common refrain in many of our comments regarding Medicare data: providing data as close to real-time as possible is essential to maximize the utility and value of the data. While older data sets may be useful for some forms of research and analysis, more and more, care delivery improvement efforts rely on and demand current data in order to have the greatest impact on patient care, efficiency, and outcomes.

MHA is grateful for this opportunity to provide our comments and suggestions. We look forward to the release of proposed rules on this matter in the near future. I expect that we will offer additional comments at that time when more details and nuances are under discussion. In the meantime, if you have any questions or concerns, please feel free to contact me.

Vice President, Regulatory/Strategic Affairs

August 29, 2013

Marilyn B. Tavenner, R.N.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201-0007

Dear Administrator Tavenner:

On behalf of physicians and hospitals across the state of Missouri, the Missouri State Medical Association (MSMA) and the Missouri Hospital Association (MHA) hereby ask the Centers for Medicare & Medicaid Services (CMS) to consider the following comments when considering policies for the disclosure of individual physician payment data arising from the recently lifted 1979 injunction by the Florida federal district court (*Florida Medical Association, Inc. v. Department of Health, Education, & Welfare,* 2013 WL 2382270, M.D.Fla. May 31, 2013).

In the request for public comment issued August 6, 2013, CMS requested input on three specific questions which we offer below. We would first like to proffer broader comments and policy considerations for CMS to weigh when developing a framework for transparent reporting of physician payment data.

MHA and MSMA are committed to working with our members to improve the quality of Missouri's health care system by enhancing health outcomes for patients, increasing efficiencies, and reducing costs. We applaud CMS for its continued effort to add value to the U.S. health care system through transparent, innovative and responsible deployment and evaluation of health data. We also appreciate the historic tradition of your agency to exercise due diligence prior to releasing new data. We recommend CMS continue that tradition by carefully weighing all policy considerations before making physician payment data available to the public.

MHA and MSMA encourage the use of physician data when the application of the data carries the potential to improve the overall quality of the health care system by improving health outcomes, capturing efficiencies and reducing costs. In order to meet these criteria the data should benefit from numerous attributes while preserving patient and physician privacy considerations where applicable:

- The release of the data should not jeopardize access to care, particularly in underserved areas, health professional shortage areas or for indigent and high-risk population groups. Making meaningful inferences on the heterogeneous quality of health care providers is dependent on the idiosyncratic contexts of the patients they treat. These patient contextual factors typically are not captured in the homogenous data-generating platforms employed by CMS, and are therefore typically not controlled for in evaluating standardized data. This calls into question the validity of comparisons based on these data without proper

adjustment. In the absence of controls for patient mix and other contextual factors, users may draw inaccurate conclusions on the actual quality and cost of care provided by individual physicians.

- The data should be adjusted for variance in the health care marketplace in which physicians practice. Physician payment data is determined in part by the various costs that they face arising from regional price indices, medical specialties, local health insurance coverage including plan design and payer mix, population health and population health literacy, pharmaceutical costs, overhead and medical liability insurance costs among other factors. Failure to control for these varying market conditions facing individual physicians may lead users to draw incomplete conclusions on the actual quality and cost of care.

- The data should not be released prior to review and verification by the original submitting physician to ensure accuracy. Further, data with fewer observations than are needed to base valid statistical inferences or maintain patient anonymity should be sequestered.

In summary, we urge CMS to thoroughly ensure safeguards are in place prior to releasing the data, so that users may make meaningful, accurate and informed decisions and inferences on the quality of individual physicians.

MHA and MSMA jointly offer the following policy considerations in response to CMS' request for public comment on the following three issues:

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.

    - On behalf of their practices and especially their patients, physicians do have a significant privacy interest in the disclosure of government payment information. Medicare claims data include a broad range of confidential and sensitive information regarding the health status of patients. CMS must first and foremost take great care to ensure that any and all if its disclosures fully are compliant with HIPAA. And of equal importance, it is incumbent upon CMS to release raw data only to experienced and reputable entities, and only upon reasonable assurance that the data will be kept secure, and only used to produce meaningful and accurate information that takes into account appropriate risk adjustment, attribution, local demographics and practice cost factors.

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?

    - MHA and MSMA urge CMS to constrain the release of raw itemized physician claims data to researchers and research organizations with the capacity and expertise to properly adjust the data to ensure valid comparisons are gleaned from the data on variance in individual physician quality.

- Publicly reported data should be limited to aggregated physician and practice-level quality composite measures with appropriate controls for exogenous determinants that influence the data but do not reflect the actual quality of the submitting physician or practice.

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).

    - MHA and MSMA recommend CMS considers releasing aggregated physician and practice cost data and composite quality measures with controls for the aforementioned factors that may contribute to variance in the data to ensure users can make meaningful and accurate comparisons of actual quality differences between individual physicians and practices. CMS also should include a detailed description of the limitations of the data and the risk to users of drawing misguided conclusions on their basis.

We appreciate the opportunity to offer these comments on this important topic and the continued commitment of CMS to improve the health care system through the meaningful use of data.

Sincerely,

[redacted]

Thomas L. Holloway
Executive Vice President
Missouri State Medical Association
Missouri State Medical Association

[redacted]

Daniel Landon
Senior Vice President
Governmental Relations
Missouri Hospital Association

tlh:dl/ds

National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

September 3, 2013

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services (HHS)
Hubert H. Humphrey Building
Room 314 G
200 Independence Avenue, SW
Washington, D.C. 20201

Attention: ***Physician Data Comments***

Dear Administrator Tavenner:

The National Business Group on Health appreciates the opportunity to provide comments on the potential release of individual-level Medicare claims data for physicians, other health professionals and suppliers, which we strongly encourage. We commend your continuing efforts to increase provider transparency, accountability and quality and to help Medicare beneficiaries and all Americans make better health care choices. Individual-level provider data will help consumers, Medicare and others, including employer-sponsored plans, identify high quality providers. The volume of patient visits that Medicare claims data will add at the individual physician level will increase the availability and reliability of data on providers' performance.

The National Business Group on Health represents approximately 377, primarily large, employers (including 66 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 50 million American employees, retirees, and their families.

The National Business Group on Health provides the following recommendations as you work to comply with the lifting of the 1979 injunction that had previously prevented the disclosure of physician-specific Medicare claims data.

The National Business Group on Health believes:

- **The public's ability to make more informed choices of high quality, efficient and effective health care providers outweighs any marginal concerns regarding physicians' privacy; and**
- **The data will benefit:**

- **Consumers, who would have more information available to check whether physicians have appropriate levels of experience performing specific procedures or treating specific conditions and how well they perform;**
- **Medicare, which could apply the research findings and data analyses to supplement its current internal efforts and studies with its research partners to improve the program;**
- **Employer-sponsored plans and others who can use the data to enhance their own efforts in value purchasing and improving provider quality more robust; and**
- **Providers, who can use the data to benchmark with others and improve their performance.**

In order to achieve HHS' goal to enhance the public's access to CMS data, the National Business Group on Health recommends that HHS:

- **Make fully disaggregated data available—for example, individual claims—to allow performance measurement at the individual physician level to account for variation among physicians within the same practices. Any data release should also abide by the Health Insurance Portability and Accountability Act (HIPAA) patient privacy protections—particularly in rural areas and small towns where limited numbers of less common procedures may possibly be identified with specific patients. In order to perform analyses of physicians' level of experience, qualifications, quality, and adherence to guidelines, the Medicare claim information must include physician-identifying information linked to each Medicare service or procedure at the individual physician level;**
- **Make the data available to the public without any restrictions on the methods for analyses, as is the case for Medicare hospital data;**
- **Require users to publicly release their analyses' methods to allow for peer review and comparison;**
- **Allow users to obtain data for a period of years and if less, filtered by physician identifiers (both individual and group), geography, procedures and chronic conditions;**
- **Do not require users to include non-Medicare claims data in their analyses—the Medicare data alone can produce much useful information; and**
- **While local and geographically-limited analyses and uses will be important, HHS should do all it can to foster national analyses and measurement results, which are more likely to have an impact on the entire health care system. National analyses will allow CMS and other purchasers to create uniform physician quality and efficiency measures.**

Again, thank you for considering our comments and recommendations on the potential release of individual Medicare physician data. We look forward to continuing our work with you to increase public access to CMS' data to improve consumers' choices and providers' performance. Please contact me or Steven Wojcik, the National Business

Group on Health's Vice President of Public Policy, at (202) 558-3012, if you would like to discuss our comments in more detail.

Sincerely,

Helen Darling
President

cc: The Honorable Kathleen Sebelius, Secretary, HHS

NHCAA
National Health Care Anti-Fraud Association®

ELECTRONIC SUBMISSION VIA **Physician_Data_Comments@cms.hhs.gov**

September 5, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Re: Physician Data Comments, August 6, 2013 Request

Dear Administrator Tavenner:

On behalf of the National Health Care Anti-Fraud Association (NHCAA), we are writing in response to the notice titled "Request for Public Comments on the Potential Release of Medicare Physician Data," issued August 6, 2013.

Established in 1985, NHCAA is the leading national organization focused exclusively on combating health care fraud and abuse. We are unique among associations in that we are a private-public partnership—our members comprise the nation's most prominent health insurance plans as well as those federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud which participate in NHCAA as law enforcement liaisons.

NHCAA's mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. Our commitment to this mission is the same regardless of whether a patient has private health coverage through an employer or as an individual, or is a beneficiary of Medicare, Medicaid, or any other public program.

On a national level, fraud infects and undermines our nation's health care system and is a drain on limited resources. The extent of financial losses due to health care fraud in the United States, while not

entirely known, is estimated to range in the tens of billions of dollars or more annually. It is a serious and costly problem that affects every patient and every taxpayer across our nation. Instances of abuse in the system, being closely related to fraud, only add to the detrimental impact. To be sure, the financial losses are considerable, but those losses are compounded by numerous instances of patient harm — unfortunate and insidious side effects of health care fraud that impact patient safety and diminish the quality of our medical care. Health care fraud is not just a financial crime, and certainly it is not victimless.

It is from this perspective that NHCAA offers its comments on appropriate policies for disclosing Medicare individual physician payment data. Although we believe that the release of Medicare physician payment data under certain conditions would add to transparency and promote other important goals of our nation's health care system, our comments are limited to the release of this data with respect to its impact on the prevention and detection of fraud and abuse.

Our nation's health care system hinges upon a staggering amount of data and countless health care claim adjudication systems while costing $2.8 trillion annually. Moreover, the vast majority of health care providers and suppliers bill multiple payers, both private and public. For example, a health care provider may be billing Medicare, Medicaid, and several private health plans in which it is a network provider, and may also be billing other health plans as an out-of-network provider. As a result, when fraud is committed, it does not discriminate between types of medical coverage. The same schemes used to defraud Medicare and Medicaid migrate to private insurance, and schemes perpetrated against private insurers make their way into government programs. However, when attempting to detect potential fraud or abuse, each payer is limited to analyzing only the claims it receives and adjudicates. Generally, it is not privy to claims information collected by other payers. For this reason, the sharing of information among the payers is critically important to the effective detection and prevention of health care fraud and abuse.

NHCAA has been both an advocate and conduit for this type of anti-fraud information sharing for more than 25 years. Additionally, the Department of Health & Human Services and the Department of Justice also have recognized the critical importance of data sharing and analysis among public and private payers to detect and prevent fraud and abuse as demonstrated by the creation of the Healthcare Fraud Prevention Partnership in July of last year.

Consistent with this recognized strategy for fighting fraud and abuse, NHCAA recommends that access to Medicare physician payment data be made available to the anti-fraud components of all public and private payers, including private insurer special investigation units (SIUs), upon specific request, for purposes of fraud and abuse prevention, detection, and investigation. For example, to obtain access, an SIU would make a request to CMS identifying the physician or physicians of interest, the payment codes and timeframes at issue, and include any other information deemed necessary by CMS. In response, the requested data then should be provided electronically, ideally via a secure, internet-based portal. Under this type of access, the data would be released on the condition that it is used only for the purposes of anti-fraud and abuse activities.

Timeliness of the data also would be critical from a fraud-fighting perspective. Fraud schemes and trends often emerge quickly and then change, migrate, morph or dissipate just as quickly. For Medicare payment data to be optimally useful in reducing fraud and abuse, it should be made available soon after it is requested.

As for the level of information provided, while aggregated data at the individual physician level could prove useful and make for easier public consumption, NHCAA believes that providing line item claim details to requestors holds the most promise for effectively identifying and combating health care fraud and abuse. Health care fraud investigations often depend upon identifying when one claim should be preceded or accompanied by other claims (for example, certain tests that should precede a surgical procedure). Aggregated data alone would not allow for this level of assessment.

This type of public-private sharing of Medicare physician payment data which is restricted to anti-fraud and abuse activities would have little or no impact on physician privacy concerns. Since physicians voluntarily participate in Medicare and are paid with public funds, we question whether there exists a recognizable privacy interest in the amount a physician is reimbursed by Medicare. Nevertheless, even if such an interest exists, the release of payment data restricted in its use to the prevention, detection and investigation of health care fraud and abuse is consistent with sound public policy as well as established legal principles which recognize the validity and efficacy of information exchanges among potential victims of fraud.

CMS continues to demonstrate its strong commitment to fighting fraud, waste and abuse in the Medicare program. The shift away from pay and chase methods of fraud-fighting to a focus on prevention with the adoption of data analytics, predictive modeling and enhanced screening of providers is evidence of this commitment. NHCAA also applauds CMS' leadership in the development of the Healthcare Fraud Prevention Partnership, an initiative dedicated to the exchange of information between the public and private sectors in order to reduce the prevalence of health care fraud. Enabling payer access to Medicare physician payment data could help ensure greater success for the goals of the Partnership.

On behalf of the National Health Care Anti-Fraud Association, thank you for this opportunity to comment on the Center for Medicare & Medicaid Services' commendable efforts to promote greater data transparency. Making Medicare physician payment data available can improve the ability of both the public and private sectors to identify and stop health care fraud. We are available for any questions that you may have.

Sincerely,

Louis Saccoccio
Chief Executive Officer

nrhi Network for Regional Healthcare Improvement

September 5, 2013

Department of Health and Human Services

Centers for Medicare and Medicaid Services

Attention: Physician Data Comments

Dear Sir/Madam:

Thank you for the opportunity to comment on key questions related to data access and transparency in provider payment.

It is our position that there is a strong public interest in having transparent access to very detailed data on healthcare costs to promote improvement. Lack of transparency has contributed to cost escalation and has inhibited physicians, patients and purchasers from understanding and optimally managing costs.

We also believe there is an existing mechanism through which CMS could expand access to this data to ensure it is effectively used for improvement of quality and affordability. The relatively short and somewhat unnoticed section of the Affordable Care Act entitled "Availability of Medicare Data for Performance Measurement" allows for "qualified entities" (QEs) to receive Medicare Parts A, B, and D data to do performance measurement on providers. To be "qualified," an entity must possess other claims data, have the ability to analyze the data and calculate quality measures, publicly report those measures, and agree to abide by the privacy and security rules CMS establishes. The bar to be qualified is set appropriately high to ensure appropriate security and responsible use of the data. Though the focus to date has been on quality measurement, this same program could be used for cost measurement and release of cost data.

Nine of eleven approved QEs in the US are Regional Health Improvement Collaboratives (RHICs) and members of the Network for Regional Healthcare Improvement (NRHI). NRHI is the national-level association representing regional multi-stakeholder groups working toward achieving the Triple Aim of better health, better health care, and reduced costs through continuous improvement. To be a member of NRHI, an organization *must* be multi-stakeholder; non-profit and working in a region to improve care quality and affordability. Our members have experience and expertise in data collection and management, analytics, performance measurement and public reporting, quality improvement and consumer engagement. NRHI and all of our members are non-profit

organizations, separate from state government , working directly with physicians, hospitals, health plans, and patients using data to improve healthcare.

Regional Health Improvement Collaboratives have demonstrated the capability to serve as QEs but building the capacity to take on the increased responsibilities required under the QE program has proven to be a financial challenge. The statute allows CMS to charge QEs a "fee equal to the cost of making the data available." Devising a sustainable business model to support QE program activities has been especially difficult for non-profit regional collaboratives to do. We believe that regional collaboratives play a vital role in their communities as impartial evaluators of health care performance. The community-based, multi-stakeholder nature of a regional collaborative lends a unique credibility to provider measurement efforts. Even federal policy makers both in Congress have expressed their support for regional collaboratives and the important role they have in health care data transparency efforts. We believe that, with additional support, they are prepared to play an even greater role in managing and using data in communities with all key stakeholders.

Regional collaboratives have also been pioneers in the efforts to integrate clinical data from registries, electronic health records (EHRs), and other sources to make performance measurement more meaningful, both for the providers being profiled, and for patients and consumers using the publicly reported data. Congress recognized this in the legislation recently passed out of the Energy and Commerce Health Subcommittee that replaces the Medicare SGR with a value-based physician payment method .[i] The markup includes language on clinical quality improvement activities, and requires all Medicare providers to receive performance feedback "at least quarterly." CMS could rely on regional collaboratives all across the country to help with providing this feedback. The QE program itself seems to lay the foundation for this capability. The draft legislation provides CMS with $100 million in funding to develop this infrastructure; regional collaboratives that already are (or wish to be) QEs could use this funding to fulfill both QE program requirements, and provide the reporting infrastructure necessary for this very large-scale physician payment reform effort.

A remaining barrier under the QE program that should be changed to maximize the potential of the program is that a provider gets access to his or her own underlying data if and only if he or she asks for it as part of a formal appeals process. Regional collaboratives understand very well the importance of proper security procedures for PHI, but if the clinical quality improvement described in the Energy and Commerce committee's proposed legislation is to actually lead to improvements, providers need to know which patients are being considered "theirs" and the details of the measure calculations. A provider should not have to undertake a formal appeals process to get this data; **the underlying claims and clinical data should be easily accessible and provided in a meaningful way to all**

providers that are being profiled. This is the only way quality improvement efforts can actually lead to measurable and meaningful improvement.

