

## ONLINE FIRST

# The Need for Access to Medicare Fee-for-Service Claims Data

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**T**HE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) is the largest US payer of fee-for-service health care claims. However, health care providers have had, at best, limited access to Medicare fee-for-service data because CMS has not made the information broadly accessible. Access to Medicare fee-for-service data could help increase efficiency in health care delivery, reduce costs, and improve the quality of care. Recent remedies have taken shape as part of implementing the Affordable Care Act (ACA), but have yet to bear much fruit.

## Where the ACA Falls Short

The ACA, enacted in 2010, has provisions to make Medicare fee-for-service data available so that provider performance can be measured and evaluated. A little-known but crucial provision, section 10332, permits Medicare claims data to be released to “qualified entities” (QEs) that meet certain criteria.<sup>1</sup> QEs are expected to combine Medicare data with that from other payers to create publicly available performance reports that are more accurate than they would have been without Medicare data. This is a hopeful step, but more than a year after the regulations were finalized, CMS certified only 6 QEs, covering relatively small population bases. Progress has been slow partially because the legislation tightly limits what organizations can do with the data and their ability to support their own data maintenance infrastructures. Thus, the existing QE program faces 2 main barriers.

First, reuse of the data is prohibited for any purpose other than creating the publicly available performance reports. This means that the most valuable potential use of the data—giving physicians access to the data set for specific group-to-group comparisons or for analysis of their own weak areas of performance—is not permitted.

Second, according to the CMS’s interpretation of the ACA, QEs are not permitted to charge users for access to the data. By contrast, some state all-payer claims organizations, such as the Wisconsin Health Information Organization (WHIO), provide subscription access to their databases. These institutions rely on subscription fees to support essential activities. If entities such as the WHIO cannot recoup costs even from willing subscribers, they are unlikely to thrive.

## A Model to Fill the Information Gap

Claims organizations like the WHIO are making strides to fill this information gap. The WHIO, for example, operates a da-

tabase of claims information from private payers and from Wisconsin’s state Medicaid program. Stakeholders from across the state—physicians, health systems, payers, and researchers—subscribe to the database to access a wealth of useful data without compromising confidential information. Subscribers can get customized reports on quality and cost performance, thereby permitting physicians to be compared. For example, physicians in La Crosse, Wisconsin, can compare their cost of care with the parallel cost for peers in Appleton, 170 miles away (eTable).<sup>2</sup>

The most important aspect of this functionality (one that the current QE provisions do not permit) is that subscribers can closely examine the data set as long as they do not identify individual patients. The granularity of such reports enables a physician office to target potential areas of improvement and quality/performance indicators. The physician community in Wisconsin has responded enthusiastically, as it empowers clinicians to improve quality and lower costs.

Despite this progress, the WHIO’s database remains critically incomplete because it lacks Medicare fee-for-service claims information. Recently, the database was used to compare cardiologists at Appleton-based ThedaCare on the congestive heart failure ETG. With only commercial and Medicaid claims available to the WHIO, one physician was assigned 17 episodes. When Medicare fee-for-service claims were applied, the number of episodes increased to 30, thereby meeting the minimum requirement for reliable statistical comparison so that improvement efforts, if needed, could be undertaken. Many Wisconsin physicians are now requesting this type of information, but the lack of availability of Medicare fee-for-service data stands in the way.

## What Needs to Change

One of us (D.M.B.) was involved in crafting the regulations for section 10332 of the ACA. However, the political process limited what was possible to achieve. The final regulations honored legitimate concerns about privacy and represented progress, but they have fallen short in helping to achieve other necessary improvements. Going forward, the following practical changes would help.

**1. After Medicare fee-for-service data are initially disclosed to a QE, permit the QE to reuse and redisclose the data for other statutorily allowable purposes.** A QE that has flexibility to reuse Medicare data, within appropriate confidentiality restrictions, could more effectively empower providers to im-

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prove quality and efficiency and offer more transparency to consumers. These goals are what Congress intended for the QE program. Currently, however, for each reuse of Medicare fee-for-service data, a QE must request and pay for the same CMS data again, secure redelivery, store it, and analyze it separately from the original, identical data set. This is inefficient for the QE and for CMS, wasting time and resources.

