nrhi Network for Regional Healthcare Improvement

320 Ft. Duquesne Boulevard
Suite 20-J
Pittsburgh, PA 15222
Voice: (412) 803-3650
Fax: (412) 803-3651
www.NRHI.org

BOARD OF DIRECTORS

James Chase
Minnesota Community Measurement
Chair

Gail Amundson
Quality Quest for Health of Illinois
Vice-Chair

Vernice Davis Anthony
Greater Detroit Area Health Council

Marc H. Bennett
HealthInsight
(Nevada & Utah Partnerships for Value-Driven Healthcare)

Nancy Clarke
Oregon Health Care Quality Corporation

Thomas C. Evans
Iowa Healthcare Collaborative

Karen Wolk Feinstein
Pittsburgh Regional Health Initiative

David S. P. Hopkins
California Cooperative Healthcare Reporting Initiative

Lisa Letourneau
Quality Counts

Mary McWilliams
Puget Sound Health Alliance

Elizabeth Mitchell
Maine Health Management Coalition

Cindy Munn
Louisiana Health Care Quality Forum

Louise Probst
Midwest Health Initiative

Christopher Queram
Wisconsin Collaborative for Healthcare Quality

Barbra Rabson
Massachusetts Health Quality Partners

John Sakowski
Institute for Clinical Systems Improvement

Thomas R. Williams
Integrated Healthcare Association

Harold D. Miller
President and CEO

September 27, 2010

Ms. Colleen Bruce
Centers for Medicare and Medicaid Services
Mail Stop C5-19-16
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: File Code CMS-0031-N (Comments on Implementation of Section 10332 of the Patient Protection and Affordable Care Act regarding Availability of Medicare Data for Performance Measurement; Federal Register Vol. 75, No. 166, p. 52760)

Dear Ms. Bruce:

Thank you for the opportunity to provide input to the Centers for Medicare and Medicaid Services on the implementation of Section 10332 of the Patient Protection and Affordable Care Act, which requires that extracts of Medicare claims data be made available to qualified entities for the evaluation of the performance of providers of healthcare services.

Summary of Recommendations

Our key recommendations are:

- Non-profit, multi-stakeholder Regional Health Improvement Collaboratives which have existing systems for collecting, analyzing, and publicly reporting information on the quality and/or cost of healthcare in their communities should be automatically deemed to be qualified entities and eligible to access Medicare claims data for providers and beneficiaries located in their communities.
- The procedures which Regional Health Improvement Collaboratives have established for protecting the privacy and security of claims and other patient information and which have been accepted by commercial health plans, Medicaid programs, and individual providers should be deemed sufficient for protecting the privacy and security of Medicare data.
- CMS should make available to Regional Health Improvement Collaboratives de-identified patient records that include all

fields on current claim forms other than patient name, street address, and other unique identifiers. Information should include diagnosis codes, procedure codes, grouper results (e.g., DRG classifications), provider identification numbers (so that data can be attributed to individual providers), tax identification numbers or Medical Group provider identification numbers (so that patients can be attributed to medical groups), charges, payment amounts, and key demographic information (birth date, gender, race/ethnicity, language, country of origin, and current zip code). In addition, a consistent, encrypted patient identifier should be included with each record to enable combining claims by patient to measure full episodes of care. It is very important that individual records, rather than merely summary measures or the numerators and denominators for such measures, need to be available so that detailed analyses can be developed to help providers improve their performance.

- CMS should provide the data as frequently as possible and as quickly as possible after claims are filed, ideally every 30 days if the Collaborative has the capacity to process claims data that frequently.
- In using Medicare claims data for public reporting on the quality and cost of care in the community, Regional Health Improvement Collaboratives should be expected to use measures endorsed by the National Quality Forum where such measures exist, but Collaboratives should also be permitted to work with providers in their community to define and publicly report additional measures where endorsed measures do not exist. In addition, Collaboratives should be permitted to generate a broad range of analyses using Medicare claims data for the purposes of helping healthcare providers identify opportunities for improving cost and/or quality and to measure progress on improvement.
- Fees charged to Regional Health Improvement Collaboratives by CMS for making Medicare claims data available should be as low as possible, recognizing that Collaboratives are non-profit agencies which are using the data to help improve the quality and lower the cost of healthcare for Medicare beneficiaries.