We share the aims of CMS to improve care quality and affordability and work in communities to implement needed changes. To achieve the shared aims of data use by and with physicians to improve care, we promote the following:

- **Greater access to all-payer claims data is urgently needed for improvement;**
- **It is critical to have a continued deliberate approach integrating meaningful analytics and measures and processes for data sharing. Release of data without regard to measurement, analytic capability or experience with quality improvement may set improvement efforts back.**
- **The Qualified Entity program is a good model that requires modifications to restrictions to better enable data sharing;**
- **Qualified Entities and Regional Collaboratives require funding to support needed analytics;**
- **Regional Collaboratives are a critical means of providing neutral access to data for all stakeholders. Regional Collaboratives are exceptionally well positioned to receive and share this data.**
- **RHICs can help physicians design and implement successful payment reforms through data analytics, measurement, quality improvement and other technical assistance.**

To summarize, regional collaboratives are integral players in the health care transparency and improvement infrastructure. They are credible, impartial, multi-stakeholder organizations whose expertise providers in a community have grown to trust. In order for the QE program to succeed, changes need to be made to the program. We recognize that some changes would require congressional action, and others regulatory action, but QEs need to have a permanent funding source, and they need to have the ability to freely exchange both quality and cost data with the providers in their communities. Quality and cost transparency are essential to improvement and NRHI members welcome the opportunity for discussion with federal policy makers, and other interested stakeholders, about potential solutions to these challenges.

Best regards,

Elizabeth Mitchell

President and CEO, Network for Regional Healthcare Improvement

[i] http://docs.house.gov/meetings/IF/IF14/20130722/101205/BILLS-113DiscussionDraftpih-DiscussionDraft.pdf

New York State Psychiatric Association, Inc.

Area II Council of the American Psychiatric Association
400 Garden City Plaza, Garden City, New York 11530 ● (516) 542-0077

September 5, 2013

VIA ELECTRONIC MAIL TO PHYSICIAN_DATA_COMMENTS@CMS.HHS.GOV

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: Physician Data Comments
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Dear Sir or Madam:

I am writing on behalf of the New York State Psychiatric Association (NYSPA), the state medical specialty association of more than 4,000 psychiatrists practicing in the State. NYSPA is pleased to provide comments in response to the Department's request for comments on the potential release of Medicare physician data.

NYSPA would like to express its support for the written comments submitted by the American Medical Association (AMA) on this issue, which comments were also supported by the American Psychiatric Association, our national organization. In its comments, the AMA acknowledges the benefits that physician payment and reimbursement data may provide in improving the delivery of health care at lower costs, but calls for appropriate safeguards to prevent the misuse or misappropriate of such data.

We would also assert that physicians should have a reasonable expectation of privacy in their personal income or data from which their level of personal income could be determined. Therefore, we strongly suggest that any physician payment or reimbursement data released publicly should not be physician specific and should be de-identified in accordance with the standards set forth in the HIPAA Privacy Regulations (45 CFR Section 164.514). Under the HIPAA definition, information is considered "de-identified" if individual identifiers are removed (such as name, geographic subdivisions, dates and ages, telephone and other contact numbers, email addresses, photographic images, and social security numbers, among others) and the information could not be used alone or in combination with other information to identify the individual who is the subject of the information. Use of the HIPAA standard for de-identification of information would ensure that any physician data released in connection with Medicare's revised policy would in no way infringe upon the individual privacy rights of Medicare providers or their patients.

At a time when many physicians, especially psychiatrists, have been forced to withdraw from government-sponsored healthcare programs due to reduced reimbursement, the contemplated release of physician payment data might only further increase this trend. In order to ensure the effective and efficient delivery of health care, particularly mental health care and treatment, physicians must be assured that their personal information, as well as patient information, will be kept private and that the confidentiality of medical information is paramount.

Thank you for the opportunity to provide comment.

If you have any questions regarding the foregoing, I can be reached at 516-542-0077.

Sincerely,

Seth P. Stein, Esq.
Executive Director and General Counsel

PBGH
PACIFIC BUSINESS GROUP ON HEALTH

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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

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September 5, 2013

VIA E-MAIL (Physician_Data_Comments@cms.hhs.gov)

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: Physician Data Comments
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Public Comments on the Potential Release of Medicare Physician Data, August 6, 2013

Dear Sirs/Madams:

The Reporters Committee for Freedom of the Press, along with the 21 undersigned news media organizations and journalism associations, submit the following in response to the Department of Health and Human Services' (HHS) and component Centers for Medicare and Medicaid Services' (CMS) request for public comments on the potential release of Medicare physician data. The undersigned have a vested and continuing interest in ensuring robust access to government information to better enable their watchdog role. Further, the undersigned are particularly concerned about access to the incredibly newsworthy information that is the subject of this comment and the means by which HHS will consider its potential release. We address each of the three questions posed by HHS in turn.

Question 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

For decades, health care policy, legislation and administration has been one of the most contentious issues in the public and political arena. The passage—and subsequent judicial sanction—of the Affordable Care Act has only heightened the public's interest in being able to evaluate the efficiencies and effectiveness of government-administered health programs. As federal health care programs continue to grow, there has also been an increasing interest in being able to access and report on data that shed light on the operations of such programs.

Responding to this demand, the Obama administration has embarked on an aggressive, multi-prong initiative to make government data more

accessible, granular and easier to analyze. This includes allowing the public to track exactly how and where federal dollars are spent. The heightened public interest in federal spending transparency coupled with the current health care regulatory landscape has thus greatly reframed the notion of what information should now be considered private. As with other similar federal spending, the idea that doctors accepting billions of dollars in Medicare and Medicaid benefits have a privacy interest in related billing records is simply an outdated view. Therefore, HHS should move toward greater transparency and find that doctors have no privacy interest in records reflecting Medicare payment information that does not directly identify patients.

Healthcare Policy, Spending and Administration Lies at the Core of Public Debate

Federal health care policy and spending has been at the forefront of domestic policy discussion for decades. As detailed in *Dow Jones & Company's* motion to vacate the injunction, in 1979 federal outlays for Medicare equaled $26.5 billion—roughly 5% of total spending.[1] Today, Medicare pays out more than $1 billion on 4.5 million claims every work day and has increased as a percentage of the total federal budget nearly three-fold since 1979.[2] Meanwhile, Medicare fraud and waste have skyrocketed in recent decades, with hundreds of millions of dollars lost.[3] The Affordable Care Act—and the continuing fiscal issues it provokes—adds yet another layer to this public debate, further cementing health care's central role in political discourse.

Given the scope of federal health programs and the potential for abuse, the public is naturally curious about how the government is administering and monitoring such programs. In addition to *Dow Jones'* own landmark 2010 reporting on Medicare fraud and abuse, other outlets regularly report on federal health care spending and administration.[4] For example, HHS' recent release of hospital charges for Medicare

[1] *See* Dow Jones & Company, Inc.'s Motion to Vacate Permanent Injunction and Incorporated Memorandum of Points and Authorities, *Florida Medical Ass'n, Inc. v. Dept. of Health, Ed. & Welfare*, No. 3:78-cv-00178-MMH-MCR (M.D. Fla.) (Doc. No. 56) (Mar. 19, 2012) at 9.

[2] *See id.*

[3] *See id.* at 9-11.

[4] It is important to note that oversight cannot be fully achieved by provisions in the Affordable Care Act that require HHS to release Medicare payment data sets to "qualified entities" for review and publication, including if they choose, individual doctor payment data. Not only does this requirement belie the rationale for keeping such information from the public but it also fundamentally stymies the role of the press. Journalists provide an additional layer of oversight over those charged with being watchdogs and can provide an outlet for voicing government abuses when internal

services generated great public interest and resulted in numerous stories across the nation detailing the wide price disparities for similar service across hospitals.[5] This data release was said to be spurred on by *Time's* comprehensive report on the state of domestic medical care, "Bitter Pill: Why Medical Bills are Killing Us."[6] Moreover, as discussed in greater detail later in these comments, journalists at *ProPublica*, *The Seattle Times*, *The Center For Public Integrity*, the *Las Vegas Sun* and *California Watch* have all used health care data—including Medicare and Medicaid data—to tell compelling stories about quality of care and billing abuses throughout the health care system.

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reporting is frustrated or stymied. *See, e.g.*, Tracy Weber, *et al.*, *Medicare Drug Program Fails to Monitor Prescribers, Putting Seniors and Disabled at Risk*, PROPUBLICA, May 11, 2013 available at http://www.propublica.org/article/part-d-prescriber-checkup-mainbar. According to an Inspector General Investigation cited in the story, contractors hired by Medicare to root out fraud "generated few of their own investigations," relying instead on outside complaints to direct inquiries. *Id*. Additionally, private insurers often lacked the necessary data to conduct effective audits of prescribing behavior. *See id*. Further, the press provides an outlet for those who cannot always turn to those supposedly charged with program compliance. For example, an *Orange County Register* 1996 Pulitzer prize-winning series detailed a UC Irvine hospital scandal involving the unknowing harvest of eggs from female patients that were then placed in other patients. UC Irvine employees who complained about the practice were pressured to remain quiet and had their jobs threatened. The entire series can be found at http://www.pulitzer.org/citation/1996-Investigative-Reporting.

[5] *See, e.g.*, Jim Doyle, *Price of a Pacemaker: $32K at St. Luke's, $75K at Des Peres*, ST. LOUIS POST-DISPATCH, May 9, 2013 available at http://www.stltoday.com/business/local/price-of-a-pacemaker-k-at-st-luke-s-k/article_57cfd452-e9aa-5aeb-932d-c1569e2f38a8.html; Barry Meier, *et al.*, *Hospital Billing Varies Wildly, Government Data Shows*, N.Y. TIMES, May 8, 2013 available at http://www.nytimes.com/2013/05/08/business/hospital-billing-varies-wildly-us-data-shows.html; Chris Isidore, *Your Heart Attack Bill: $3,300 in Arkansas, $92,000 in California*, CNN, May 13, 2013 available at http://money.cnn.com/2013/05/08/news/economy/hospital-bills/index.html; Sarah Kliff & Dan Keating, *One Hospital Charges $8,000 – Another, $38,000*, WASHINGTON POST, May 13, 2008 available at http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/08/one-hospital-charges-8000-another-38000/; Annie Feidt, *Dramatically Different Medicare Bills Set Hospitals Thinking*; NPR, May 11, 2013 available at http://www.npr.org/blogs/health/2013/05/10/182916297/dramatically-different-medicare-bills-set-hospitals-thinking.

[6] *See* Steven Brill, *An End to Medical-Billing Secrecy?*, TIME, May 8, 2013 available at http://swampland.time.com/2013/05/08/an-end-to-medical-billing-secrecy/.

To be sure, the public needs the ability to monitor federal health care administration and be fully informed about its operations and costs. Doctors who participate in these federal programs cannot be allowed to shield billing data from the public when it serves as a primary means to monitor administration. Even assuming there was a privacy interest in such records in 1979, the current health care system has grown so central to the lives of every citizen and has become such a significant federal budget item that HHS can no longer find any cognizable privacy right in such data.

Releasing Medicare Doctor Billing Data Serves Many Public Interests

While a primary purpose of open government is to shed light on government operations, other public interests exist that HHS should consider in finding that doctors have no legitimate privacy right in Medicare billing data. The Obama administration has made it a priority to foster derivative uses of public information in order to spur innovation, creativity and develop new products that help consumers make better choices in their lives.[7]

To this end, sites like Recovery.gov, USASpending.gov and Data.gov have been developed to proactively disclose myriad data sets ranging from granular spending/contracting information to scientific data. Payment data is a particular focus of Recovery.gov and USASpending.gov as they disclose very similar payment information in other areas of federal spending to what is at issue here.

Part of this transparency push is driven by the desire to simply set data free. By placing it directly in the hands of the public, users can develop independent applications and products that the government may never have the time, funding or knowledge to produce. Efforts like this not only serve transparency oversight policy goals but can also fuel potential economic and social innovation, reform efforts and scientific discovery. HHS itself has been part of this "innovation and reform through transparency" push to improve the quality of health care via its "Health Data Initiative." Unlocked Medicare payment data has the same potential to serve additional public interests beyond oversight. This ability to quickly distribute bulk government data to countless developers and third parties with a particular interest has further altered the public interest/privacy calculus in favor of disclosure. HHS should recognize the power inherent within such data sets and adopt a policy of proactive release.

[7] *See infra*, notes 8-13, 24, 32-33, and accompanying text, highlighting Obama administration data disclosure initiatives.

Question 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

As the Obama administration has recognized, "it is important to make information not merely available but also useable."[8] To that end, it has regularly supported efforts to put raw government data directly into the hands of those who can extract the greatest value and insight from it. Consistent with this executive policy focus—and given the nature of the data sets at issue here—CMS should provide Medicare physician data in electronic, open data formats, proactively posted to a dedicated department website. This section highlights how such a disclosure would comport with the administration's commands on open data disclosure and the federal Freedom of Information Act (FOIA). It also includes a select survey of how journalists have used electronic, bulk data to produce compelling narratives.

Open, Machine Readable Data as the Minimum Standard

The Obama administration has made clear through numerous orders, memorandums and directives that agencies should harness the power of technology and emerging distribution platforms to foster greater government transparency and private-sector innovation through data use. Chief among these policies is the enhanced use of proactive disclosure of government data in open, electronic formats. OMB's 2009 Open Government Directive states that "[t]o increase accountability, promote informed participation by the public, and create economic opportunity, each agency shall take prompt steps to expand access to information by making it available online in open formats."[9]

This May, the administration reaffirmed its commitment to machine readable data disclosure when it ordered the development of an "Open Data Policy" to be implemented throughout all departments and agencies noting that "across fields such as health and

[8] Cass R. Sunstein, Office of Mgmt. & Budget, Exec. Office of the President, Memorandum for the Heads of Executive Departments and Agencies, *Disclosure and Simplification as Regulatory Tools*, 7 (June 18, 2010) available at http://www.whitehouse.gov/sites/default/files/omb/assets/inforeg/disclosure_principles.pdf.

[9] Peter R. Orszag, Office of Mgmt. & Budget, Exec. Office of the President, Memorandum for the Heads of Executive Departments and Agencies, *Open Government Directive*, 2 (Dec. 8, 2009) available at http://www.whitehouse.gov/sites/default/files/omb/assets/memoranda_2010/m10-06.pdf.

medicine, education, energy, public safety, global development, and finance" the public has utilized open government data "to develop a vast range of useful new products and businesses…."[10] The resulting Open Data Policy memorandum (issued the same day as the executive order) again supports electronic, open data as a default and further encourages agencies to "improve the discoverability and usability of existing datasets by making them 'open'…prioritizing those that have already been released to the public or otherwise deemed high-value or high-demand through engagement with customers."[11]

Journalists need ready access to large data sets in open, electronic formats to transform complicated and overwhelming volumes of information into rich, sophisticated reporting, informative graphics and interactive presentations. Bulk data sets containing numerous fields have particular value to journalists engaged in computer-assisted reporting (CAR) techniques. Indeed, it is often only with the use of sophisticated statistical analysis software that such data can be manipulated to reveal newsworthy facts, patterns and relationships.

Naturally, journalists therefore frequently play a primary role in informing the public about complex health care issues that enable people to make better choices. This reality is directly reflected by the Obama administration's commitment to "smart disclosure," that is, the "timely release of complex information and data in standardized, machine readable formats in ways that enable consumers to make informed decisions."[12] Indeed, "third-party intermediaries," like journalists, "may also create tools that use these data sets to provide services that support consumer decision-making."[13]

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[10] Exec. Order No. 13642, *Making Open and Machine Readable the New Default for Government Information*, 78 Fed. Reg. 28,111 (May 14, 2013). *See also*, Office of Mgmt. & Budget, Exec. Office of the President, *Digital Government: Building a 21st Century Platform to Better Serve the American People* (May 23, 2012) available at http://www.whitehouse.gov/sites/default/files/omb/egov/digital-government/digital-government-strategy.pdf.

[11] Sylvia M. Burwell, *et al.*, Memorandum for the Heads of Executive Departments and Agencies, *Open Data Policy—Managing Information as an Asset*, 6 (May 9, 2013) available at http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-13.pdf.

[12] Cass R. Sunstein, Office of Mgmt. & Budget, Exec. Office of the President, Memorandum for the Heads of Executive Departments and Agencies, *Informing Consumers Through Smart Disclosures*, 2 (Sept. 8, 2011) available at http://www.whitehouse.gov/sites/default/files/omb/inforeg/for-agencies/informing-consumers-through-smart-disclosure.pdf.

[13] *Id*. ("In practice, it is often time-consuming and difficult for consumers to track and analyze the complex information they need to make judgments. Smart disclosure can

Journalists have produced profound news packages using large government datasets. In a piece co-published with *The Washington Post*, *ProPublica* analyzed over four years of Medicare Part D prescription data and found that "some doctors and health professionals across the country prescribe large quantities of drugs that are potentially harmful, disorienting or addictive."[14] Among other things, the piece catalogued instances where elderly patients with dementia were being wrongfully administered drugs that increased their risk of death and cases where Soma was being prescribed—more than 500,000 times in all—to elderly patients despite being on a list of drugs seniors should avoid.[15]

Similarly, the non-profit journalism outlet, *The Center for Public Integrity* select Medicare billing claims data spanning close to ten years to produce its "Cracking the Codes" series.[16] Key findings included: (1) thousands of medical providers billing Medicare at progressively higher rates over time leading to $11 billion in inflated charges; (2) abuse of Medicare billing codes and "upcoding" to charge for more expensive services than what were actually delivered; and (3) an alarming increase in "upcoding" in hospital emergency rooms where hospitals set their own rules for outpatient billing (with little oversight by Medicare).[17]

The Seattle Times won a 2012 Pulitzer Prize for its series, "Methadone and the

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help consumers to find and use relevant data, including data about the effects of their own past choices and those of others, to make decisions that reflect their individualized needs, and to revise and improve those decisions over time or as new circumstances arise.") *Id.* at 2-3. *See also*, Sunstein, *Disclosure and Simplification as Regulatory Tools*, at 7. ("Full disclosure will frequently involve large amounts of complicated data, and most people may not find it worth their time to seek out and analyze all or most of it. In such cases, the data may be most directly useful to groups and organizations with technical capabilities and with an interest in obtaining, analyzing, and repackaging relevant information. Such groups and organizations may reorganize and disseminate the information in ways that turn out to be highly beneficial to the general public….").

