AMA
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Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

Like this Administration, the American Medical Association (AMA) believes that Medicare data will be a key ingredient in any successful effort to move toward a value-based Medicare payment and delivery system. We recognize that access to Medicare data, as well as other payer information, has the potential to improve the quality of care while reducing costs. Yet, as demonstrated in the recent data release by the Centers for Medicare & Medicaid Services (CMS), raw Medicare claims data can be potentially harmful. **We offer the comments below, opposing the flawed approach taken by CMS, in the hope that CMS will draw from this experience to develop and refine a more selective data set that could help patients and physicians make better care choices.**

In releasing this data set, the agency said it was following the pattern established a year earlier with hospitals. While hospital data focused on a restricted list of high-frequency services, however, the physician data theoretically included all services and was hailed as a "treasure trove" by the media. **Ironically, in many ways this new data set is less complete than other data sets that have been available for years.** For example, an AMA code-by-code comparison of this file to another 2012 data file with 100 percent of fee-for-service claims found that **codes for nearly 3,300 or 40 percent of physician services that appear in the 100 percent file are missing entirely from the new data file. When combined with other codes, where significant numbers of claims are missing, 70 percent of codes have less than 50 percent of their utilization represented, and 80 percent have less than 75 percent of their utilization included.** Admittedly, CMS pointed out that the recently-released data include only $77 billion or 86 percent of the $90 billion of services delivered by physicians and others covered in this data release. This understates the scope of the problem, however, and untrained observers nonetheless are using the data to make flawed regional, specialty, or other comparisons that CMS should do more to discourage.

As you may know, the AMA developed and provided to CMS in advance of the data release a list of likely problems and limitations that the agency should highlight in the text preceding the data files. Unfortunately, the data were released to several major newspapers, and CMS did not follow this advice.

Instead, users were referred to a separate file that left out a number of data limitations, failed to fully explain others, and required an extra step to access. Early press reports largely ignored these caveats and, for every follow-up article attempting to correct the record, there has been another that compounds the problem. Reports from physicians in the field have confirmed our early concerns and pinpointed additional systemic issues with the data.

An updated and expanded discussion of systemic issues we have detected with the data is attached. We conclude from our review of the issues that:

CMS should concentrate on identifying a data set that could be of use to patients and physicians. While the data launch generated intense interest and many "hits," we submit that over the longer term, the data set will be judged on the degree to which it helps physicians and patients make wise medical care choices. Success on this front will require joint effort by CMS, physicians, patients, and others to identify the relevant information needed to improve care. As you know, the AMA has not argued against all public release of physician-identified data. In fact, we have worked with CMS and Congress to develop a set of safeguards that would facilitate wider availability and dissemination of the data by knowledgeable users who can translate the data for physicians and patients. We also have worked with CMS staff engaged in the development of Quality and Resource Use Reports (QRURs), which provide confidential performance information to physician practices about the quality and efficiency of their care.

The problems in this recent CMS data release are not unique. CMS itself is confronting similar problems in the development of the QRURs, which will serve as the basis for performance-based physician payment adjustments starting next year. For example, the significant data gaps in the recent Medicare rollout are attributable in large part to the decision to include physician's data only for services where there were claims for at least 11 different patients. With the QRURs, CMS measures performance at the group level, which mitigates this issue somewhat. Also, feedback goes only to the group and its physicians, who are familiar with the various billing and payment conventions that may create a result that would trigger concerns in less informed observers. In addition, a number of community-based groups and other entities are developing data systems intended to promote efficient and effective care. Organizations participating in the Qualified Entity (QE) program are seeking to develop and publish public reports that combine data from Medicare and other payers to improve their reliability and representativeness. Clinical registries—developed and maintained by medical specialties and now authorized to serve as an alternative to the Physician Quality Reporting System—also combine data from various sources and are based on clinical data, not claims. Data in these initiatives typically are adjusted for variation in such factors as patient risk and geographic cost, often focus on a set of high-frequency services, and in the process provide far more transparency about cost and quality of medical care than found in raw claims data.

CMS should not add claims from earlier years to the data set at this time. To publish more years of data before there has even been time to assess the full impact of the initial launch is a diversion from the real work that is needed. Releasing more data, without recognizing and correcting the flaws in this initial roll out may also compound some limitations with the data if, as we suspect, erroneous enrollment information and certain billing practices, such as shared use of a single National Provider Identifier (NPI), were more common in past years than they are today.

