October 16, 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 Building
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 Building
Washington, DC 20515

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

On behalf of the undersigned organizations, we are writing to request that, as you formulate your proposal to repeal and replace the Medicare sustainable growth rate (SGR), or consider a shorter-term fix to the SGR, you include provisions addressing the availability of Medicare data. We believe that expanding the availability of Medicare data through the Centers for Medicare and Medicaid Services' (CMS) existing Qualified Entity (QE) program goes hand in hand with efforts to reform the broken fee-for-service system and replace it with payment systems that reward value, as well as with CMS' broad goals of reducing over-utilization of care, improving quality and controlling costs. We appreciate your respective Committees' 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 QE program established under Section 10332 of the Affordable Care Act and administered by CMS. In fact, several of our organizations are multi-payer Regional Collaboratives or all-payer claims databases (APCDs) that have become QEs. We believe the QE 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 QE 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 intelligence that is useful for providers, patients, and other stakeholders.

Medicare claims data, especially when combined with other payers' claims data, is a powerful tool that has the potential to drive real change in our health system. Such data not only allows

patients and payers to make more informed purchasing decisions (e.g., paying for high-value versus low-value care), but also allows providers to better understand and improve how they deliver health care to their patient populations. The QE program was established with the goal of harnessing the power of this data to assess provider performance and encourage quality improvement and cost reduction. However, the existing law is overly restrictive in terms of how QEs can use, analyze and share the Medicare data they receive, and it restricts a QE's ability to charge a fee for its services. These restrictions limit the ability of our organizations to maximize the utility of our data for patients, purchasers and policymakers, as well as our ability to develop a sustainable business model not entirely dependent on public funds.

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 their SGR reform proposals the following key changes to the QE program:

1. Allow QEs to provide their subscribers access to Medicare data and develop custom, proprietary (i.e., non-public) reports that are specific and useful for improvement purposes. 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, 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 significant costs for integrating and maintaining the data systems to support the analysis. A number of Regional Collaboratives and APCDs rely upon member or subscriber fees to operate. Potential subscribers should include as broad a group as possible, including physicians, medical groups, medical societies, hospital and health systems, insurers, other payor organizations, data analytic firms and other participants in the healthcare marketplace. Without allowing these financing models, QEs will be forced to rely on public funding, which may or may not be available.

Our organizations were pleased to see these changes embodied in H.R. 2810, the Medicare Patient Access and Quality Improvement Act of 2013, passed by the Energy & Commerce Committee on July 31, 2013. Section 3 of this bill would provide QEs with more flexibility to provide or sell Medicare data to downstream users or subscribers for non-public uses, and would exempt such uses from the stringent requirements put in place for public reporting of Medicare data. We believe this language will strengthen the QE program and allow our organizations to better serve the providers, consumers and other stakeholders in our communities.

We respectfully request that you include, in any permanent or short-term fix to the SGR, provisions expanding the availability of data through the Qualified Entity program, taking into consideration the issues we outlined above. We are eager to work with the Committees in

making these improvements and sharpening the tools that will help drive quality and efficiency in health care delivery and innovation in Medicare payment.

Sincerely,

Wisconsin Health Information Organization
Center for Improving Value in Health Care (Colorado)
Wisconsin Medical Society
ThedaCare Center for Healthcare Value
Wisconsin Collaborative for Healthcare Quality
California Healthcare Performance Information System
Virginia Hospital & Healthcare Association
Network for Regional Healthcare Improvement
Alliance for Health (Western Michigan)
Better Health Greater Cleveland
Finger Lakes Health Systems Agency
Greater Detroit Area Health Council
Health Improvement Collaborative of Greater Cincinnati
Healthy Memphis Common Table
Integrated Healthcare Association (California)
Kansas City Quality Improvement Consortium
Louisiana Healthcare Quality Forum
Maine Health Management Coalition
Massachusetts Health Quality Partners
Midwest Health Initiative (St. Louis)
Minnesota Community Measurement
Oregon Health Care Quality Corporation
P2 Collaborative of Western New York
Puget Sound Health Alliance
HealthInsight Utah
HealthInsight Nevada
HealthInsight New Mexico

Cc:

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U.S. House of Representatives
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The Honorable Henry A. Waxman
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