[14] *See* Weber, *supra* note 4, *Medicare Drug Program Fails to Monitor Prescribers, Putting Seniors and Disabled at Risk.*

[15] *See id.*

[16] *See* Fred Schulte & David Donald, *Cracking the Codes: How Doctors and Hospitals Have Collected Billions in Questionable Medicare Fees*, THE CENTER FOR PUBLIC INTEGRITY, Sept. 15, 2012 available at http://www.publicintegrity.org/2012/09/15/10810/how-doctors-and-hospitals-have-collected-billions-questionable-medicare-fees.

[17] *See id.*

Politics of Pain."[18] *The Times* used state health datasets, death certificates, census data and mapping software to expose state-subsidized health practices that, for cost-saving reasons, prescribed the sometimes deadly pain drug Methadone to patients.[19] The investigation used the data to establish a link between methadone deaths and poverty and in the series' wake state health officials reversed course and advised that methadone should only be administered as a last resort.[20]

Finally, a 2010 multi-part series by the *Las Vegas Sun* examining the quality of hospital care in Las Vegas analyzed more than 2.9 million hospital inpatient visit records for over a decade.[21] Fueled in part by this analysis, the *Sun* uncovered numerous risks and dangers patients faced upon admission to specific Las Vegas hospitals including, for example, hospital-acquired infections and myriad preventable injuries occurring while in a hospital's care. Lawmakers vowed to introduce reform legislation in the aftermath of the series' revelations.[22]

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[18] *See Methadone and the Politics of Pain*, THE SEATTLE TIMES, Apr. 30, 2012 (last updated) available at http://seattletimes.com/flatpages/specialreports/methadone/methadoneandthepoliticsofpain.html. The series included a variety of graphics and interactive maps based on the analyzed data.

[19] *See* Micheal J. Berens, *How We Linked Methadone Deaths to Poverty*, THE SEATTLE TIMES, Dec. 10, 2011 available at http://seattletimes.com/html/localnews/2016987143_silenthow.html.

[20] *See* Michael J. Berens and Ken Armstrong, *'Preferred' Pain Drug Now Called Last Resort*, THE SEATTLE TIMES, Jan. 27, 2012 available at http://seattletimes.com/html/localnews/2017356441_methadone28m.html; Seattle Times Staff, *Seattle Times Methadone Investigation Wins Pulitzer Prize*, THE SEATTLE TIMES, Apr. 16, 2012 available at http://seattletimes.com/html/localnews/2017994882_pulitzer17m.html.

[21] *See Do No Harm: Hospital Care in Las Vegas*, LAS VEGAS SUN available at http://www.lasvegassun.com/hospital-care/; *A Breakthrough in Medical Transparency*, LAS VEGAS SUN, June 27, 2010 available at http://www.lasvegassun.com/news/2010/jun/27/complete-guide-vegas-health-care/. Like the *Seattle Times'* Methadone package, this series also included a wealth of interactive maps and informational graphics utilizing the analyzed data.

[22] *See Overview of the Sun's Series on Health Care*, LAS VEGAS SUN, Nov. 14, 2010 available at http://www.lasvegassun.com/news/2010/nov/14/overview-suns-series-health-care/.

While data-driven reporting is certainly not limited to the health care sphere,[23] the above examples demonstrate how CAR uses bulk data to tell compelling stories and in many cases effect positive change. But it is only through CAR that such reporting can be realistically accomplished and for this reason, CMS physician data needs to be disclosed in open, machine readable formats.

Complete Proactive Disclosure on the Internet

CMS should also adopt a policy of non-discriminatory, proactive disclosure on a dedicated department website. This would best ensure that the public has quick and easy access to CMS physician data without having to engage in the often delayed process of making a formal request under FOIA. As noted in the numerous administration information policy announcements, timely access to information and proactive dissemination are both markers of transparent government and open data policy.[24]

Given the immense public interest in CMS physician data and the size of the data sets, they are well-suited for online, proactive disclosure. If ultimately determined to be public, CMS physician data would likely be the subject of ongoing FOIA requests from journalists, health care policy advocates, private industry and otherwise interested members of the public. Placing this information online would unburden HHS from having to respond to continual requests that increase processing backlogs and costs. At the same time, it would relieve requesters from having to wait their turn in a FOIA

[23] *See, e.g.*, INN Staff, *Aviation Database Reveals Frequent Safety Problems at Airports*, INVESTIGATIVE NEWS NETWORK, Feb. 17, 2011 available at http://investigativenewsnetwork.org/2011/02/aviation-database-reveals-frequent-safety-problems-at-airports/; Jennifer LaFleur, *et al.*, *Recovery Tracker: How Much Stimulus Funding is Going to Your County?*, PROPUBLICA, Oct. 1, 2012 (last updated) available at http://projects.propublica.org/recovery/.

[24] *See* Orszag, *Open Government Directive*, at 2 ("Timely publication of information is an essential component of transparency. Delays should not be viewed as an inevitable and insurmountable consequence of high demand.") ("Agencies shall respect the presumption of openness by publishing information online (in addition to any other planned or mandated publication methods) [and] [t]o the extent practical and subject to valid restrictions, agencies should proactively use modern technology to disseminate useful information, rather than waiting for specific requests under FOIA."); Sunstein, *Informing Consumers Through Smart Disclosure*, at 5. ("Smart disclosure should generally make information as accessible as possible to the consumer, which ordinarily means that such information should be made available on the Internet…."); Sunstein, *Disclosure and Simplification as Regulatory Tools*, at 6 ("Disclosed information should be as accessible as possible. For that reason, the Internet should ordinarily be used as a means of disclosing information, to the extent feasible and consistent with law.").

request processing queue in which it often takes considerably longer than the 20-day statutory deadline to complete a request. Even assuming the data could be retrieved and released with relative ease, a "first-in, first-out" processing queue means unnecessary delay for requesters for information pre-determined to be public.

Such a policy would also be consistent with FOIA's mandate that frequently requested records be proactively disclosed.[25] Moreover, allowing public access without restriction based on intended use or requester identity comports with FOIA's maxims that "a release to one is a release to all" and that the identity of a requester is immaterial when considering whether to disclose a record. Indeed, given the power of CAR tools, crowd ingenuity and the yet unknown ways in which such data could be used to innovate and inform the public, executive policy requires CMS physician data to be accessible online and in the whole to all interested parties.

Crowdsourcing Requires Unrestricted, Open Data

A final consideration in determining how best to promote transparency, facilitate public understanding of HHS operations and provide oversight is to allow large data sets to be "crowdsourced." As the administration's information policy mandates acknowledge, releasing bulk data to the public at large leverages collective power and insight in ways that can produce otherwise unachievable results. Due to its unprecedented power and reach, journalism outlets are beginning to experiment with various types of crowdsourcing to facilitate newsgathering and dissemination.[26] One such crowdsourcing method is to engage the public to help analyze large data sets, and CMS physician data is the exact kind of information that lends itself to such collaborative journalism.

One of the more notable examples of this was *ProPublica's* "Free the Files" initiative where it looked to the crowd to help retrieve, analyze and compile reported data from local television stations regarding 2012 political advertisement spending.[27] Almost

[25] 5 U.S.C. § 552(a)(2)(D) states that agencies must make available for inspection and copying "copies of all records, regardless of form or format, which have been released to any person [pursuant to a FOIA request] and which, because of the nature of their subject matter, the agency determines have become or are likely to become the subject of subsequent requests for substantially the same records…."

[26] For a more detailed description of how journalists can use crowdsourcing to aid news production see Johanna Vehkoo, *Crowdsourcing in Investigative Journalism*, Reuters Institute for the Study of Journalism (Aug. 2013) available at https://reutersinstitute.politics.ox.ac.uk/fileadmin/documents/Publications/fellows__papers/2009-2010/Crowdsourcing_in_Investigative_Journalism.pdf.

[27] *See Free the Files*, PROPUBLICA available at http://www.propublica.org/series/free-the-

1,000 members of the public participated in helping *ProPublica* track spending data to create a public database detailing more than $1 billion in advertisement spending.[28] Among other things, the effort uncovered a number of "dark money" funding sources that obscured donation sources and supposed "grassroots" organizations funded by large electric companies.[29]

Other noted projects include the 2011 efforts by *The New York Times* and *The Washington Post* that called on the public to help crowdsource nearly 25,000 pages of released Sarah Palin public record e-mails.[30] Additionally, in 2009, the British national daily, *The Guardian*, enlisted the aid of its readers to analyze and publish a comprehensive list detailing many interesting—and often questionable—expenses claimed by Members of Parliament.[31]

As CAR techniques and collaborative journalism efforts become ever more present, it is critical that government provide data in formats and by means that enable large amounts of data to be digested and presented to the public in an informative way. As the Obama administration recognizes, third-parties such as the media are critical sources of such information and are particularly equipped to help the public better understand and make informed decisions extracted from complex data. Therefore, CMS data should be posted online proactively in open data formats.

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files.

[28] *See* Amanda Zamora, *Crowdsourcing Campaign Spending: What We Learned from Free the Files*, PROPUBLICA, Dec. 12, 2012 available at http://www.propublica.org/article/crowdsourcing-campaign-spending-what-we-learned-from-free-the-files.

[29] *See* Theodoric Meyer, *What We Learned from Free the Files—and How to Make it Better*, PROPUBLICA, Nov. 14, 2012 available at http://www.propublica.org/article/what-we-learned-from-free-the-files-and-how-to-make-it-better.

[30] *See* Derek Willis, *Help Us Review the Sarah Palin E-Mail Records*, N.Y. TIMES, June 9, 2011 available at http://thecaucus.blogs.nytimes.com/2011/06/09/help-us-investigate-the-sarah-palin-e-mail-records/; Ryan Kellett, *Read the Palin E-mails*, WASHINGTON POST, June 9, 2011 available at http://www.washingtonpost.com/blogs/the-fix/post/help-analyze-the-palin-emails/2011/06/08/AGZAaHNH_blog.html.

[31] *See MPs' Expenses–What You've Discovered*, THE GUARDIAN, Dec. 16, 2009 available at http://www.theguardian.com/politics/2009/dec/16/mps-expenses-what-we-learned.

Question 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)

Data granularity is yet another focal point of the Obama administration's open data initiative and given the powerful statistical analysis CAR allows for, it is critical that the public have access to as many unique data fields as possible that do not directly identify individual patients. The administration has made clear that open data means complete data "with the finest possible level of granularity" including "robust, granular metadata (i.e., fields or elements that describe data), thorough documentation of data elements, data dictionaries, and, if applicable, additional descriptions of the purpose of the collection, the population of interest, the characteristics of the sample, and the method of data collection."[32]

Moreover, the administration has also recognized the limitations inherent in using aggregated, summary data to achieve a more transparent government and providing the means to unlock information living within complex data sets. Noting that "summary disclosure" may be more appropriate for consumers at the "point of decision," the administration has issued a preference for "full disclosure" as the "best method" for encouraging detailed analysis and information dissemination in creative ways that inform public and private decisions.[33]

Access to line item claim details is critical as it enables CAR journalists to track, analyze and cross-reference data across multiple fields. The non-profit investigative reporting outlet *California Watch* would likely never have been able to produce its multi-part series on questionable hospital chain billing procedures, including highly irregular Medicare billings, had it not had access to individual line item billing entries that contained exact per treatment billing and diagnosis codes.[34] Similarly, *ProPublica* would likely not have been able to produce such exact reporting on Medicare Part D prescription data had it received aggregated information that untethered patient age data from

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[32] Burwell, *et al.*, Memorandum for the Heads of Executive Departments and Agencies, *Open Data Policy—Managing Information as an Asset*, at 5.

[33] *See* Sunstein, *Disclosure and Simplification as Regulatory Tools*, at 8. (noting also that "full information" should be made available on the Internet).

[34] *See Decoding Prime*, CALIFORNIA WATCH available at http://californiawatch.org/prime; Lance Williams, *Hospital Chain, Already Under Scrutiny, Reports High Malnutrition Rates*, CALIFORNIA WATCH, Feb. 19, 2011 available at http://californiawatch.org/health-and-welfare/hospital-chain-already-under-scrutiny-reports-high-malnutrition-rates-8786. A related interactive chart detailing unusually high diagnosis rates for relatively rare conditions is available at http://static.apps.cironline.org/prime-health-care/.

prescription types and frequencies.

Internal granular data collection and analysis even helped the Cleveland Clinic identify excessive costs and make its doctors more cost conscious when directing treatment.[35] While not sacrificing prudent care for cost savings, doctors were tasked with breaking down the exact costs of their top three procedures in detail. They were asked for example "to record the price of sutures, count how many instruments were on the table, tag the devices on the shelf and record how long patients spent in post-anesthesia care."[36] By analyzing this kind of data, the Clinic was able to pinpoint where excessive and unnecessary costs were being incurred, ultimately saving more than $155 million dollars over three years.[37] While this was purely a private effort, it illustrates why granular detail is needed when seeking to fully understand a process or situation. Had doctors been given more general orders to aggregate or summarize data, the exact factors driving higher costs may never have been identified.

The need for access to granular data when analyzing complex issues with multiple variables is self-evident and consistent with the administration's view on why such data should be released in its most complete form. CMS physician data should therefore also be released in granular form if it is to serve the interests of transparency and oversight of the federal health administration system.

We appreciate the opportunity to comment on this important issue for health care transparency and hope you consider our recommendations. If you have any questions or need additional information, please do not hesitate to contact us.

Sincerely,

The Reporters Committee for Freedom of the Press
Bruce D. Brown, Executive Director, bbrown@rcfp.org
Mark R. Caramanica, FOI Director, mcaramanica@rcfp.org
American Society of News Editors
The Associated Press
Bloomberg L.P.
The Center for Public Integrity
The Daily Beast Company LLC

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[35] *See* Dr. Toby Cosgrove, *The Kindest Cut: How One Hospital Lowered Costs by Making Doctors More Budget Conscious*, TIME, Feb. 20, 2013 available at http://healthland.time.com/2013/02/20/the-kindest-cut-how-one-hospital-lowered-costs-by-making-doctors-more-budget-conscious/.

[36] *Id.*

[37] *See id.*

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NBCUniversal Media, LLC
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Online News Association
Radio Television Digital News Association
Reuters America LLC
Society of Professional Journalists
Tribune Company
The Washington Post

RowdMap

9.2.13

Public Comment on the Potential Release of Medicare Physician Data

The following is a response to the August 6th, 2013 CMS request for public comment on the potential release of Medicare physicians data.

The public would be well served if CMS were to release, at a minimum, aggregated data at the individual provider level and corresponding interpreted information (second-order facts, benchmarks, indices, etc.) in addition to the data.

As the health care paradigm in the U.S. moves from fee-for-service to performance-based interactions and compensation, the nature of the data and information needed to effectively interpret meaningful trends and act on them to achieve measurable and significant outcomes will also change.

CMS has been groundbreaking in empowering this transformation by releasing data, and by transforming the data into meaningful information for all parties attempting to improve member and patient care and experience, and mitigate unwarranted cost, expense and fraud.

An analogous example that could inform this discussion was the wildly successful release of hospital level data and corresponding benchmarks such as Medicare Spending per Patient and Excess Readmission Ratios by major clinical conditions (Pneum, HF, AMI, etc.).

This type of information, in additional to the underlying data, increases that data's utility for the public and renders it more readily applicable for a broader base of users. Such an approach provides not only the materials but the contexts necessary to determine complex correlation and even causality throughout the delivery topography. Further, it enables its users to undertake tactical and actionable interventions to improve efficiency, quality and costs for all participants in the health care ecosystem.

Joshua Rosenthal, PhD
Co-Founder & Chief Scientific Officer
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Robert Wood Johnson Foundation

September 6, 2013

Marilyn Tavenner
Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201
Attention: Physician Data Comments
Submitted electronically to: Physician_Data_Comments@cms.hhs.gov

Dear Ms. Tavenner:

The Robert Wood Johnson Foundation (RWJF) respectfully submits these comments in response to the Centers for Medicare and Medicaid (CMS) request for input on the appropriate policies concerning the release of physician payment data. As you know, RWJF is 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.

Our main message is this: 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, and others need timely, accurate, helpful and comprehensive information on cost and quality to make smart decisions that will help the nation achieve high value care. Alternatively, without that information, we will not achieve the goal of maximizing value in health care. Below, please find RWJF's response to the CMS questions published on August 6, 2013.

CMS Question 1: How to Weigh the Balance between Public Interest in Disclosure and Provider Interest in Privacy?