Physicians must be allowed to correct and explain their data. CMS has argued that it is unnecessary to correct the data because they came from physicians themselves. With all due respect, that answer is

simply unacceptable. Problems with the Provider Enrollment Chain and Ownership System (PECOS) have declined from a few years ago, but we continually hear from physicians whose PECOS listings do not reflect the information they have entered into the system. We do not accept the argument that all errors in the database were put there by physicians. Nor do we agree that unintentional administrative errors by physicians justify the deliberate release of inaccurate information that misleads patients and reduces trust in their physician.

CMS itself has struggled with ensuring accurate and correct information in its own data sets. A perfect example is the Physician Compare website that required a complete overhaul due to inaccurate search functions and other problems with the underlying data. Accordingly, CMS should understand that when trying to release information, especially for the first time, inaccuracies are likely to occur. We strongly urge CMS to allow physicians to correct their information so that the data are accurate and do not contribute to erroneous conclusions about the appropriateness of a physician's care. For example, an oncologist treating patients requiring very expensive physician-administered drugs could easily be suspected of fraud if they are incorrectly listed in the database as a cardiologist. We would also note that, in at least one case that we know of, an error in this data may have exposed a physician to new threats from an unstable patient.

Limitations of the data should be conspicuously displayed and clearly communicated. CMS took a step in the right direction when it created a patient tool that requires those visiting the website to view a list of limitations. Much more work in this area is needed, however:

- All versions of this data set should have limitations listed up front. Limitations that should be added include specialized expertise, coding variation, and erroneous claims or enrollment information (see attachment);
- More context is needed. Users should be told that: (1) neither Medicare nor most other payers base their payments on charges; (2) that the payments listed in this file are revenues, used to run a practice, not pure physician income; and (3) higher payments from Medicare typically represent higher expenses;
- Reimbursement for physician-purchased drugs should be displayed separately from payments for administering the drug; and
- Certain subjects deserve a fuller explanation, including the impact of the 11-patient minimum, shared NPIs, site-of-service payment variations, and Medicare coding conventions.

It is not sufficient to say that Medicare uses payment modifiers or that "units" may be defined differently depending on the service being delivered. Formatting and labelling changes along with more specific guidance on these coding and payment conventions are needed to avoid erroneous assumptions about what the data mean. An expanded discussion of the missing data should define its magnitude and consequences, including the possibility that some physicians and some services will fall out of the data altogether, its potential to generate inaccurate conclusions, and the existence of other more complete data sets such as the 100 percent file. Full disclosure on site of service cost differences would require a statement indicating not only that care in a hospital outpatient department will include additional costs, but that total costs of care may be significantly higher there than in a physician's office.

Spending more time and effort to stimulate the use of this data set is putting the cart before the horse. Dissemination of "apps" built on a data set that is incomplete will only spread erroneous and misleading information and draw attention away from more fruitful uses of Medicare data. The data also

did not include any new information for government contractors and staff charged with eliminating fraud and abuse, and, based on press reports that we have seen to date, many of the fraud efforts using CMS' data may incorrectly target physicians, wasting resources instead of saving them.

In our view, the lesson to be learned from the release of raw 2012 physician-specific Medicare claims information is that transparency is twofold; it requires not only access to data but understanding the scope, exclusions, and limitations of the information. Without this context, conclusions and analyses are likely to be wrong.

Having released the 2012 raw data, CMS is now obligated to correct and explain it. Instead of new insights into health care, the recently-released data have brought a series of sensationalist news stories, the majority of which inaccurately reported on the data, confused the public, and in some cases may have encouraged patients to make care changes that were not in their best interest.

There is much that the agency could do to encourage meaningful data development by other players and foster the methodological improvements that are needed to create real transparency. First and foremost, CMS should encourage the development of complete, accurate, and timely data that could support a more value-driven health system. CMS' attention, however, has been diverted away from these more meaningful efforts to pursue information that fails to convey useful and accurate data. A continued focus on publication of raw claims data would only stand in the way of true transparency efforts, and we urge you not to take this detour away from the real task at hand.

We look forward to continuing to work with CMS on this important issue. If you have any questions about our comments, please contact Sharon McIlrath, Assistant Director, Federal Affairs, at (202) 789-7417 or sharon.mcilrath@ama-assn.org.

