nrhi Network for Regional Healthcare Improvement

217 Commercial Street
Suite 205
Portland, ME 04102
Voice: (207) 747-5104
EMitchell@NRHI.org
www.NRHI.org

October 28, 2013

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Bldg
Washington, DC 20510

The Honorable Dave Camp
Chairman
Committee on Ways & Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
Ranking Member
Committee on Ways & Means
U.S. House of Representatives
1102 Longworth House Office
Washington, DC 20515

Dear Chairman Baucus, Ranking Member Hatch, Chairman Camp, and Ranking Member Levin:

Thank you for the careful consideration you have given to the need to transform provider payment and the critical role of data in that transformation. We strongly support this direction and recognize that improved care at lower cost will only be possible with these changes. We believe that expanding the availability of Medicare data through the Centers for Medicare and Medicaid Services' (CMS) existing Qualified Entity program goes hand in hand with efforts to reform the broken fee-for-service system and replace it with payment systems that reward value. We appreciate your respective Committee's efforts in this area and we look forward to working with the Committees to improve our current health care delivery system.

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.

In order to realize the full potential of the QE program as a tool to drive quality improvement and value in our health care system, we urge the Committees to include in its SGR reform proposal the following key changes to the QE program:

1. **Fund QEs to perform data management and analyses to develop the critical information for use with physicians in communities. This could be one time funding to develop analytic tools and reports.**

2. Allow QEs to provide their subscribers access to claims level Medicare data and develop custom, proprietary (i.e., non-public) reports that are specific and useful for their organizations. This is a key factor in a QE's ability to provide useful and actionable information. For example, QE users can run reports comparing one provider to another on a given quality metric using comprehensive claims information.

3. Permit QEs to work with their statewide stakeholders to define the measures that they will use to compare provider performance, 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.

Nine of the eleven approved Qualified Entities 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 care, and reduced costs through continuous improvement. To be a member of NRHI, an organization *must* be multi-stakeholder 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 Collaboratives are exceptionally well positioned to receive and share QE data given their experience in data management, measurement, and using data with community stakeholders for improvement. **It is the use of data with physicians and key stakeholders that uniquely qualifies Regional Collaboratives to be stewards of the QE data to ensure that communities benefit from this critical resource through improved care.** RHICs can help physicians design and implement successful payment reforms through data analytics, measurement, quality improvement and other technical assistance.

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 significant financial challenge. Devising a sustainable business model to support QE program activities has been especially difficult for non-profit regional collaboratives to do given current program restrictions. 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 leverage the existing network of Regional Collaboratives and QEs to help with providing this feedback and supporting improvement. 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 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.

In summary, 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. **Embedding QEs in Regional Collaboratives creates the optimal combination of transparent data access with local improvement capacity.** In order for the QE program to succeed, changes need to be made to the program: QEs need funding, 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