Through Aligning Forces, the Beacon communities, Chartered Value Exchanges and other funding initiatives, we know that measurement and reporting on provider performance and payment is critical to improving health care quality and reducing cost nationwide. The number of States, regional collaboratives, hospitals, providers and health plans that are part of health care public reporting

programs in this country is growing. However, in most cases, the data are currently incomplete because they do not include all public and private payers. This incompleteness restricts the impact that these efforts toward greater transparency can make toward the goal of getting more value for our health care dollars. The release of Medicare payment data will significantly expand the comprehensiveness and reliability of available data, thereby intensifying the current benefits of measurement and reporting efforts. A fully transparent health care system is key to optimizing value because it:

- ✓ Empowers and activates consumers to make educated choices about their care, to better understand cost and quality differences across providers, and to work with their doctors to get the best health outcomes.
- ✓ Allows all providers on a health care team to identify areas for quality improvement. For example, an Aligning Forces study of 567 health care practices in Wisconsin provided evidence that public reporting of several ambulatory care measures was associated with improved performance.[1]
- ✓ Gives payers better tools to understand and improve the value of the care they are paying for, such as pay for performance programs, value-based insurance design, and other provider incentive programs. It also helps payers to identify outliers, and to intercede where prices are unnecessarily high.
- ✓ Helps identify areas of waste, fraud and abuse. The Institute of Medicine attributes approximately $105 billion in wasted health care spending to avoidable price variation across providers.[2]
- ✓ Supports stakeholder efforts to better understand and address disparities in health care cost, quality and outcomes

CMS has the ability to put the necessary protections in place to address physician privacy concerns while at the same time growing the strength of the health information enterprise that will enable a fully transparent health care system. CMS should consider doing specific outreach to providers to address their concerns about privacy. RWJF and its partners have learned through Aligning Forces and other public reporting initiatives that stakeholder engagement is critical to the success of public reporting efforts. Physician buy-in is especially important. Aligning Forces alliances ensure that physicians participate in each phase of a reporting initiative. In fact, one common practice for the alliances is to develop private reports for physicians, medical group administrators, and clinic managers so they can ensure the data are accurate before they are publicly reported.

CMS Question 2- What specific policies should CMS consider to further the goals of improving the quality and value of health care, enhancing access and availability of CMS data, increasing transparency in government and reducing fraud, waste and abuse within CMS programs?

- Minimize barriers to data usage and access. CMS should work to get Medicare payment data into the hands of entities that are reasonably experienced with handling data and will partner with CMS in the common goal of achieving high value care in the public and private sectors. Once CMS puts these payment 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. As such, CMS might consider reforming the qualified entity program to facilitate wider participation and to foster better data sharing.

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[1] See http://www.wchq.org/measures/initiatives/impact_study.php. Accessed on August 22, 2013.

[2] *The Healthcare Imperative: Lowering Costs and Improving Outcomes*–Workshop Series Summary. Washington: Institute of Medicine, February 2011, www.iom.edu/reports/2011/the-healthcare-imperative-lowering-costs-and-improving-outcomes.aspx (accessed August 28, 2013).

- Promote the growth of our regional health information infrastructure. Local multi-stakeholder organizations, such as regional alliances, some of which participate in Aligning Forces, are well-positioned to receive and share Medicare physician payment and other data because of their potential to provide innovative lessons that can be replicated elsewhere. They are equipped with analytic capacity, vast experience with public reporting, multistakeholder governance, stable business models, and the ability to provide neutral access to information which governments, consumers, providers and payers can trust. They will be able to use the data to help providers and payers develop and execute successful payment reforms through data analytics, measurement, quality improvement and other technical assistance but may need additional resources to contribute their maximum potential to quality improvement and cost reduction efforts.
- Encourage innovative uses of the information. These payment data used for publicly reported metrics have tremendous potential to drive high value oriented innovations and the release should promote innovative use of the data. For example, CMS might consider partnering with other organizations (such as RWJF) in sponsoring a data challenge, which rewards people for using the data in innovative and useful ways.
- Maximize transparency. These data will only be helpful if they are shared and used widely by key health care decision-makers. The release should promote maximal health care information transparency. CMS might also consider leveraging the release of Medicare payment data to encourage other efforts toward increasing transparency, such as providing incentives to States or other entities to develop all payer claims databases.
- Be timely. In order for decision makers to use these payment 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 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 allies who are similarly working toward those ends.
- Empower consumers. Consumers and patients are the end users of our health care system and can play a critical role in improving the value of health care delivered, as long as they are given adequate tools to do so. They need to be equipped with sufficient information to make good choices about their treatment and about their providers. Consumers also need to be encouraged to use this information to ensure they are given valuable care. Aligning Forces has developed multiple resources demonstrating how employers, plans, and purchasers, like CMS, might strengthen reporting efforts to encourage consumer use of the information. Some ideas for engaging consumers include providing them with specific financial incentives, investing in specific consumer training activities, and presenting information in a clear and meaningful way.

CMS Question 3- In what form should CMS release these data?

Stakeholders need access to detailed information about the performance of both individual health professionals as well as groups of professionals to understand how to improve the cost and quality of care. CMS should make every effort to release physician payment information at its most granular level. By that we mean that CMS should release this information not only at the group level but also at the individual physician level. This type of information will be instrumental in helping those payers, providers, and other stakeholders interested in improving the value of our health care system to develop a comprehensive appreciation for precisely how to do that. We strongly encourage CMS to provide as much information to the public as possible to help all of us understand the full context of the physician practice patterns

Thank you very much for this opportunity to comment. We believe that the comments submitted in response to your request will inform a robust and timely discussion around this important issue and respectfully request that you make all of the comments public. In the spirit of transparency, we will release our comments after submitting them to you, as we routinely do.

Also, we would be happy to help CMS by synthesizing the comments to help identify the most common themes and/or disseminating the comments to the public. Please be in touch with Tara Oakman, Program Officer, at (609) 627-6255 if you have any comments or questions or to follow up on our offer of assistance. We appreciate your leadership in fostering greater transparency in our health care system.

Sincerely,

[redacted]

Risa Lavizzo-Mourey, M.D., M.B.A.
President and CEO
Robert Wood Johnson Foundation

To Whom It May Concern:

Service Employees International Union (SEIU) represents healthcare workers, and is also a purchaser of healthcare services. As such, we conduct analyses of claims data in order to comment on regulations, conduct quality and access to care research projects, and conduct statistical analysis for public reporting and to inform public policy making.

I am writing on behalf of SEIU in support of release of physician claims data. Because physicians order and determine the medical necessity for services, this information is essential to understanding the issues of cost, quality and access as they impact Medicare beneficiaries.

1) It is our belief that the public interest in disclosure of Medicare payment information, including physician-identifiable reimbursement data, outweighs physician privacy interests. Specifically, public dollars fund these services, and the public has a right to know this information.
2) Medicare should consider making physician claim data widely available. It ought to be released to researchers at the individual claim level, and to the broader public in some aggregate form.
3) Specifically, CMS should release 100% of the carrier file, with physician NPI unencrypted, and including date of service. Additionally, CMS should release the various Limited Data Set Standard Analytic Files, LDS MedPAR files, and LDS OPPS files with physician NPI unencrypted.

As the Principal Investigator on many research projects utilizing Medicare claims data, state Medicaid claims data, and state administrative data sets, I have found the lack of physician identifiers in the Medicare claims data a barrier to fully understanding physician practice patterns. For example, our initial research has indicated that the type of treating physician in the Emergency Department (specialist vs. “generalist”) may influence the type of treatment that patients receive. We have been unable to fully test this theory, as without the NPI, we are unable to link to state licensing records to determine Board certifications for treating physicians.

Additionally, the limitation of the carrier file to a 5% sample limits the ability to analyze physician practice patterns at the individual physician level. That is because it is a random, 5% sample of beneficiaries, not of physicians. For this reason, the carrier file obscures variations in the physician practices that determine the cost, quality and type of care that Medicare beneficiaries receive.

Thank you for your consideration.

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Cecelia Kirkman, MSW, PhD
Research Coordinator, Health Services Division

Service Employees International Union
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UNITEDHEALTH GROUP®

September 5, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attention: Physician Data Comments
Hubert H. Humphrey Building
Office 341D-05
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via http://www.Physician_Data_Comments@cms.hhs.gov

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

Dear Sir or Madam:

UnitedHealth Group is pleased to provide the Department of Health and Human Services, Centers for Medicare & Medicaid Services with our comments regarding the Request for Public Comments on the Potential Release of Medicare Physician Data published in the Federal Register on August 6, 2013.

UnitedHealth Group is dedicated to helping people live healthier lives and making our nation's health care system work better for everyone through two distinct business platforms – UnitedHealthcare, our health benefits business, and Optum, our health services business. Our workforce of 150,000 people is working to modernize the health care system to enhance the consumer experience, improve access, drive quality outcomes, and reduce health care costs. We provide a highly diversified and comprehensive array of health and well-being products to 85 million consumers, 250,000 plan sponsors, and 780,000 care providers. Our core strengths are in care management, health information and technology.

As America's most diversified health and well-being company, UnitedHealthcare not only serves many of the country's most respected employers, we are also the nation's largest Medicare health plan— serving nearly one in five Medicare beneficiaries across all major senior health benefits product categories—supporting underserved communities in 24 states through acute and Long-Term Care Medicaid plans, the Children's Health Insurance Program, and Special Needs Plans, and providing benefits administration and services for approximately 2.9 million active duty and retired military service members and their families in the 21-state TRICARE West Region. Recognized as America's most innovative company in our industry by Fortune magazine for four years in a row, we provide innovative health care solutions to help create a modern health care system that is more accessible, affordable and personalized for all Americans.

Optum employs nearly 45,000 individuals who are working to create a more connected an intelligent health care system through technology solutions, intelligence and decision support tools, health management and interventions, administrative and financial services, and pharmacy solutions. Optum serves approximately 60 million individuals, four out of five U.S. hospitals, 2,400 medical centers, more than 66,000 pharmacies, approximately 400 global life sciences companies, approximately 300 different health plans, and 140 Federal and State Government Agencies. It is this experience that is the basis upon which we offer the following comments.

1. **Do physicians indeed have a "privacy interest" in their Medicare payment data, and if so, how should the CMS balance that privacy interest with public interest in that information?**

The release of detailed physician-identified claims-level payment and clinical data by CMS (subject to appropriate privacy and security considerations) will create substantial public value. Previous releases of data such as the Uniform Hospital Discharge Data Set (UHDDS) and the Health Cost and Utilization Project data sets (HCUP) have rendered tremendous value to researchers, policy makers, care purchasers and patients about hospital quality and cost performance. Indeed, availability of this data may well have contributed to the development of new approaches to purchasing hospital care, helping to ameliorate health care cost trends and substantially reducing hospital-associated morbidity and mortality. The greatest long term benefits will likely come from enabling physicians to better understand how their performance compares to peers and with evidence-based practices, as well as further empowering patients to make informed choices about their health care. With physician identification, linkage to private sector databases with comparable information will be possible, extending the scope of analyses and enhancing the value of released Medicare data.

When physician-identifiable financial information is linked with other physician-level detail about specialty, clinic and hospital relationships, new insights emerge. Drivers of total cost and health care quality – including the role of specialty, academic relationships, clinic composition, care delivery patterns, and other physician practice factors – become apparent. These insights will lead to identification of new opportunities for impacting the cost and quality of health care in Medicare and for other purchasers and users of health care services.

Physicians have reasonable concerns that their practices will be represented accurately, fairly and appropriately. Methodologies used for risk adjustment and sample size should be transparent. Giving physicians a preview of their data several months prior to public release and providing them an opportunity to comment and re-mediate, where appropriate, may address concerns and provide a path forward toward releasing valuable data.

2. **What specific disclosure policies should CMS consider to improve patient care, lower costs, and otherwise promote the public good?**

CMS's transparency goal should be to reward exemplary provider practices and elevate positive provider performances as much as it highlights fraud and abuse.

CMS should adopt the least restrictive policies regarding release of physician-specific data consistent with protecting patient privacy. It should be noted that researchers and application developers are likely to continually discover new ways of deriving insights and value from the data over time. This innovation effect becomes more likely and fruitful as greater levels of detail are released in the data sets. Standardization of the data must be assured and careful analysis must be undertaken to ensure that the level of detail in released data sets does not risk the privacy of individuals receiving care.

3. **In what form should the CMS release information about individual physician payment (e.g., line-item claim details, aggregated data at the individual physician level)?**

Data should be made available at the claim line level, with appropriate embedded linkages so that the data can be rolled up to a physician level. This approach provides the greatest flexibility to researchers and policy makers to perform analyses that are accurate, insightful, and measureable over time. The data should include:

- Procedure codes

- Diagnosis codes
- Payment information
- Patient counts

Inclusion of service detail such as procedure codes with associated payments will support numerous analyses speaking to efficiency, patterns of care and patient outcomes. Information on the unique count of associated patients will also be important. Diagnoses codes, provided in a manner consistent with patient privacy considerations, will extend findings to the disease level and understanding of the impact of co-occurring conditions. Release of data in standard formats analogous to the UHDDS and HCUP data sets will facilitate analyses and reduce likelihood of analytic errors.

Provider quality measurements should be done on the broadest set of data to insure the greatest representation of practice patterns and largest possible sample size. This should extend to both public and private data sets. Uniformity has been cited by providers as being crucial to reducing confusion, administrative cost and inefficiencies to the system. Being able to consider broader administrative and clinical data sets will allow more providers to be eligible for credible performance measurement due to sufficient sample sizing.

Concluding Remarks:

Release of physician-identified claims data can be done in a responsible manner, which addresses physician concerns about privacy, security and misrepresentation of their data. Commercial provider transparency initiatives like UnitedHealth Group's "Premium Designation" program have historically provided physicians with a preview of their data several months before public release, offering physicians a chance to review, comment and remediate, as appropriate. Similar procedures have been used by commercial health care entities for many years to facilitate other provider transparency initiatives.

Detailed Medicare claims data would benefit stakeholders around the health system. Accountable Care Organizations, integrated delivery systems, physician group practices, IPAs, as well as individual physicians, all have interest in Medicare data for identifying opportunities to improve clinical performance and assessing specialty provider quality for patient referrals. The Federal Government will be able to harness the power of researchers and constituents across the health continuum to analyze Medicare provider data and generate new insights and approaches to improve the quality and efficiency of U.S. health care.

Finally, while releasing this data will clearly enable new insights and additional payer-provider collaboration, more importantly it will allow consumers and patients to make more informed health care and health purchasing choices. Individuals will gain transparent access to information that will enable them to become active participants in health decisions rather than bystanders in a siloed system.

Thank you for your thoughtful consideration of our comments. Please do not hesitate to contact me if you have any questions regarding our recommendations.

Sincerely,

[redacted]

Richard J. Migliori, M.D.
Executive Vice President,
UnitedHealth Group

West Health Policy Center
1909 K Street, NW, Suite 730
Washington, DC 20006-1172
www.westhealth.org/policy

September 4, 2013

Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attn: Physician Data Comments
Hubert H. Humphrey Building, Office 341-D
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Public Comments on the Potential Release of Medicare Physician Data

The Gary and Mary West Health Policy Center is pleased to submit comments in response to the Centers for Medicare and Medicaid Services' (CMS) request for public comments on the potential release of Medicare physician payment data. We appreciate this opportunity to offer comments and applaud CMS's commitment to greater data transparency and consideration of input from multiple stakeholders as it works toward incentivizing high quality care and better health at lower costs.

Established in 2011, the Washington, D.C.-based West Health Policy Center is a non-partisan, non-profit organization solely funded by the philanthropic Gary and Mary West Foundation. The West Health Policy Center is unique: it does not join other groups, does not accept outside contributions, does not make political donations, and has no financial interest in the outcome of any policy it explores.

At West Health, our single aim is to lower health care costs while preserving quality and access for patients. We believe that increased transparency is an indispensable part of that conversation. Transparency is needed desperately in health care, both for improvement of the patient experience and to address the rising cost of health care in the United States.

While many refer to this concept as "health care price transparency," we refer to it as "health care transparency," reflecting our position that pricing information alone is necessary but insufficient to achieve meaningful transparency in the health care system. A truly efficient medical marketplace is one that not only promotes price transparency but readily provides information on the capabilities and limitations of health care services. In other words, *value* must be part of any transparency discussion. We offer several comments below in response to the Agency's request for comments on the potential disclosure of physician data.

West Health Policy Center
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www.westhealth.org/policy

General Comments

West Health encourages CMS to release payment data in partnership with physicians and as a tool to drive behavioral change.

The goal of meaningful transparency cannot be accomplished without the leadership of the Centers for Medicare and Medicaid Services (CMS). As the administrator of the largest health programs in the country, CMS is uniquely positioned to lead by example for other payers through a thoughtful approach to introducing meaningful transparency into government health programs.

The release of Medicare physician data carries with it some unique Privacy Act implications because it traces to individual physicians instead of entities. Undoubtedly, CMS will receive numerous comments from groups outlining these valid concerns in more detail; as such, our comments are confined to the potential value of this data to the health care system – value that we believe is so significant as to motivate the planned public release.

The value of the data is twofold. First, as CMS points out in its request for public comments, making this data readily available could help root out fraud and abuse. Estimates regarding the annual amount of taxpayer dollars lost to Medicare fraud vary widely, but have ranged as high as $90 billion.[1] While the government has made some aggressive recoveries – $4.1 billion in 2011 alone – it had to spend significant funds to obtain those recoveries. Release of data could help identify unusual treatment patterns earlier and lead to quicker action and recovery.

Second, the data may be useful from a treatment protocol perspective in order to identify practice patterns. For example, the data could help beneficiaries identify physicians who prescribe accepted preventive measures for specified conditions. In order to have the data serve beneficiaries in this way, however, it must focus on diagnostic codes and patient outcomes. Simply posting online what a given physician earns from Medicare will not be useful in this regard.

As an overarching point, we urge CMS to take into account all of the feedback it receives from practicing physicians. Those who paint all doctors as skeptics or resistant to change simply have not talked to enough doctors. Indeed, physicians are an increasingly active voice in the movement toward greater transparency, but the Agency must consistently engage physicians so that releasing claims data becomes something they participate in with CMS as a trusted partner, rather than something that is forced upon them by a government agency.

[1] "Feds charge 107 with defrauding Medicare of $452M" by Michael Winter, *USA Today* (May 2, 2012).

West Health Policy Center
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The West Health Policy Center is working with other stakeholders to understand and implement those public- and private-sector strategies that can best maximize the beneficial impacts of health care transparency, with public symposia planned for October in San Francisco, CA and November in Washington, D.C. to gather input, advance the discussion, and chart a more transparent future in healthcare.

Conclusion

West Health appreciates the opportunity to offer comments to CMS on this important topic and we look forward to working with the Agency to achieve its transparency goals as part of a broader conversation about improving the delivery, quality, and cost of care in the health care system. We appreciate your consideration and are happy to provide further information. Please feel free to contact me at jmsmith@westhealth.org, should you have any questions or wish to discuss our comments in further detail.