Sincerely,

James L. Madara, MD

Attachment

DATA LIMITATIONS

1. **The data could contain errors.** Physicians do not have a way to correct the information reported. As expected, the AMA has received numerous reports of physicians who have not practiced in the group or at the address listed in the database for years. Some have been listed with specialties that would typically have lower reimbursement levels than the physicians' actual specialties. A pain doctor who has previously been threatened by a patient with a gun had her home address listed. In most cases, these physicians were getting Medicare payments at their current office address and had no reason to believe that they were listed incorrectly elsewhere in the Medicare database.

2. **Care quality cannot be assessed from the information reported.** The set of data focuses solely on payment and utilization of services and does not include explicit information about the quality of care provided or the appropriateness of the services that were delivered.

3. **The reported number of services could be misleading.**
   - CMS has pointed out that data for some physicians are missing or incomplete because some or all of their care was billed under their group practice's National Provider Identifier (NPI) or because CMS excluded services performed for 10 or fewer Medicare beneficiaries to protect patient privacy. The AMA's analysis suggests that the impact of this is quite significant. Specifically, at least half of the cases are missing for about 70 percent of the approximately 8,000 physician services covered by Medicare.
   - In some services, there are a number of different codes to identify certain variations in technique or gradations of difficulty. In these cases, the service may be dropped from a physician's data even though the physician had well over 10 cases across all the codes for the service. One peculiar consequence of this phenomenon is that some surgeons are listed as providing evaluation and management services and no surgeries.
   - There also are a number of situations where it will appear that one physician has performed services that were actually delivered by many practitioners because Medicare permits the use of a single NPI without identification of the individual who delivered the service in a number of situations. These include "incident to" services provided by residents and other health care professionals who bill for their services under a supervising physicians' NPI.
   - Labs, ambulatory surgical centers, and independent diagnostic testing facilities also are not required to report which individual actually performed a service. Moreover, some pathologists bill for the comprehensive blood test while others bill for the individual components of the test. Payments are the same but the number of services will look much higher for those who bill the individual components.
   - Many surgeons also will appear to have highly inflated utilization rates due to CMS' failure to clearly account for modifiers such as those associated with assistants at surgery and co-management. Services that can be split into technical and professional components may also be over-counted. On the other hand, the data appear to show that some surgeons perform virtually no surgery, presumably because the individual services they billed fell out of the data set due to the exclusion of services billed 10 or fewer times a year.

- Drugs are billed as units which represent varying dose sizes. This makes it impossible to compare physicians' drug treatment practices. In addition, some physician-administered drugs are available as patient-administered drugs which would be covered under Part D and therefore not included in the data.

4. **Billed charges and payments are not the same.** CMS will report both the physician's billed charge and the actual amount paid, which is set by the Medicare Physician Fee Schedule. Payments from Medicare and private insurers generally are much less than the billed amount.

5. **Important information is missing.** The data set does not account for patient mix or demographics, and it does not point out that a significant share of Medicare payments is used to cover such costs as office overhead, employee salaries, supplies, and equipment. Payment rates are designed to reflect these costs and are therefore higher when a service requires highly-trained staff or high cost supplies and/or equipment.

6. **Reimbursement for drugs purchased and administered by physicians is co-mingled with other physician payments.** Such reimbursement is not separately identified and there is no indication that these payments are compensation for the price of the drugs themselves, many of which are very expensive and are required to treat such serious conditions as cancer and macular degeneration.

7. **The data set does not represent the physician's whole patient population.** The database only includes fee-for-service Medicare patients and even for these patients, much of the data is missing. Medicare Advantage patients are not in the database at all. Neither are privately insured patients. As a result, it is impossible to determine the total number of times a physician does a particular procedure and make comparisons to other physicians or regions of the country.

8. **Payment amounts vary based on where the service was provided.** Medicare pays physicians less for services provided in a hospital outpatient department than for services provided in the physician's office to reflect a difference in the practice costs. But Medicare makes another payment to the facility to cover its practice costs when services are provided in the outpatient department. This means that in reality, the total costs to Medicare and the patient are often higher when a service is provided in a facility setting.

9. **The data set does not enable clear comparisons of physicians.** Medicare's specialty descriptions and practice types are not very specific, so physicians who appear to have the same specialty could serve very different types of patients and provide a dissimilar mix of services, making some subspecialists appear to be "outliers."

10. **Coding and billing rules differ over time and across regions.** Changes to Medicare's coding and billing rules need to be taken into account in any analysis because these rules frequently change over time and across different parts of the country.