Additional information on the role of Regional Health Improvement Collaboratives and the rationale for the above recommendations is provided below:

The Key Role of Regional Health Improvement Collaboratives in Measurement, Reporting, and Improvement of Healthcare Cost and Quality

A growing number of states and metropolitan regions across the country have formed multi-stakeholder Regional Health Improvement Collaboratives to improve the quality of healthcare services while controlling skyrocketing costs. These Collaboratives bring together healthcare providers (physicians, hospitals, and other providers), payers (health plans, state Medicaid agencies, etc.), purchasers (both businesses and state and local government employee healthcare purchasing agencies), and consumers to collaboratively design and implement important programs and initiatives such as:

- public reports on the quality of care delivered by physicians and hospitals in the community;
- education for consumers on how to select high-quality healthcare providers and services;
- technical assistance for healthcare providers on ways to improve the quality of care they deliver;
- redesign of payment and delivery systems to support higher-quality care.

The importance of the work that Regional Health Improvement Collaboratives do has been nationally recognized. Twenty-four Collaboratives have been designated as Chartered Value Exchanges (CVEs) by HHS and receive technical assistance from the Agency for Healthcare Research and Quality. Seventeen of the Collaboratives participate in the Robert Wood Johnson Foundation's Aligning Forces for Quality program. The thirty leading Regional Health Improvement Collaboratives in the country are members of the Network for Regional Healthcare Improvement (NRHI), which provides a mechanism for the Collaboratives to share best practices among themselves and to work jointly on national quality improvement issues. These Collaboratives are:

Regional Health Improvement Collaboratives in the Network for Regional Healthcare Improvement (NRHI)

- Albuquerque Coalition for Healthcare Quality
- Aligning Forces for Quality – South Central PA
- Alliance for Health (West Michigan)
- California Cooperative Healthcare Reporting Initiative
- California Quality Collaborative
- Finger Lakes Health Systems Agency
- Greater Detroit Area Health Council
- Health Improvement Collaborative of Greater Cincinnati
- Healthy Memphis Common Table
- Institute for Clinical Systems Improvement (Minnesota)
- Integrated Healthcare Association (California)
- Iowa Healthcare Collaborative
- Kansas City Quality Improvement Consortium
- Louisiana Health Care Quality Forum
- Maine Health Management Coalition
- Massachusetts Health Quality Partners
- Midwest Health Initiative (St. Louis)
- Minnesota Community Measurement
- Minnesota Healthcare Value Exchange
- Nevada Partnership for Value-Driven Healthcare (HealthInsight)
- New York Quality Alliance
- Oregon Health Care Quality Corporation
- P2 Collaborative of Western New York
- Pittsburgh Regional Health Initiative
- Puget Sound Health Alliance

- Quality Counts (Maine)
- Quality Quest for Health of Illinois
- Utah Partnership for Value-Driven Healthcare (HealthInsight)
- Wisconsin Collaborative for Healthcare Quality
- Wisconsin Healthcare Value Exchange

All of the functions that Regional Health Improvement Collaboratives perform depend on having access to current data on the quality and cost of healthcare in their communities. Most Collaboratives have sophisticated programs to assemble and analyze data from health insurance claims, electronic health records, or other physician records to identify where there are opportunities to improve the quality or cost of care. They then disseminate the results to the public and all healthcare providers as a community service to help providers improve the overall quality and value of care and to help consumers select the highest-quality providers. The methods by which Collaboratives generate and report measures are developed through a cooperative effort among providers, purchasers, payers, and consumers so that energies are focused on improving performance in areas where the measures indicate problems exist, rather than on challenging the validity of the measures.