Sincerely,

Joseph Smith, MD, PhD
Chairman and President
Gary and Mary West Health Policy Center

September 5, 2013

Department of Health and Human Services
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

On behalf of the undersigned organizations, we are writing to offer our comments in response to your August 6, 2013 Request for Public Comments on the Potential Release of Medicare Physician Data. We appreciate the opportunity to provide our thoughts and look forward to working with CMS as it formulates policies to promote transparent, innovative, and safe data use and foster the use of health care data to drive innovations that improve our health care system and patient outcomes.

In the proper context, Medicare physician data can provide accurate and meaningful information to patients, physicians, and other stakeholders that can improve quality at the point of care, promote transparency in the system, and drive long-term improvements in how care is delivered at both the provider and system level. As organizations that work directly with the physician community, we know that physicians are hungry for actionable data. Good data is essential to help doctors improve their practices, and in this era of payment reform initiatives, inform physicians on how to move from the current payment model to future models, especially where models ask physicians to assume more clinical and performance risk.

Our organizations support efforts to utilize Medicare data to inform and improve our health care system. As such, our organizations strongly support the Qualified Entity ("QE") program established under Section 10332 of the Affordable Care Act and administered by CMS. In fact, several of our organizations are all-payer claims databases (APCDs) that have become Qualified Entities. We believe the Qualified Entity program has the potential to harness the power of Medicare data to improve the quality of care, empower purchasers of health care services, and drive overall value in our health system. The Qualified Entity program ensures that Medicare data is used responsibly, as entities must be pre-selected by CMS and must demonstrate expertise in a variety of areas, including quality and cost measurement, risk adjustment, combining data from different payers, correcting measurement errors and implementing rigorous data privacy and security policies. As a result of this screening process, Medicare data is going into the hands of responsible organizations with the proper tools to turn raw data into data that is useful for providers, patients, and other stakeholders.

Again, we support efforts to utilize Medicare physician data to inform and improve our health care system, and we offer the following comments in response to CMS' specific questions:

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**

- *Physicians have legitimate interests in information concerning payments they receive from Medicare, and any such information released should be accurate and not misleading to the public*

Indeed, we believe that physicians have a strong and legitimate interest in information concerning payments they receive from Medicare. Inaccurate data, e.g., where there are mistakes in the data itself or errors in patient attribution, could harm a physician's practice and livelihood and could also mislead patients. In releasing payment data, CMS therefore should put in place a process whereby physicians are allowed an opportunity to review the information that will be released and make any necessary corrections.

As Jonathan Blum noted in his recent testimony before the Senate Finance Committee, raw data on physician payments might be misleading to an individual without the proper context or analytic tools to really understand what the data means. CMS should therefore take steps to ensure that the release of data does not mislead the public into making inappropriate and potentially harmful health care treatment decisions. Specifically, CMS should release data along with appropriate disclosures and explanations as to what the data represents, and that various factors, such as geographic location, overhead, demographics, and patient characteristics can impact the cost of a service. Further, if CMS will not be presenting quality information along with the cost information, CMS should clearly present the data in a context that raises the importance of considering quality in decisions about providers, treatments, and health care services.

We believe that the release of data to Qualified Entities adequately protects physicians' interest in the privacy and accuracy of their information. The QE program has built-in safeguards to ensure the accuracy of physician payment and information and place the information in the proper context such that it is useful to both physicians and purchasers of health care services. For instance, reports must include an understandable description of the measures used to evaluate performance, risk adjustment methods, physician attribution methods, and data specifications and limitations, and QEs must give providers the opportunity to review and correct information prior to publication. These safeguards appropriately protect physician' legitimate interests in their payment information. QEs are also required to have in place rigorous privacy and security standards to protect patient privacy.

- *Patients also have a privacy interest in how their identifiable data is used, and CMS must ensure their privacy is protected.*

In addition to physicians' privacy interests, patient privacy must also be protected. It is therefore critical for CMS to insure that for any claims data released, there are adequate safeguards in place to protect patient privacy. CMS should be careful that all release of data is HIPAA compliant, and that patient data cannot be re-identified through any data release. Data released through the QE program protects privacy interests, as QEs must comply with the data requirements in their data use agreements with CMS, and are required to maintain privacy and security protocols throughout the duration of their agreement.

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

We believe that CMS should release payment data in a manner that allows providers to better understand and improve how they deliver care with an eye toward improving value for patients and that is useful to patients and payers to help them make informed, value-based purchasing decisions.

- *CMS should release data in a manner that furthers its goal of improving the quality and value of care, and we support an expansion of the QE program to achieve this goal*

Quality, we believe, is an essential component of value and therefore CMS to the extent possible should ensure that any data released is useful for purposes of ascertaining not just the cost but also the quality of services. Data disclosed through the QE program achieves this goal. QEs are sophisticated organizations with experience in analyzing claims data and applying quality metrics, and are expected to evaluate the performance of providers of services and suppliers on measures of not just cost, but also quality, efficiency, effectiveness. QEs are currently charged with generating and releasing public reports on provider performance, using measures approved by consensus-based entities, combining Medicare data with other claims data, and making data used available to providers and suppliers.

While we believe that Section 10332 was an important first step in putting Medicare physician payment data to use for the greater good, it is overly restrictive in terms of how QEs can use, analyze and share the Medicare data they receive. Section 10332 also will not allow a QE to charge downstream users for access to data or analytics derived from Medicare data. These restrictions in use and in revenue generation limit the ability of QEs to maximize the utility of their data for patients, purchasers, policymakers and quality improvement, as well as their ability to develop a sustainable business model not entirely dependent on public funds.

To better utilize the QE program as a vehicle through which CMS can release useful Medicare payment data, we propose some of following changes:

1	Allow QEs to provide their subscribers access to Medicare data and run reports that are specific and useful for their organizations. This is a key factor in an APCD's ability to provide useful and actionable information. For example, APCD users can run reports comparing one provider to another on a given quality metric using comprehensive claims information.
2	Permit QEs to work with their statewide stakeholders to define the measures that they will use to compare provider performance for non-public reports (i.e., accessible by subscribers), consistent with nationally approved or endorsed measures or developed through a transparent process. This change would better reflect the fluid and evolving nature of the healthcare delivery system and afford greater flexibility for the incorporation of new measures over time.
3	Permit QEs to charge a fee to subscribers accessing data and reports. QEs are required to pay CMS for access to the data; they also incur costs for integrating and maintaining the data systems to support the analysis. A number of APCDs rely upon subscriber fees to operate. Without allowing these financing models, QEs will be forced to rely on public

	funding, which may or may not be available.

We encourage CMS to the extent possible to build this additional flexibility into the QE program and allow QEs to use data for innovative purposes in addition to the public reports already called for under the statute.

- *CMS should release data in manner that promotes transparency in our health care system and continue to explore ways in which the QE program can be leveraged to achieve this goal*

The undersigned organizations fully support the goal of increasing transparency with regards to how Medicare dollars are spent. We believe that health care consumers – the individuals that seek health care for themselves and their families – as well as payers, should have access to Medicare payment information that allows them to make informed purchasing decisions. We also believe that transparency can only be achieved to the extent that the data exposed is accurate, complete and can be readily understood by the public at large. Further, we believe that any organization that publicly publishes analyses using Medicare data should be transparent in its methodologies, and provide an accurate description of the methodology used to assess the data.

The Qualified Entity program, through the public reporting function, increases the transparency of provider and supplier performance and provides beneficiaries access to information that will help them make more informed decisions about their health care. Importantly, the QE program has built-in safeguards to ensure that the data released to the public is accurate, complete and understandable. First, QEs are required to give providers and suppliers the opportunity to review and correct information prior to publication. Second, for purposes of public reporting, QEs are required to combine Medicare data with claims data from other payers to offer a more complete picture of provider performance. Third, QEs are required to measure performance using standard consensus-based measures, or alternatives approved by the Secretary, and prepare an understandable description of the measures used to evaluate provider performance so that consumers, providers and suppliers, health plans and other stakeholders can more easily assess performance reports. Finally, before even accessing Medicare data, QEs must meet stringent eligibility criteria and demonstrate experience in quality and cost measurement (including, for example, experience in risk-adjustment, attribution methodology, combining claims data), and are subject to CMS oversight. We encourage CMS to continue to explore ways in which the QE program can be used to enhance transparency in the health care marketplace.

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).**

An effective format for the transmission of the CMS Medicare data to organizations can facilitate both the processing of the information by the organizations and consistency in creating valid measures of performance. We recommend a design that reflects the standards employed by most regional health

information organizations, APCDs, data consortiums, and health plans in sharing claims and enrollment data to support aggregation for measurement.

Subject to the considerations discussed above with respect to the need for data that is accurate, complete and understandable to the ultimate user, we consider the following general elements key for the effective transmission of Medicare data to our organizations:

- Medical claims data,[1] including one record per service.
- Institutional claims data, including one record per service for acute care, rehabilitation, SNF and other institutional services.
- Pharmacy claims data, including one record per prescription.
- Enrollment records describing monthly enrollment status for each beneficiary.
- Files that identify each unique provider ID, including NPI, TIN, provider specialty and other relevant information, including name, address, TIN description, etc.
- Files have referential integrity – i.e., provider IDs match across relevant tables and member IDs match across relevant tables.
- Maps and labels – e.g., Look-up tables on all key categorical data elements.

For data transmitted through the QE program, the CMS files contain a robust number of data elements that line up well with the commercial data feeds already coming into the APCD. The Medicare data layouts have more data elements in some areas (provider info) and fewer in others (prescription drug costs). With identifier crosswalks (that are available through QEs), we will be able to assign the unique member identifier that allows alignment of patient records over time and across source of insurance. The current file format includes physician identifiers, which are needed to accurately map patients to practices. CMS should keep the current layouts and should not create aggregated data at the individual physician level. We hope that CMS will be responsive to suggestions about changes as we learn more about the files.

Currently, quarterly Medicare data files are available no sooner than three months after the end of the calendar quarter. The data lag is even more pronounced for Part D claims, where claims data takes 18 months to release. We recognize that CMS/Buccaneer incurs a cost each time a file is created and that CMS must retain prudent controls around data distribution. CMS should consider whether files could be available at earlier intervals with fewer months of run out. CMS could also consider creating an automatic purchase program for the duration of a particular data use agreement.

We appreciate the opportunity to comment on this important matter.

[1] Claims data should include header information that has been distributed appropriately to the individual records. Procedure and diagnosis codes should represent the service performed, the clinical reason for the service and appropriate comorbidities. Precise incurred and paid dates of service and rendering provider ID are assigned to each record. Financial amounts, including allowed amounts, are assigned appropriately to each record.

Sincerely,

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

We believe that CMS should release physician-specific payment information. This information combined with other available data sources can help us all better understand the total cost of healthcare, and get insight into which behaviors are leading to a higher total cost of healthcare. One key to doing this is granularity of data – not just how much was paid, but what exactly was done with a patient (repeated lab tests, multiple procedures, unnecessary procedures, procedures done too early, drugs used to reduce future care cost etc.). We recognize that patient anonymity needs to be fully preserved, but the granularity of the doctor's actions (aggregated across patients or by anonymous patient) is critical to identify the drivers of healthcare costs. Without this insight, the public will only compare cost per action as opposed to the context of all the actions performed. We hope that CMS will release itemized detail about physician activity tied to the context of that activity instead of aggregated physician-level payment data. We also suggest that they provide this detail with a common physician identifier (such as NPI) that allows this dataset to be linked to other data sources easily (such as the data being reported for the Sunshine Act and other healthcare data sources) and reduce confusion when used by consumers. This approach can help present a more complete picture of how physicians deliver healthcare and help all healthcare stakeholders improve quality, reduce costs and increase transparency.

-Pratap Khedkar, Managing Principal at ZS Associates

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Individual Comments

Comment 1

CMS,

Thank you very much for offering public input on such an important matter as physician reimbursement publication.

1. If physicians want to accept money from Medicare, then how much they're reimbursed should be publicly published. If you are willing to take taxpayer money, then the taxpayers get to know how much you're getting reimbursed.

2. In truth, physicians should be held responsible for the quality of care they provide for the reimbursement amount they receive. For example, CMS should hold physicians who provide high cost services such as spine surgeries responsible for the outcome of their surgery. Did the spine surgeon have the patient seek preventative care prior to surgery? I don't mean 6 weeks of physical therapy 2 times a week. Herniated discs take months to heal. Did the surgeon try everything he/she could before performing the surgery? What are the types and complication rates for a physician, how long are this physicians patients in the hospital for, what are the different types of procedures he performs, how often do his patients return to the hospital? These are the types of things which will help patients pick a good surgeon. Right now we are in the dark going off Yelp reviews. Please help us make choices in important decisions such as which surgeon to pick for a life changing surgery. If I know a certain surgeon gets paid X for a procedure he is going to perform on me, then I'm going to hold him responsible for delivering a service which holds up to that dollar amount. If I know a certain surgeon is better at a certain procedure, then I will go to him instead of the guy next door who performs the same procedure but isn't as good. Help us by providing us data!

If I have surgery done by my surgeon I want to see who else was in that room with him and why. Did he bring in an extra surgeon? If so, who and how much did that person get paid? If I don't know this information, how can I question what is happening to me and my tax dollars? The more information we have, the more we can hold our providers responsible for the type and quality of care they provide. Surgeons are also less likely to commit fraud if they know their data is publicly available. This is long overdue for surgeons. My spine surgeon has a few high end cars such as a Bentley, and Ferrari and those are only the ones I've seen. Should physicians who accept tax payer money be paid this much on based on other people's misery? Help us by making their data public!

3. CMS should release summary and line item data. This is the way the world works for everything else. We are purchasing a service, why shouldn't I know what exactly it is I'm paying for? CMS should show a summary of how much money a surgeon has been paid on a year by year basis. If it is the current year, then I want to know what they got paid in Medicare reimbursements year to date. Like I said above, I

want to know how many times a surgeon operates with another surgeon, on which cases does he do that for, who that other surgeon is, and what they both got paid by summary and line item. None of this information should be a secret! It's taxpayer money and taxpayers should know what these high priced physicians are getting paid for the services they provide.

Comment 2

To whom it may concern,

As a Medicare physician, I would like to express my feelings regarding CMS' consideration of releasing physician-identifiable Medicare payment data (http://downloads.cms.gov/files/Request-for-Public-Comment-rePhysician-Data-8-6-2013.pdf). I certainly would view this move as a violation of my privacy. While I agree that the data is useful on some level, I believe that open public disclosure of such information is more likely to lead to misuse and abuse. CMS lists some factors influencing its decision to consider release of such information:

•Public interest in the information has increased given the substantial growth in size of Medicare since 1979, both in terms of total cost per year and as a portion of the federal budget;

The data associated with any one individual physician should hardly influence anyone's impression of Medicare as a whole. Higher level data which does not identify individual practices and physicians serves the purpose of analyzing the health care system and the changes within it affecting overall Medicare spending.

• Changes in the Medicare reimbursement system that have resulted in greater standardization of payment amounts for physician services;

I'm not sure why this should influence the decision to identify physicians specifically. If the point is that it would not influence physician pricing of services, since regional service reimbursements are the same, I think it would still influence physician billing activity. I would suggest that physicians themselves would use the data in ways that would increase overall spending, which is perhaps an unforeseen and presumably unwelcome consequence. For example, physicians in a specific area with high levels of billing, such as a high rate of level 4 exam codes relative to the mean, are not likely to regress to the mean. Practices that particularly stand out in the data are likely already subject to audits on a routine enough basis that there practices are either modified or justified. Physicians below the mean, on the other hand, are more likely to strive to approach the mean in response to learning the billing practices of their colleagues. The overall effect over time would likely be increased billing.

• The creation of the Qualified Entity program (known as Medicare data sharing for performance reporting), authorized by Section 10332 of the Affordable Care Act, which allows CMS to disclose Medicare claims data to qualified entities for the production of public performance reports;

I agree that quality care initiatives and physician performance evaluations may be very valuable, but physician quality is not likely to be accurately reflected in this data, just physician reimbursement. This targets the cost of the care, not the quality. Cost containment is a worthwhile goal, but misleading information may harm individual physicians unjustifiably. Until more reliable and scientifically valid ways of assessing quality are developed, individual physician privacy should be protected. Even the PQRS measures I and almost everyone else report are virtually meaningless quality measures affecting an incredibly narrow area of practice, for which the act of voluntarily reporting (as opposed to peforming) has no proven impact on patient outcomes.

• The greater consequences of Medicare fraud, waste, and abuse, which disclosure of payment information could help expose.

I am part of a large subspecialty practice that stands out among our peers in billing and reimbursement. Our practice is audited constantly. We have been subjected to multiple CMS and RAC audits in the past several months alone, with virtually no judgement against us. Our practices are routinely justified in every audit, but they still keep coming. It seems to me, in other words, that CMS is already working diligently with this data to try to pinpoint fraud and abuse. I doubt public disclosure of the same information would be any more productive without the associated clinical data to which CMS has access. Furthermore, such data could still be analyzed by interested parties without physician-identifiable information.

I personally would like my reimbursement data kept private for multiple reasons. I am concerned that patients might gain knowledge of such data. It is unlikely that they would be able to interpret it in any meaningful way, and my overall Medicare reimbursement would likely greatly exaggerate my actual "salary", perhaps several fold. I don't consider it the business of my patients to know such things, and such issues may muddy the patient-physician relationship, which is built in large part on trust. I am concerned that competing physicians would use such data to gauge the health of my practice. I am concerned that referring physicians to a subspecialty practice such as mine might use such data to determine whether they should utilize my services, hire a competing physician, or refer to some "hungrier" colleague. And I am concerned that the press might target me for whatever reason and affect my reputation just because I happen to be a busy practitioner in a field where patient care tends to be expensive, and in which Medicare makes up the vast majority of my patient base.