**2. Allow a QE to create or sustain revenue-generating business models consistent with the mission of the QE program.** QEs must perform complex functions to use CMS data, which costs money. If QEs cannot ask even willing providers to support the work financially, QEs must subsidize it with their funds. If entities that pay a subscription fee for services provided (eg, by the WHIO) are willing to support the analytics and interfaces needed to create the reports, that support should not be impeded. The current statute does not allow QEs to charge users for this support if Medicare data are involved. That restriction should be removed. These 2 statutory changes are essential for making the existing QE program more effective. However, on their own, the improvements are insufficient. Providers of all types, especially physician practices and newer models such as accountable care organizations (ACOs) and medical homes, need assistance with data analytics and performance improvement. It should be made easier for organizations with those capabilities to assist them.

The WHIO, other potential QEs, ACOs, physician offices, and CMS all face the challenge of offering sufficiently detailed information to providers as they strive to improve patient care. After all, CMS is beginning to tie payment to performance metrics. Truly effective health care reform requires policy changes that expand access to Medicare claims data beyond organizations that meet criteria to become QEs. Specifically, 2 CMS policy changes are needed that probably do not require legislative action.

**1. Use the policy making authority of the Health Insurance Portability and Accountability Act (HIPAA) to permit providers to obtain and use data for specified purposes and to contract with QEs and others as business associates.** HIPAA allows protected health information to be used for payment, treatment, and health care operations. The activities of the WHIO and CMS's various reporting, feedback, and performance incentive programs fit squarely in the health care operations category. For such purposes, HIPAA policy permits health information to be disclosed between 2 covered entities and to business associates of those entities. Therefore, the CMS division that is considered a covered entity—the Center for Medicare—should be permitted (but not required) to disclose such information to other covered entities such as providers, adding whatever privacy and security constraints are necessary. To its credit, the CMS did use this authority when it allowed ACOs to rely on business-associate relationships with physicians, as covered entities, to obtain and use Medicare claims data. This construct should be applied more widely so a broader range of providers can obtain the information.

**2. Allow data to be disclosed, for research purposes, to entities that want to create marketable products.** Many providers, including ACOs and other new models of care, lack the technical sophistication for analyzing Medicare data to identify performance deficits, analyze variation, design interventions to address them, measure progress, and create performance reports. Data mining and analytics organizations, whether for-profit or nonprofit, have capabilities that are highly sought for these purposes. CMS's outdated prohibition on using Medicare data to create marketable products hinders providers from developing relationships with such organizations, even though neither the privacy act nor HIPAA definitions of research specifically rule out this activity. Furthermore, the CMS prohibitions can be lifted selectively. For example, no company should be allowed to obtain beneficiaries' addresses or phone numbers for marketing purposes. Appropriate restrictions must protect beneficiaries from misuse of their data, with severe penalties for violations.

### The Future of CMS

CMS is no longer just a payer of bills. It should identify, measure, collect, and analyze data; create feedback reports; and calculate payment on the basis of such metrics. CMS should seed the health care system with its data so that the information can help improve quality and efficiency. To do these things effectively, CMS must invest resources and become more efficient in how it uses data and data analytics.

The agency should be commended for several current efforts: launching the QE program providing data to ACOs; releasing geographic variation data on utilization, cost, and quality; and expanding the release of data to states. However, these new responsibilities should be recognized by Congress and supported with adequate resources and regulatory flexibility to prevent ineffectiveness.

Allowing and supporting much broader use of Medicare fee-for-service claims data is key to delivering better health care. It will take both congressional and presidential leadership, as well as ongoing cultural change within CMS, to make that happen. The benefits of better care at lower cost would be enormous if Medicare participated fully in the new era of transparency, using the enormous wells of information at the nation's disposal to pursue the Triple Aim.

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**Online-Only Material:** The eTable is available at <http://www.jama.com>.

### REFERENCES

1. Patient Protection and Affordable Care Act, HR 3590, §10332, Availability of Medicare data for performance measurement. <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.
2. Rosen AB, Liebman E, Aizcorbe A, et al. Comparing commercial systems for characterizing episodes of care. [http://www.bea.gov/papers/pdf/meg\\_vs\\_etg\\_paper.pdf](http://www.bea.gov/papers/pdf/meg_vs_etg_paper.pdf).