The Need for Timely Data on the Quality and Cost of Care for Medicare Beneficiaries

Unfortunately, the ability of Regional Health Improvement Collaboratives to identify and address opportunities to improve quality and reduce cost has been severely impeded because claims data on the care delivered to Medicare beneficiaries is not available. In many cases, the lack of Medicare claims data means that quality and cost measures have to be based on fewer patients than would be desirable or necessary for reliability; in most cases, it means that the quality and cost of care for senior citizens cannot be accurately measured at all, and disparities in care between seniors and others cannot be identified.

In the few communities where Medicare data has been made available, it has typically been several years old. Data that are out-of-date are of relatively little value in communities where there are active efforts to improve the quality and cost of care; indeed, using old data can be counterproductive since it may unfairly imply that problems exist when, in reality, they have already been addressed. Providers need access to timely information so that they can measure progress towards improvement, and consumers need timely information so they can choose providers wisely and fairly. Ideally, data would be available within 30 days after claims have been filed.

The Need for Flexibility in the Types of Quality and Cost Measures and Analyses Generated Using Medicare Data

Regional Health Improvement Collaboratives support the use of standardized measures endorsed by the National Quality Forum where such measures exist. However, for many types of care, there are as yet no endorsed measures or a limited

set of such measures. Many Collaboratives have played a lead role in developing new measures, particularly critically needed measures of patient outcomes, rather than merely clinical processes, and they need the flexibility to use Medicare claims data to continue playing this leadership role.

The need for Medicare claims data goes far beyond the production of measures for public reporting on the quality and cost of care, however. A key role that many Regional Health Improvement Collaboratives are playing is helping healthcare providers and purchasers analyze data to identify opportunities to improve the quality and reduce the cost of healthcare in their communities. This requires the ability to conduct exploratory analyses of data to identify where over- or under-utilization of key services exists and to develop strategies for rectifying those problems in the most cost-effective ways possible. Consequently, it is essential that individual records, rather than merely summary measures or the numerators and denominators for quality and cost measures, need to be available so that these detailed analyses can be developed.

In order to successfully support quality improvement and cost reduction in a community, the stakeholders in the community – providers, purchasers, consumers, and health plans – need a common, objective, trusted source of information. For example, if a provider develops a proposal to a payer for changes in payment to support changes in care delivery, it is critical that the payer (including CMS) be able to trust that the data supporting the proposal are accurate. Regional Health Improvement Collaboratives are increasingly playing this key, central role in implementing health reform, but they need access to data to do so, particularly Medicare claims data.

Building on Existing Data Use Agreements and Data Privacy/Security Methods for Analysis of Commercial and Other Non-Medicare Data

Regional Health Improvement Collaboratives which are currently using commercial and Medicaid claims and other patient information have established detailed procedures for protecting the privacy and security of the information and for assuring that the data will only be used in appropriate ways. These procedures have been accepted by commercial health plans, Medicaid programs, and individual providers and are working very effectively. To the maximum extent possible, CMS should base its requirements on the procedures and protections already being used by Collaboratives with other payers. In addition, we would recommend that CMS automatically deem Regional Health Improvement Collaboratives which utilize commercial claims data as eligible to receive comparable claims data for Medicare beneficiaries. Differences in requirements and burdensome application and review processes will increase the costs Collaboratives must incur to use the data, and delay the benefits that can be achieved for the country in improving the cost and quality of care, and thus should be avoided.

We greatly appreciate the opportunity to provide these comments, and we would be happy to answer any questions or provide any additional information that you would find helpful. We would be pleased to work with you to help you define the standards and procedures for releasing Medicare data in ways that will reduce the costs of producing the data and protect the privacy of beneficiaries while enabling communities to improve the quality and reduce the cost of health care for seniors and all citizens.

Please feel free to contact me if we can be of assistance as you implement the provisions of the law.

Sincerely,

Harold D. Miller
President and CEO

cc: NRHI Members