In summary, I see little reason to sacrifice my personal information in this fashion. CMS' goals may be addressed without identifying individual physicians, and there may be secondary consequences leading to increased overall spending, damage of the physician-patient relationship, and instability of medical practices. Cost containment and quality enhancement are critical initiatives for our healthcare system, but are unlikely to be achieved with such narrow measures.

Comment 3

Comment on “the potential release of Medicare physician data.”

1) The public has right to know what Medicare pays individual doctors for specific procedures. Furthermore, the public has a right to know if the procedures Medicare paid for were beneficial to the patient. The public's right to know this information far out-weighs a doctor's privacy right.

2) Hand out Medicare swipe cards to Medicare patients and Medicare doctors. Place card readers in each exam room. Each time a patient and doctor enters or leaves the exam room they swipe their cards and punch in a procedure code. The information should be made available to the public immediately.

3) A detailed line item account should be publically available for each doctor-patient encounter.

Comment 4

These comments are in support of releasing Medicare Physician Data.

As a consumer, a Medicare beneficiary, and as someone who has spent her entire career in the hospital environment, I know that every service a patient receives, or does not receive, is a product of a physician's decision. Research has demonstrated time and again that those interventions are often personal choice rather than evidence based and with each occasion, the patient is placed at either financial or clinical risk.

Hospitals are simply the storehouse for the services prescribed by physicians. Those services are owned by the hospital on behalf of the community it serves. Physicians are privileged to used those services. But when use of those services are abused, there must be consequences. Regrettably, hospitals are loathe to sanction members of the medical staff for fear of losing patients and regulators are intent to penalize the hospital based on the assumption that the 'hospital' has control over the use of those services. If it were so, then we would have no issues with excessive, non-contributory interventions and perhaps 70,000 deaths each year could be prevented. But in reality the physician-financial landscape still rewards volume: admit more patients, prescribe more interventions, bring in more consultants, and add more unnecessary days to the patient's length of stay.

I don't expect the financial landscape to change for physicians in my life-time - that would take a major cultural upheaval. But unless the physicians have 'skin in the game,' they really have no incentive to use proven medical practices to improve care for their patients; they have no incentive to consider their patient's financial situation before prescribing an inpatient service when a less costly and less risky alternative is available; they have no incentive to talk to their patients about end-of-life choices; and they have no incentive to work with hospital leaders to reduce costs.

Making physician-specific payment data available is a weak, but progressive step in the direction of full medical accountability. Hopefully, it will be followed by other physician-specific data, which is, after all, the key piece of information that we, as consumers, need to make informed choices. How many of a certain procedure has a physician done (not the hospital); what is that physician's complication rate

(not the hospital's rate); how many diagnostics does the physician prescribe when those services are physician-owned versus diagnostics owned by other entities; what is the physician's rate of readmission (not the hospital's); and how many resources does the physician use in the care and treatment of a patient population when compared to his/her peers for the care and treatment of a similar population (eg: Wennberg: Dartmouth Atlas; Rand).

The 1980 policy that the "public interest in the individually identified payment amounts is not sufficient to compel disclosure in view of the privacy interests of the physicians,"

was specious at the time, and irrelevant today. Public interest among us baby boomers is off the chart. Any information that prompts questions to our physicians pushes the envelop for broader provider accountability. I presume that "the privacy interests of the physicians" relates to income reporting. Given that average annual incomes of physicians are routinely reported in the medical and popular press (Medscape, Profiles LLC, et al) I think that argument has lost credibility.

Future HHS/CMS policies should include the use of payment penalties similar to those for hospitals that significantly deviate from expectations.

Physician payment data is of limited value (comparative physician use of hospital resources is much more valuable for cost reduction purposes and to inform the public) but it's a good start. The data should be line itemed so the public can distinguish payment made for hospital care, diagnostic services, and office visits.

Comment 5

I would definitely feel that my personal information was compromised if physician specific Medicare payment information were made available to 3rd parties.

Medicare may be public, but my practice is private.

I would not object to having aggregate information made available.

Comment 6

I strongly oppose the public release of physician specific payment information for Medicare patients. As a subspecialist, I must treat the more difficult and sickest patients. These data have previously been used in private settings to indicate that our costs are higher for managing patients. Well, of course, we are taking care of the sicker patients with the same diagnosis. Colleagues with the same diagnosis and less intensive use of services due to patient's mild illness do not have the same costs. Furthermore, recognizing major negative prognostic factors and treating a milder patient prior to them having more serious and expensive problems also requires more intensive services and enhances quality of life.

As a physician, I see absolutely NO BENEFIT to me or my patients of this data becoming public. Furthermore it result in many comes of intellectual and time-consuming bureaucratic torture. It is an invasion of my privacy. It will lead to less access for the public to my services because I will definitely discriminate against severely affected Federally funded patients for whom my information is being disclosed, as I will limit my services and availability.

I am very likely to give up caring for Medicare patients altogether due to the ongoing invasive Federal bureaucracy. I already did it for Medicaid in the state.

Stop the madness.

Comment 7

1. I do not think that there is a privacy issue with payments to anyone (including doctors) from any government program, this is tax payer money being paid out, we all as tax payers have a right to know how are money is being spent!

2. Whatever is disclosed, it should resemble the information given to Medicare Recipients on their EOB's for the Medcare Claims! It should definitely show the billed amout as well as the actual amount paid by the Medicare Program! This is crucial in showing just how much the providers are writing off when it comes to seeing Medicare Patients.

    a. Definitely would help show the massive cost shift that is required by medical providers to offset the Medicare Reimbursement shortfalls/write off's!

3. Line item claims details would be best!

Comment 8

To The Department of Health and Human Services:

I applaud HHS's release of data in machine-readable form. The release of Medicare Physician Data would be the most revolutionary large-scale physician database that I have yet to see. For example, with the release of claim information, a person who needs a rare surgery can finally search to see which providers have performed that surgery before (at least, which providers have done so for Medicare). Closer to home, the pricing information might have gone a long way earlier this year in helping my family figure out which doctors to approach when someone needed to undergo a specific procedure.

In regards to the questions,

1) It would be the prerogative of any insurer (whether public or private) to release claims data unless they specifically bound themselves with confidentiality agreements. Additionally, considering that

government employee salaries are public information and that government payments to contractors are generally disclosed, withholding Medicare payment data would be an odd exception. The public benefit of releasing Medicare information is immense. First, the sheer volume of data from the nation's largest payer would give the public tremendous insight into health care practices. Second, the release of this data creates a powerful example for private insurers to emulate: empowering their customers with useful information when selecting a provider. Any privacy concerns must be weighed against this potential of catalyzing the next generation of tools that could transform the health care industry for the better.

2) CMS should be as open as possible and release as much information as it legally can without encroaching on patient privacy. To add limitations is to limit the innovative uses of this data. Even seemingly unimportant details such as dates of claims can be used to help the public understand when certain conditions tend to occur, or to help provider institutions better allocate their resources on a seasonal basis. Physicians can also use procedure volume information to make more informed referrals.

3) CMS should release the data in as detailed form as possible (e.g. line item claim details). The data should identify physicians by their National Provider Identifiers, include the date of the procedure, the procedure name and code, the condition for which the procedure was prescribed, and the address where the procedure was performed. Presenting claim-level data is important because it would be helpful, for example, to know which procedures are being applied to which conditions. Observing such relationships can be instrumental in detecting fraud, but presenting the data in aggregate form would obscure such relationships. Researchers and others can aggregate data themselves; they cannot reverse the process, so only releasing aggregate data will limit innovation. Patient privacy can be protected by combining records for specific procedures into one line when there are less than five occurrences for a provider in a given year. It would be helpful for the data to be catalogued by individual calendar years or quarters for ease of downloading.

Although not an immediate priority, it would be helpful for CMS to automatically translate CPT codes to codes from an open code set (e.g. SNOMED). After all, one of the same organizations that lobbied so hard to keep this information private owns the CPT code set and might come up with creative ways of restricting usage of the data.

I am encouraged by the increasing availability of physician information over the last few years, and the release of Medicare Physician Data will greatly advance transparency in health care. Empowered by better information, patients will be able to take the next step in making decisions for a higher-quality and more efficient health care marketplace.

Comment 9

should absolutely not be released and should remain private just like any other health data. it should be an individual choice by the practitioner. It would be safe to assume that litigation would certainly rise

once data is released and would risk leaving physicians as targets for greedy litigators. this would increase the physician departure form the medicare/aid option.

so a resounding NO on releasing the data

Comment 10

Thank you from the bottom of my heart for finally bringing this issue to light. It is long overdue.

1. If you are willing to take money from taxpayers, then what you're taking should be made public. I don't see where the confusion is with this. This has nothing do with privacy at all. They are happy to take our money but don't want us to know what they are taking? This is insane.

2. CMS should make all payments paid to any physician public. If I go to see a physician and pay cash, I know how much I'm paying for his services. Why should this be any different? Why don't I get to know how much my physician gets paid with my tax dollars? If you want to tie payment to quality, then CMS really needs publicly display their outcomes data. I'm not talking about a regular internal medicine physician who treats colds. There are physicians who make top $$, surgeons being in the front of that line. I'd like to see their outcomes data across the different hospitals they have privileges at broken down by hospital and patient satisfaction. If I know what I'm paying, then I know what kind of service to expect in return. Right now if I wanted to have a hip replacement, I would have no idea which Medicare provider is good. How many hip replacements does a certain physician do? How much does he get paid? Is this surgeon all about volume, and I might be just another car payment for him, or is this person a really good doctor? We need information, we're in the dark. Of course making reimbursement data publicly available will help to reduce fraud. People will know what they are paying for and hold their doctor accountable for it.

3. CMS should release summary data and line item data both for office visits and what they got paid for surgeries. Honestly, it takes many, many office visits to amount to one surgery payment so if I had to pick between office visit data and surgery data, I would say please display surgery payment data for surgeons. Unnecessary surgeries are a huge problem and cost tax payers millions of dollars. Displaying physician reimbursement data shouldn't be an issue. Like I said, if you want to take public dollars, then the public gets to know what you get reimbursed.

Thank you.

Comment 11

The healthcare system needs to change and reduce the growth in costs. Doctor behavior and orders are a key drivers in this increase. There have been many examples of doctors, being human beings, act in the best interest of themselves and not the healthcare system. Just look at the usage of services when

physicians have a financial interest in the service provider. Change in the system cannot happen without this data transparency.

Comment 12

As the manager of a moderate size ophthalmology practice in Columbus, Indiana, I have concern that a decision to publish the payment data for the members of our group practice may used by our patients as an additional excuse for not paying their legitimate bills which largely consist of deductibles and co-payments. Many patients already believe that their healthcare should be provided for free. They do not recognize that a physician practice has expenses which take up a considerable portion of the gross income that the business generates. Any publication of that gross income data fuels the patient feeling that payment of their portion of their bills is unnecessary.

Medical practices are bound by law and/or contract to collect those deductibles and co-payments. Adding to the cost of those collection efforts will add to the ultimate cost of providing healthcare. Therefore, the longstanding policy of not releasing specific Individual Physician Payment Data should not changed.

Comment 13

As a non-physician health care consumer, I am opposed to the release of this data. Unless there is some indication together with the data of the costs associated with the individual practice, and some indication of the volume of business, and some indication of the rurality/urbanity of the practice, this data will only be used by those who have bought into the 'consumer driven" model to justify additional cuts to providers.

The so-called 'consumer driven" health care movement is nothing more than a thinly disguised move by the government to cut cost in order to free up dollars to spend in other areas. It is extremely ludicrous to believe that in the long run, lower cost health care is going to be better.

Comment 14

Hello- I feel this information is valuable and that the info would be adequately protected if it was kept to facility or regional payment data vs individual provider data for release to the public

Comment 15

Below are my comments on Physician Data release:

CMS Prompt #1 of 3: 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;

Comment: A physician should have an interest in keeping protected health information private, especially core clinical data of their patient. It should always be a patient's decision on how their data/health is shared. But, as Private Payers request claims data from Providers and their Patients/Members – we the public, should have access to data on where our taxpayer funding is spent. It is in public interest to know what, where, and whom (physicians, groups, etc) we are sending tax dollars. This data may be used for population health mapping and is no less important than data we see publicly reported from the US Census.

CMS Prompt #2 of 3: (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;

Comment: This payment data, coupled with data on quality and other public health metrics, will support the triple aim: improved access, improved quality, and effective cost. Policies that should be considered are the timeliness of the data, data dictionary of the de-identification means of any private health information, and formatting the data into effective modalities that can aide public research.

CMS Prompt # 3 of 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).

Comment: Data should be released in both line-item claim modalities and aggregated data on individual physician levels. Making complete and transparent data available is of importance, making it more difficult to decipher will not support anyone's best interest. I personally like making the data in various publicly accessible data marts like Microsoft Azure.

Comment 16

Hello CMS,

Thank you for asking for input to this privacy question. I support complete transparency of tax spending. So, everyone should be able to see every line item, every implant, and every billable item or minute that a physician or a company is paid by public funds including Medicare and Medicaid. I would extend this to any disability claims and long term care as-well-as inpatient and outpatient billings.

Part of the physician acceptance of these funding sources should be a contractual right to publically post all such data and payments. The same applies to hospitals like the data in the AHRQ H-CUP database. The data could be another form of data managed by AHRQ and released on its H-CUP website and available in aggregate and detail by purchase. IMS and NDC currently sell all retail prescribing data and physicians have not en mas revolted against that or the pharmaceutical companies that purchase it. One has a choice in engaging in a contract and that is their chance for privacy. I seriously doubt that this will cause many physicians to leave these payers and therefore, access should not be impacted.

Thank You

Comment 17

To whom it may concern:

Thank you for the opportunity to comment on how and when the Centers for Medicare and Medicaid Services (CMS) should disclose what individual physicians receive as reimbursement from Medicare.

Obviously, there is a privacy concern on whether physician pay should be disclosed to the public, but there is a greater concern on how the public will interpret physician reimbursements without being given subsequent information on how the reimbursements translate into take home pay. Unfortunately, the later part is not easily collected or disclosed.

As an ophthalmologist in private practice, I can use my practice as an example. If my Medicare reimbursements are close to a $1,000,000, the public could easily think that is how much I have available as take home income. What the public would not realize is that my partner and I employ over 35 employees and have fixed expenses for 3 different offices. My overhead can easily reach over 80% because of the amount of the amount of staff we employee, the advanced diagnostic and treatment modalities we utilize, and the number of Medicaid patients we see. Additionally, my overhead also varies from month to month and year to year based on if we buy new equipment, borrow money, pay off debt, etc. Several ophthalmology practices consistently run at 50% overhead, whereas other high volume practices in urban communities may reach 90%. Even within my own practice, my partner and I have vastly different percentages of overhead. Furthermore, some ophthalmologists, but not all, also receive additional reimbursement from their optical shop, ambulatory surgery centers, refractive surgery, cosmetic surgery, and/or rent collections. None of that information could be summarized or disclosed easily. If there is that much variation in one field of medicine, imagine how much it varies from one specialty (e.g. family medicine) to another (e.g. dermatology).

Further, none of this reflects the amount of student loan debt (often in excess of $200,000) of a physician completing residency or the amount of debt ($200,000 to to >$1,000,000) incurred by a physician starting/acquiring a practice.

If the public is truly interested in knowing how much physicians make in take home pay, this information is already widely public on the web via various surveys and advertisements for job opportunities.

Thank you again for the opportunity to submit comments.

Comment 18

To whom it may concern:

I am a practicing pulmonary and sleep specialist. I am a Medicare provider. I work in a group of 4 physicians. Each of us has a different practice pattern and work ethic. I work more hours in the clinic than any of my partners, and work-at-home interpreting sleep test. It is not unusual for me to work 60-70 hours a week.

Any reporting of physician payment by Medicare that is not qualified by the amount of work performed could be misinterpreted and or inappropriately used by uninformed individuals.

I no longer participate in pharmaceutical meals. I have no way of controlling what is reported by pharmaceutical representatives, other than nonparticipation. Unfortunately you may get the same response from physicians if they feel reimbursement information is inappropriately revealed and or characterized.

Comment 19

To whom this may concern:

I believe that CMS payments to physicians should be made public. However, the data should be presented in a way to maintain the confidentiality of each individual patient. Privacy is important and should be respected but needs to be balanced against the right of taxpayers to see where the money goes.

I believe that public knowledge of the money involved would help increase the tax-paying public's confidence in this government/medical collaboration.

I believe that the public has a right to know (within reason.) I am a healthcare professional and make a decent salary but not great. If someone wanted to make my salary public I would have no problem with it.

Comment 20

I feel that, although one can argue that payment information is appropriate to share, there should be a denominator associated with a payment figure. For instance, if a physician is receiving a very high CMS payment amount, the number of patients that doctor sees should be provided to the public. Those of us with very busy clinical practices should not fear the sharing of this information because it is consistent with what other high volume practices bill and receive. It is the smaller volume practices that bilk or over-bill CMS that should be concerned. The only way that the viewing public will be able to discern one from the other is by providing the absolute number of CMS beneficiaries seen and treated by the doctor. If this denominator is not provided then it will be the large volume, busy practices that will inappropriately be singled out.

Comment 21

Customers have the right to know what a physician gets paid for services provided by the government – US citizens

Since we have to pay the bill privacy has no place in this. There should be a list of CMS charges available on line that could be compared to the bILL sent to patients.

All physician bills should include the amount paid by the govt and the amount due by the patient in clear and understandable language the same language used by CMS to pay the charges.

THAT WAY ANY UPCHARGES BY THE PHYSICIAN CAN BE FULLY COMPARED TO THE ACTUAL CHARGES BY CMS.

Comment 22

The critical point to evaluate would be "same work for same pay," specifically as it pertains to the work done by primary care vs. specialists. As a primary care physician (or generalist) I often perform the exact same work as a specialist, but do I receive the same pay for the same work? From what I understand I do not. All outpatient office visit codes should be of the same value whether generalist or specialist. There is rarely anything that a specialist does in the office (not related to surgical pre- or post-op care) that a well-educated generalist does not also do for their patients.

We need to end any discrimination and over-payment to specialists that exists and the burden of costs on society will be decreased. Don't let lobbying sway what the right decisions are for the country.

Comment 23

In response to the request for comment relative to the release of physician Medicare data, I offer that it is time for the U.S. Federal Government to become transparent rather than constantly the other way around. I would be pleased to see my federal government focusing on society in a manner that produces transparency of what the government is doing with my money, how they are being frugal with my taxpayer dollars, and focus on spending some time at "home" rather than aboard. The government has way too many issues that are much bigger than trying to figure out to display physician Medicare data to individuals surfing the internet!

Comment 24

I find it appalling that the standard of transparency, that is acceptable to other public servants that consume tax revenues, somehow has to be changed for physicians. The data about compensation for public servants is in the public domain... As a consumer of healthcare services, I find myself a pawn with little or no control over the cost or quality of my care. The services are charged based on the direction from a panel of physicians and neither the quality, compensation and performance of the provider is in the public domain. This opaqueness is a slippery slope to an era of substandard care and higher costs, with little or no competitive pressure on the provider.

Comment 25

The disclosure of payments physicians receive should not be disclosed for 2 reasons:

1. Physician privacy

2. Many physicians are employees and payments made to them are received by their employer and not directly paid to the physician.

Physician is paid an hourly wage so it is not a true reflection of what they physician is being paid.

Comment 26

I think Medicare reimbursements should be disclosed on an individual provider basis (NP, PA, MD etc) except in cases where the provider cares for so few Medicare patients that disclosure of such information would potentially violate the patient's privacy.

I believe that the gov't should err on the side of disclosure of information whenever possible such disclosure would certainly help reveal differing practice patterns and potentially root out fraud and abuse.

Comment 27

Comments regarding Physician Data Availability

Approaching this topic from a quality and legitimate transparency perspectives, a data dump of physician payments de-identified by patient has little value to a consumer. It does not speak towards any kind of quality measures. It would identify who sees Medicare patients and who sees the most patients, which is not very helpful.

I do believe CMS could create metrics from the data, such as average frequency of office visits with a beneficiary, average number of hospital visits, or average number of nursing home visits. Since there are no benchmarks for this data, it would only be comparative for consumers. It would only answer the question of who sees patients a lot or little. It would mostly confuse consumers since there is much variability of this based on the patient's condition and physician specialty.

I can see diagnosis data being used for unintended and bad purposes, such as pharmaceutical companies targeting physician marketing based on number of diagnoses for their medication. I could see a patient not going to a clinic because of seeing the diagnosis of HIV being treated at the clinic.

I see little legitimate use for this data being public, so please limit the release of this data.

Comment 28

It's important, in disclosing payments to physicians, that CMS avoid creating the false impression that this is actually personal income – the reality is that it's PRACTICE income, not personal income.

In some practices, actual personal physician income is related to CMS payments, in others, it is not. My own income, for example, is related to my RVUs and to performance on quality measures, not to CMS collections or any other practice income.

Comment 29

No problem.

As long as the transparency includes:

1. Separation of Medicare and Medicaid payments. So the public can SEE who is actually seeing Medicaid patients.

2. Actual NET dollar amounts earned by physician after calculation of that residual after deduction of overhead from gross. So the public can see what we actually earn AFTER expenses. Overhead % to be supplied by physician's CPA.

3. Publication of the total salaries and benefits paid to any local hospital or clinic administrators whose salaries are supported by MCR / MCD funds and who are earning more than $150,000 year in salary and benefits.

4. Publication of the total salaries and benefits paid to all local pharmacists whose salaries are supported by MCR / MCD funds and who are earning more than $150,000 year in salary and benefits.

Go for it.

I DARE you.

I DOUBLE DARE you!!

Comment 30

Do physicians indeed have a "privacy interest" in their Medicare payment data, and if so, how should CMS balance that privacy interest with public interest in that information?

No- it is taxpayers dollars and the public has a right to know how it is spent and to whom.

What specific disclosure policies should CMS consider to improve patient care, lower costs, and otherwise promote the public good?

Readmission rates, office visit rate average per patient, vaccination rates, and other preventative metrics

Comment 31

I appreciate the opportunity to comment on the possibility of Centers for Medicare and Medicaid Services (CMS) disclosing what individual physicians receive as reimbursement from Medicare.

There is a serious privacy concern when an individual physician's pay is disclosed. There is an even greater concern on how the public will interpret physician reimbursements without being given adequate information on how the reimbursements translate into take home pay. Unfortunately, the later part is not easily collected or disclosed.

As an ophthalmologist in private practice, I can use my practice as an example. If my Medicare reimbursements are $500K, then the public could easily think that is how much I have available as take home income. What the public would not realize is that my partner and I have a number of employees. My overhead can reach nearly 60% due to rent, salaries, medicaid/farmworker patients and new equipment acquisition. Furthermore, some ophthalmologists, but not all, also receive additional reimbursement from their optical shop, ambulatory surgery centers, refractive surgery, cosmetic surgery, and/or rent collections. None of that information could be summarized or disclosed easily. Each specialty in medicine will have such additional factors that affect their true take-home income.

Further, none of this reflects the amount of student loan debt (often in excess of $200,000) of a physician completing residency or the amount of debt ($200,000 to to >$1,000,000) incurred by a physician starting/acquiring a practice.

If the public is truly interested in knowing how much physicians make in take home pay, this information is already widely public on the web via various surveys and advertisements for job opportunities. This information about physician salaries is really no secret. It is simply that an individual physician's salary should be their own private information.

Comment 32

Giving the public raw revenue data is counterproductive at the worst and misleading at the best.

If I receive $1000 today from Medicare, and weekday this month that I work, I would get about $22-24,000. "Wow", says the retired teacher who is on Medicare, "that's more than I made in 6 months when I worked," and she would be right. What the data did not show was that my overhead this month was $41,000, So, at best, if I worked every day, I would lose $17,000. Doesn't sound as good.

I would then have to work a few extra shifts in the ER or perhaps open my office at night or on the weekend, and get that Medicare reimbursement up to $41,000. Then she'd think I made as much this month as she made in a year when I would have made a grand total of $0.

So, does anyone really think that would be productive from a societal standpoint? It would be, at the very least, misleading.

If Medicare is willing to take the full picture and allow us to submit our validated overhead, I would love for the public to see how little we make for what we do and how little we are reimbursed. And, it should probably show our amortized cost of training into our 30's before we make a dime in practice.

Also, to make things transparent, each patient's data should be made public on how much they paid into the Medicare system compared to what was paid out for them. THAT would be productive and educational for the public, and then if you take those three things (my revenue, my overhead, and the inquiring person(s) personal contribution and expenditures), we would have a transparent system.

Otherwise what we have is what I suspect the real purpose is – political pressure to pay MD's less for what they do.

Comment 33

If the state and federal government mandate financial payment information to the public, what good will it do for patient care? How will releasing the amount I am paid by Medicare improve diabetes, cancer or heart disease?

If you are going to make these demands on physicians then you should pay them enough to cover the cost of providing the services. Access to care is declining because physicians in my state are starting to not accept anymore medicare patients.

These policies are punitive. The decisions your organization make have repercussions on the individual lives of physicians and the patients they serve.

The sad fact is the number of primary care physicians is declining.

My voice is small but you need to know there are a lot of my peers that are quitting and there is no one there to replace them .

Comment 34

The data needs to have FULL transparency including time spent so the public can differentiate between money given for very little effort or if it is given for substantial work which may be appropriate.

Inclusion of research funds much of which goes to patient care and travel to research meetings should not be included.

Lets have transparency from the companies who should publish all details on how much money they spend on lobbyists, politician meals etc (legal bribery in this country) and also illegal bribery in other countries such as China

Comment 35

Dear CMS--

The CMS wants the public to answer three questions to help it apply transparency to Medicare reimbursement:

- Do physicians indeed have a "privacy interest" in their Medicare payment data, and if so, how should the CMS balance that privacy interest with public interest in that information.

- What specific disclosure policies should CMS consider to improve patient care, lower costs, and otherwise promote the public good?

- In what form should the CMS should release information about individual physician payment (eg, line-item claim details, aggregated data at the individual physician level)?

Here are my responses:

1. I do not believe that physicians have a privacy interest in their Medicare payment data. Physicians operate in the public trust and are free to not accept Medicare patients should they so choose. I believe that physicians should have the same transparency requirements as any government contractor. Furthermore, the benefit of disclosure in terms of fraud and abuse mitigation far outweighs any argument for non-disclosure.

2. I have no specific thoughts on this other than to err on the side of increased disclosure.

3. Data should be aggregated at the MD level, certainly. This means the individual doctor, not just the practice. I don't believe individual claims should be released simply because it would be blizzard of information. Claims should be aggregated into meaningful buckets with, perhaps, a list of the top 25 codes by aggregate dollar value.

Comment 36

As the move towards disclosing CMS payments to physicians continues, it is worth considering what CMS discloses about itself. Who influences CMS policies? How does CMS justify changing policies that directly affect patient care, eg, documentation requirements, pay-for-performance, auditing, and lack of reimbursement for a host of services (on-call care, phone call care, re-fill of prescriptions, lab reviews, changes in insurance or pharmacy benefits that require office admin time.) It is pathetic to see this bureau-crazy prey on the industry that feeds it.

This doesn't even begin to touch the transparency issues of the FDA (how much $ do they get for enforcing minor violations or reviewing the 4th, 5th, 6th or 7th members of the same drug class?) It doesn't begin to touch the pharma industry who negotiate multimillion dollar deals with insurance payors and fight each other with complex co-pay cards that physicians are expected to interface with the patient. It doesn't begin to touch the transparency issues of the insurance companies themselves who speak publicly about their dedication to patient care while hindering payments of the same. CMS is equally non-transparent on this score as well.

Physician payments are a small fraction of the total health care bill these days. Wake up a smell your own hypocrisy. Do you think we don't know WTF is going on? Blind guides. Blow your smoke up your

own assets. You should be making things more simple for doctors, not more bureaucratic. Your "transparency" on this issue will have little effect, good or bad; it is a smoke screen.

PS: As per usual, this message will go unanswered. Why? Because you are drones in a bureaucratic death spiral. FUBAR

Comment 37

Comments below:

A) Anticompetitive action

Consider the possible legal ramifications (lawsuits), from the aspect of anticompetitive law. As a patient, who would I rather see-- A) a physician who received very little income or B)one who had a lot of income.

Obviously B--he is better at his trade and has more experience.

B) Disclosure of funds dispersed AND received.

Secondly, if we are disclosing the payment of Medicare dollars on an individual basis, should we not disclose the source of those funds on an individual basis? Perhaps we should publish the contributions (FICA and Additional Medicare Tax) made by each individual. What reasonable objection could be made?

C) Backlash and collateral effects.

Finally, the public may be shocked to discover how little income is being received through professional fees. The public may also be shocked to see the disparity in fees paid to hospital. We should also report the Medicare derived income of the Hospital CEO, CFO, and other chief officers of the billing hospital corporation.

Can we all just look into each others wallets? Surely that can't be a problem, can it?

Comment 38

Three comments:

1. Individual physician payment data is meaningless and misleading. For example, it would not take into account "cost of goods sold" in financial terms. I administer expensive biologics in the office, for which MCARE reimburses almost exactly the true cost of the drug. This office administration is good for my patients, because it is easier and more customizable for them, and good for the "system" because hospital outpatient administration is more costly.

Hundreds of thousands of dollars in medication costs go through my office to the supplier, but could look like my personal reimbursement to anyone unfamiliar with the practice and with these medications. Potentially fatal disease such as severe rheumatoid arthritis or vasculitis are devastating and costly. MCARE does NOT want to give disincentive to providing these medications in appropriate cases(or not to treat these complex patients at all); a single hospitalization could easily cost more than several years' worth of these drugs.

[The cost of part B administered drugs needs to be addressed with the manufacturers, who raise prices long after recouping development costs.]

2. Individual taxpayers are entitled to privacy regarding their tax returns (it is always a big deal when politicians release theirs). How are individual payments to physicians any different? At least the adjusted gross income from a 1040 form would reflect the physician's actual income, while MCARE payment information to an individual physician does not address practice costs that must be paid from those payments.

3. Hospital employed physicians would seem much more efficient by these measures, as the data is unlikely to reflect the multiple facility costs.

There is a better though more complex way. Quality of care is represented by factors such as patient functioning, pain levels, survival, number and length of hospitalizations, all of which need to be controlled for the severity of the patient mix. A heart failure specialist will have worse measures than a cardiologist who practices a lot of general internal medicine. CMS and insurers should spend their effort developing these measures and models. These would provide a better measure of "bang for the buck."

Comment 39

As a rheumatologist, I am concerned that release of payments from Medicare would include payment for drugs which are equal to their cost. That would be very misleading.

Comment 40

As a physician, I feel strongly that the data regarding medicare payments to individual physicians should not be made public because it violates the right to privacy of the physicians who provide services to medicare patients. Despite the recent court decision, I feel that this type of information should remain private and that the right of privacy supersedes the right of the public to have access to it. I think it is reasonable for de-identified data to be available for research on utilization, but that making it available to the public in a way that allows for the amounts paid to individual physicians to be known violates the right to privacy of the participating physicians.

Comment 41

As a Medicare provider I endorse making Medicare physician data public because:

1) It is taxpayer's money and the public is entitled to see where their money goes

2) Most of the public will not care about the issue or the money - but the data will generate interest if out of line

3) And this will help keep physicians from cheating

Comment 42

Dear Sir/Madam,

I strongly support the view that Physician reimbursements for various procedures should be released to the public.

Almost all commercial service and goods sellers/providers list their prices. However, that is not true about medical services and there is absolutely no transparency. You may have already seen reports that the hospitals do not provide any price sheets for any services and they charge whatever comes to their mind. This is so true especially with uninsured patients and no wonder medical charges is the number one reason for personal bankruptcies.

I became a victim of this even they I had insurance coverage but went to see a doctor who was not covered my insurance. I have regularly seen the doctors take a 50% or more cuts from their charges from insurance. However, they don't do this to self-pay patients. That was true with me too. I was made to pay a ransom.

Once you make the prices available to public, they might have a tool to use to fight back.

Comment 43

I am glad to give comment on this issue. It is incredible to me that there is even a question about wether to release this data. This type of information should not be secret. The secrecy of pricing and reimbursement is a part of the problem with modern healthcare, and maintaining this secrecy would only serve to perpetuate that. Secrecy obscures the trail of money, making fraud, waste and abuse more difficult to detect and eradicate. Money that is stolen and/or wasted is not available to provide more care to eligible recipients; this leads to unnecessary suffering.

Medicare also sets the example that the private sector often eventually follows. There needs to be pricing transparency throughout the public and private healthcare system, and the release of this data will facilitate transparency for all.

Where secrecy is permitted, suspicion can easily grow, along with mistrust. I want to be able to trust the doctors who provide my treatment, and not suspect them of something nefarious because they keep secret how much they get paid to treat me. This is part of the public trust, it is part of trust on an individual level.

If my car is damaged and my insurance company pays for it to be fixed, I expect to know what was paid. That is only a car. This issue has to do with costs paid to save and maintain human life - how can the standards for transparency be less?

Comment 44

I support public disclosure of physician data in general, but have grave concerns about how that information will be used. When raw data is used as the publicly reported arbiter of truth, it can lead to false conclusions on the part of both the public and policy makers.

In this era of accreditation and sub-specialization, the volume of specific clinical activity that one physician performs, most especially for non-E&M services like surgery/procedures/imaging, is not necessarily reflective of that physician's individual utilization of that medical procedure or technology, and does not often indicate that physician's personal referral patterns.

For example, I am an expert in non-invasive cardiac imaging. I work in an ICAEL accredited echocardiography laboratory, to which many other cardiologists and all other local physicians (Internists and family practitioners, OB-GYN, Oncologists, surgeons, other non-echo board certified cardiologists) refer patients for echocardiographic studies. I am reading echocardiograms for a healthcare community that is far larger than my individual referral pattern for echocardiography. Nevertheless, I received last year a CMS utilization report (erroneously) suggesting I had above average utilization of echocardiography simply because we have a policy of whereby only cardiologists with National Board of Echocardiography subspecialty board certification can read echo studies in our lab. Taking the raw data out of context, someone or some group at CMS determined that my volume of echo reading was 1 for 1, directly linked with my individual referral patterns and utilization of that technology - a false syllogism to say the least!

In order to determine comparative and cost effectiveness, and to identify fraud and abuse, the data can and should be made public. I simultaneously urge CMS not to draw false conclusions from that raw data. Lastly, in an era of physician-hospital integration, it is imperative that if data is to be made public, that both HOPPS and MPFS data must be summed and reported to fully capture to whole of one's clinical activity. The comparison made between physicians must not discriminate if one is billing predominantly via HOPPS versus MPFS.

As the practice of medicine becomes ever more subspecialized, it is important to understand that individual physician volume for procedures and imaging technology (essentially all non E&M services) is most reflective of that physician's degree of subspecialization combined (even multiplied) the healthcare community in which they work. It is rarely, if ever, indicative of that individual physician's utilization or personal referral rate of that medical procedure or technology.

Comment 45

It is reasonable to share data regarding billing to, and payments from, government agencies such as Medicare, Medicaid and other programs. If the public provides the monies to support such programs, they should be able to share information as to where the $$$ go. The only physicians who would have concern are those who may be at risk for collection of improper payments.

If my practice were focused on a diagnosis or procedure that impacted an older adult population, it would be expected that the bulk of my income came from Medicare. Similarly, if my population was more indigent, I would anticipate greater billings associated with Medicaid. I don't think the public has any problems with this. What they do have a problem with is fraud. As such, holding physicians' feet to the fire is a good thing.

By the same token, whoever sees the data needs to avoid equating billing with quality or a lack thereof. Similarly, patient satisfaction should not be tied to any billing data as they are two separate issues.

Comment 46

I writing to voice my opposition to public disclosure of MEDICARE payments to physicians. My objection is founded on the lack of context of this disclosure. The public cannot see or appreciate that what is paid does not go solely to the providers but also pays for the their staff, equipment, rent, supplies etc.

Comment 47

Allow me to start with the fact that I am a physician, I am an Emergency Medicine doctor, employed by a single hospital group that in turn contracts with the hospital for ER services. Although the billing may be under my name it is the hospital that bills and collects and then we bill the hospital at a previously agreed rate per RVU.

The concerns are several:

Why should my income be less private than anyone else, i.e. lawyers, accountants, etc.

It provides competing groups information on our collections, indirectly but just the same,

News media or for that matter anyone should not have access to a privately owned company numbers, there may be a need for transparency, which is debatable by itself but there is the much touted privacy right on many issues, again, debatable too.

Comment 48

Raw numbers are misleading..

Some added helpful info to ward off abuse and waste.

1) number of patient visits per year/ month/ week/ and day

2) Avg. payment per patient visit

3) MD is top 1% biller of certain code(s)

4) separate office visit from surgical codes and from testing codes and tally.

MDs who are extreme outliers would be audited. I question the benefit of public disclosure of physicians payments / salary. Our society still holds salary as a meaningful private matter.

Comment 49

The reported desire for transparency, and a whetted public appetite notwithstanding, it is not clear to me how the public release of individual physician reimbursement data would change anything significantly. Look at any of the rationale that has been listed on the website, and ask what one of these would be positively impacted if Mr or Mrs John Q Public had the information on their primary care physicians Medicare reimbursement data. Is there similar disclosure for all of the employees in the CMS office? If there is, has that changed any of the parameters listed below? If not, why not? Perhaps if the individual physician had more or less than two standard deviations from the norm for their particular procedure or intervention, that would make a difference in public policy discourse. Perhaps if the reimbursement rate for visit, and procedure, was public knowledge, that would be information of consequence. But for the general public to have raw physician specific data, serves no discernible purpose to my eye. I put my responses to the specific comments in bold print.

Growth in Medicare spending has whetted public appetite for more information. (raw information is of little value, without including volume of patients, severity of illness, procedure volume, and geographic qualifiers.)

The Affordable Care Act already authorizes the release of a physician's payment data to qualified entities such as consumer groups and employers wanting to measure physician performance. (Why not LEAVE IT at qualified entities?)

Medicare pay to physicians is more standardized. (Why not release the standard reimbursement numbers instead? How about identifying physicians that deviate significantly from the "standard" assuming of course adjustments are made for volume and other confounding circumstances)

Disclosure of what physicians receive from Medicare could help the government battle rampant Medicare fraud, abuse, and waste. (If qualified entities already have that information, than this qualifier, weak as it is, is probably already being met.)

"more data transparency," particularly as crunching the numbers can improve the quality of healthcare while lowering costs. (Crunching numbers does NOTHING to improve the quality of health care. It is analysis of that data, and determining what changes have a negative or neutral impact on health that impacts on quality. Crunching the numbers may identify opportunities to reduce costs, but there is no direct correlation to QUALITY)

CMS wants the public to answer 3 questions to help it apply transparency to Medicare reimbursement:

- Do physicians indeed have a "privacy interest" in their Medicare payment data, and if so, how should CMS balance that privacy interest with public interest in that information?

- What specific disclosure policies should CMS consider to improve patient care, lower costs, and otherwise promote the public good?

I think physicians, like any other group, are entitled to some privacy with regard to income. In the absence of that consideration, the raw unqualified disclosure of that data (volume of patients, community standards, procedure related reimbursement, deviation from standards—all serve as qualifying information). A single individuals reimbursement rate, I think would make no more difference than knowing what the reimbursement rate for every employee or contracted entity in the CMS chain makes.

You should stop pretending that quality of patient care, and costs are tied together. One takes real measurements, with real people with full review of intended and unintended consequences, and the other is a necessary but totally separate function.

Comment 50

I cannot believe that CMS would stoop so low to even consider publishing and disseminating payment information from Medicare to physicians. Most of the public wouldn't understand what the information means. This is nothing more than a blatant attempt to drive a wedge between physicians and their patients who will undoubtedly be driven by envy to view this data.

There should be a release of information what attorneys are paid for representing clients to be fair about this. I predict that if this occurs most physicians will stop accepting Medicare due to this grievous, underhanded method of cutting costs at any cost.

Comment 51

Go ahead and post my Medicare reimbursement.

When you do, it should be mandatory that I receive notice of who requests my income data.

I want to send that person an itemized listing of my expenses over the same time period.

It is only fair that patients know what I spend each year on taxes, rent, utilities, cleaning fees, office supplies, liability insurance, accountant's fees, legal fees, license fees, CME, employee salaries, health insurance premiums we pay for our employees AND their families, the medical expense stipend we provide employees, retirement contributions we make for our employees, administrative fees, office supplies, meals we provide.

You want to make it seem like we doctors are getting rich on Medicare and Medicaid and you'll do all you can to perpetuate that myth to the public while you cut reimbursement over and over again by cutting payments, bundling services, eliminating codes and setting differential rates for different providers. My liability exposure doesn't decrease just because procedure codes are bundled (become unreimbursible) and my insurance premiums doesn't go down either.

It's only fair that people know both sides of the balance sheet when they ask.

Comment 52

As an employee of the local hospital, I am unsure how the pay the hospital receives from medicare for my services rendered can be correlated to money I receive. More of my peers (General Surgery) are becoming hospital based employees, and with this fact, I would think the release of information regarding funds paid by medicare should reflect when the money is received by a non-profit organization, as opposed to my personal practice.

Comment 53

Who else receives government pay? If fraudulent billing is the issue, go after that minority. This will discourage the individual practitioner from accepting Medicare and Medicaid - already a problem. When I was in private practice I would rather see a few people for nothing than take Medicaid. I am also close

to 65 and worry about the availability of Medicare accepting docs. I would not encourage anyone to go into medicine the way things are going.

Comment 54

I suggest that Medicare payments to physicians data would be released the following way:

1. Yearly payment data

2. How many patients doctor cared for

3. Percent of time spent in clinical work

4. Median payment per doctor in the similar situation (i.e. private non invasive cardiologist practicing full time in the state of Massachusetts) for comparison

5. Years in practice.

Comment 55

Dear CMS:

I am an attorney who regularly represents health care plans in disputes concerning reimbursement of non contracted physicians. The reasonable value of the services rendered by the provider physicians is the central issue in the disputes. The CMS data of payments accepted by physicians should be discoverable and should be available as evidence of what provider physicians regularly accept as payment for their services that are frequently billed at rates that many multiples of the CMS payments.

(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;

The public interest outweighs any privacy interest of the physician providers. However, the data should be available even with the individual physician name redacted. Specific patient PHI could be redacted as well.

(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;

Public disclosure of the physician provider data will contribute to increased transparency in the pricing and delivery of health care services. Disclosure of individual physician payment data will further the goals of improving the quality and value of care. Enhancing access and availability of CMS data will increase transparency, increase public confidence in government, and likely contribute to efforts of reducing fraud, waste, and abuse within CMS programs.

(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).

Line item claim data should be available for meaningful comparison and analysis of services.

Thank you for your consideration.

Comment 56

Doctors vs Data...

There is a storm brewing in Healthcare. Doctors have been in charge of healthcare for a long time, and have become comfortable, sometimes even arrogant, with their authority and power. But dumb data beats smart doctors every time. Forward thinking doctors are embracing data, with surprising grace and humility. Others are having much more trouble adjusting.

Doctors, as a group, have been in charge of how healthcare operates for centuries. In times past, the only way to determine if a doctor was doing a good job was to become a doctor yourself, and then perform case reviews. Even in court, if you wanted to refute a doctor, you needed another doctor.

Doctors, historically, have been the "end of the discussion" on clinical matters. Doctors make the diagnosis, they make the calls in the Surgery Suite, they get to decide if someone is suffering enough to justify pain medications, they frequently decide if someone is mentally incompetent or merely eccentric. Our society places a lot of trust in doctors, because they have the training needed to make really hard choices.

But that time has changed. Now we have data on doctors. We have data on how they work together, on how the prescribe. We can tell if they wash their hands well enough, and whether they use the right procedures in the right situation. In many ways the zenith of the EHR adoption is really the dawn of doctor science. We can now tell, with a fair amount of objectivity, how good doctors are at their jobs.

But doctors are very resistant to being evaluated in this way. Recent polls done by acpe.org. Many doctors find the notion of subjective patient ratings on various online websites distasteful. What is also problematic is that another poll from the same organization showed that doctors were split on whether CMS should release more medical claims data. It is apparent that there is a contingent of doctors that is opposed to being rated and evaluated, no matter if the data is subjective or objective.

Medical errors are so common that many estimate that just “getting what we know right consistently” would be the equivalent of curing Cancer or AIDS. Mostly eliminating medical errors is achievable, but only when we start to be open about our flaws. If there were a better data store than the CMS data on doctors I would recommend that we open that up.. but there isn’t such a store. This is the best we have.

And curing Cancer or AIDS is probably going to be much much harder.

We are not going to make the kind of progress we need to until we start ignoring the opinions of those who feel like -any- data about them is unreasonable. You will get lots of doctors who give reasonable sounding feedback on why you releasing CMS data will hurt them somehow. And they are right, it will hurt them, some providers will be damaged when their models, practices and outcomes are revealed. In at least some cases, we will also hurt doctors who did not deserve to be hurt. This is a classic false positive/negative problem that will play out on a national scale.

But the alternative is to continue flying blind in our healthcare system. That is unacceptable. Rather than hurting a few people tremendously, we are ensuring that ongoing substantial damage is hidden. There is no way that those that are hurt by bad doctors who should not be in practice will not outnumber, by factors, those that are hurt by the result of data releases.

Still, there is a valid reason for doctors to have a dim view on both patient ratings and claims data. Both data sources are biased in different ways.

Claims data are particularly problematic. Doctors feel that they should have privacy with regards to how much they are paid by the Federal Government (via Medicare and Medicaid). Which is reasonable, except for one hiccup. Using claims data as a source it is not possible to describe precisely what a doctor is doing without also describing how much they have been paid with reasonable accuracy. Without describing precisely what a doctor is doing, there is no way to even begin determining whether a doctor is doing a good job. It may still be impossible to tell if a doctor is doing a good job, but at least the data science community would have some place to start.

Claims data is severely limited, it is not, by any stretch, good data. Doctors know this and are reluctant to endorse it as a data set. But being down on bad data is only a valid response when you are proposing some better data source. Claims data is much better than patient anecdote in terms of validity.

I am put in the position, almost daily now, to advise people on how which doctors to work with based on data that I have. I can happily say that my data set (DocGraph) is likely the best available data for making these kinds of decisions. But "best" does not mean "good". What I can do with bad data now is impressive to healthcare administrators, because the alternative is trusting in blind luck, which is how healthcare has been coordinated before now. This is a standard that I am comfortable beating.

As we shift from using no data, to using bad data, to using better data, to good data, we need to be fair to doctors regarding where we are. But we already have enough data to know when a doctor performs badly. Given what we already know, simply resisting evaluations is not an attitude that is going to pay

off for doctors. This is not the kind of movement that you can opt out of. Medical science used to be so complex that it was impossible to evaluate, that is changing. Slowly, painfully, but it is changing.

Comment 57

Level of information release for physicians or Medicare-created entities such as Independent Diagnostic Testing Facilities would have enormous public value by showing much more information on the flow of funds and use of funds in the healthcare system. I worked for four years as a regional Medicare contractor in a high fraud state (California). As shown in several years of Wall Street Journal reports, relatively rapid availability of data at the biller level (e.g. IDTF, Physician, Medical group) would be an enormous incentive that would force the government contractor, auditor, and enforcement system to reduce waste and abuse. I believe the savings could easily be greater than 1% of payments (e.g. greater than $5B for $500B of care). This estimate is based on ten years of working full time on Medicare policy, four for the agency and six as a consultant outside the agency.

Comment 58

I have practiced since 1976 and have always cared for Medicare patients. I believe that release of physician data would be beneficial in that it would allow research and analysis that would be helpful in meeting new challenges in Health Care (ACOs, Networks, etc).

Comment 59

I see no public benefit from having CMS release physician payment data. Patients currently receive their individual EOBs which outline the services they were billed for. These individual EOBs already create the needed transparency and fraud monitoring CMS is concerned about. In my opinion, releasing physician payment data will do nothing but create an adversarial relationship between patients and their doctors and not lead to greater fraud detection. Many of our local doctors have already dropped Medicare and Medicaid as payers simply out of frustration with attacks on our profession such as this. Many others are on the fence as to continue their relationship with CMS. I have personally found it a challenge to have my Medicare patients seen in a timely manner for referrals due to an insufficient number of providers. I think releasing such data would not increase transparency but further promote a sense of class warfare and have even more providers refuse to participate with Federal payers such as Medicare.

Comment 60

No one probably enjoys having their incomes made public and, as a researcher, I have little interest in the total amount of payments made to individual Medicare providers. I am, however, very interested in the services and products that are supplied by individual providers and the payments they receive for them. This information is encoded in claims data. Access to this data (line item claim details), combined with Medicare payments scales, would enable researchers to gain an understanding of the impact of program changes on the delivery of services and aid in the development of tools to detect fraud and abuse.

Comment 61

I strongly object to the release of physicians' Medicare payment data to the general public. This release is a blatant invasion of physician privacy.

Costs within our medical system are clearly out of whack, but by and large, the bulk of the expenses are not physician payments, but rather business industries vested in medicine--pharmaceuticals, medical supplies, etc.

Release of this data biases the public further against physicians. And reporting the gross payment in no way reflects the time spent on patient care or the overhead expenses to be taken from the payments. Nor do the payments reflect physician quality.

Please do not single physicians out, in releasing our payment data.

Comment 62

1. The Health Care environment has changed radically since 1980. It is now a business model. HHS has encouraged consumers to shop for the highest quality, while at the same time keeping economics In mind (what is the best bang for your buck?) Consumers cannot do so for physicians unless what Medicare pays them is (and it should be physician identifiable). I think the public interest outweighs the physician's privacy interest. We cannot make informed choices without all information available to us.

2. Describing what policies could be developed would take days to answer.

3. CMS should release the information via line item detail, aggregated data is too hard too make sense of (unless you are a statistician or an accountant).

Thank You for pushing ahead with this, it has been too long coming.

Comment 63

As much as possible, HHS CMS should release as much detail as possible on the line item details without compromising physician privacy concerns. If need be, the details can be rolled up at the physician level.

This data should be made available on a monthly basis to allow for additional research, trending, tracking.

I believe that medicare payment details should be made public to allow for cost comparison and pricing options. In addition, referrals need to be made available.

Comment 64

My opinion is that if a physician or any individual or organization is receiving federal funds then that payment/funds/performance data, services levels, outcomes and feed-back information and the terms surrounding those agreements and subsequent transaction should be available to the public. Why should physicians or any health organization be any different than any other organization receiving federal funds? If I sell goods and/or services via a federal contract that data is available through a number of channels including a FOIA request.

Get rid of this double-standard that I am sure is being propped up by special interests. If you want to drive free-market competition, improve services, reduce fraud & abuse and insist on true transparency then the release of Medicare physician data is paramount to driving these goals. If not, the system will continue to experience the same kinds of problems that overwhelm it presently.

Sunshine is the best disinfectant!

Comment 65

In reference to proposed rule change allowing disclosure of physician payment data, I am opposed to this rule change because:

1- This would be a gross and unfair invasion of privacy for billing physicians

2- Fraud and abuse can be better fought through other means, such as closer scrutiny of physician billing outliers, durable medical equipment providers, home health providers

Comment 66

It has come to my attention that CMS is weighing the most appropriate policy regarding release of physician payment data. This is a clearly unwarranted invasion of my personal privacy as a physician who cares for Medicare patients. I am afraid such a policy would force me to withdraw from accepting Medicare patients, despite the growing need this population has for specialty care.

In the event that a case of physician Medicare fraud is identified – that, in my opinion, is of the public interest and should be publicly released in order to deter further fraud, waste and abuse. However, blanket release of private financial information for those clinicians doing the job justly is unconscionable and will drive quality providers out of the system.

I find it interesting that CMS is not considering public disclosure of any information that could directly or indirectly reveal patient-identifiable information and is in fact committed to protecting the privacy of Medicare beneficiaries. I am puzzled how physician-identifiable reimbursement data is not afforded the same regard.

Comment 67

Dear Sirs:

Our office is a privately owned, small group, orthopaedic practice. We are writing to submit comments for consideration on the public release of Medicare physician data.

We are strongly concerned with CMS physician payments becoming public. Physicians have a significant privacy interest in information concerning payments received by Medicare. If physician reimbursement data became public it is very probable that this would affect the public's decision making regarding choices in their medical care providers in an unfair manner. For example, if a sub specialist narrows their practice to performing an uncommon but complex surgery, their reimbursement numbers may appear unusually "high" against the general orthopaedist next door who does not perform this procedure. In essence, the numbers are skewed from the beginning giving a false impression. This is not providing transparent or accurate information to the public.

Another negative is that many patients already assume that the doctor "makes tons of money" from their insurance, however this couldn't be farther from the truth. In our practice Medicare reimbursements barely cover overhead costs.

Our group is a strong advocate of transparency and the enhancement of patient access, however giving patients "half" of the information is irresponsible and potentially damaging to the very physicians CMS needs in order to care for Medicare patients. A better way of improving the quality and value of care would be to have voluntary data submission from physicians.

Thank you for your consideration.

Comment 68

1. Physicians have a privacy interest in information concerning payments they receive that significantly outweighs public interest in disclosure of Medicare payment information.
2. Disclosure of information at the federal, state, county, and hospital levels is sufficient to get a sense of Medicare spending in the country for the purposes of eliminating waste. There is no additional public benefit that can be derived from infringing upon an individual physician's privacy rights. There is little gain at the grave cost of trampling individual privacy. This is America; an individual's privacy is held in high regard.
3. CMS should not release information about individual physician payments. Aggregated data release would be less of a privacy infringement than line item claim details.