Attention: Physician Data Comments
Department of Health and Human Services
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Office 341D-05
200 Independence Avenue SW
Washington, DC 20201

September 4, 2014

Dear Secretary Sebelius, Ms. Tavenner, and Mr. Brennan,

On behalf of the Center for Data Innovation (www.datainnovation.org), I am pleased to submit these comments in response to the Centers for Medicare & Medicaid Services (CMS) request for public comment on the potential release of Medicare physician data.[1]

The Center for Data Innovation at the Information Technology and Innovation Foundation, a non-profit, non-partisan, Washington-DC based think tank, conducts high-quality, independent research and educational activities on the impact of the increased use of information on the economy and society. In addition, the Center formulates and promotes pragmatic public policies designed to enable data-driven innovation in the public and private sectors, create new economic opportunities, and improve quality of life.

The recent ruling by a federal district court to vacate a 1979 injunction barring the Department of Health and Human Services (HHS) from disclosing Medicare claims data for physicians is a welcome step forward in the path towards more transparency in government and data-driven innovation in health care. This ruling has freed HHS to modify its current policy (adopted in 1980), which states that "the public interest in the individually identified payment amounts is not sufficient to compel disclosure in view of the privacy interests of the physicians." As it stands, the current policy is incongruent with the recent Presidential Executive Order mandating that government information be open and machine readable by default, as well as the great strides HHS has taken to be a leader in open data initiatives in the federal government.[2]

In this request for public comment, CMS seeks responses to the following three questions:

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[1] Centers for Medicare & Medicaid Services. "Request for Public Comments on the Potential Release of Medicare Physician Data." August 6, 2013. http://downloads.cms.gov/files/Request-for-Public-Comment-rePhysician-Data-8-6-2013.pdf (Accessed September 3, 2013).
[2] White House. *Executive Order -- Making Open and Machine Readable the New Default for Government Information* (Washington, D.C., 2013). http://www.whitehouse.gov/the-press-office/2013/05/09/executive-order-making-open-and-machine-readable-new-default-government (Accessed September 3, 2013).

1. Whether physicians have a privacy interest in information concerning payments they receive from Medicare and, if so, how to properly weigh the balance between that privacy interest and the public interest in disclosure of Medicare payment information, including physician-identifiable reimbursement data;

2. What specific policies CMS should consider with respect to disclosure of individual physician payment data that will further the goals of improving the quality and value of care, enhancing access and availability of CMS data, increasing transparency in government, and reducing fraud, waste, and abuse within CMS programs; and

3. The form in which CMS should release information about individual physician payment, should CMS choose to release it (e.g., line item claim details, aggregated data at the individual physician level).

Each question is addressed in turn below.

PHYSICIANS DO NOT HAVE A PRIVACY INTEREST IN MEDICARE PAYMENT INFORMATION

The information that CMS is considering releasing is not personally identifiable information about patients but rather information about the payments sent from the government to physicians. CMS is likely to receive some resistance from the American Medical Association (AMA) for releasing this information given the AMA's past public statements on the topic; however, physicians do not have a privacy interest in Medicare payment information.[3] Numerous court cases have found that privacy consideration should not be used to restrict disclosure of this type of information. In addition, professionals do not have a right to privacy for information about their professional activities.[4] The government should also not restrict individuals from publishing lawfully obtained, truthful information about a matter of public concern.[5] Finally, individuals do

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[3] Fiegl, Charles. American Medical News. "CMS mulls how to unseal Medicare doctor pay data." August 19, 2013. www.amednews.com/article/20130819/government/130819958/4/ (Accessed September 3, 2013).
[4] Organization for a Better Austin v. Keefe, 402 U.S. 415 (1971) http://caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=us&vol=402&invol=415 (Accessed September 3, 2013).
[5] Bartnicki v. Vopper, 532 U.S. 514 (2001). http://www.scholar.google.com/scholar_case?case=2171346211086974391&hl=en&as_sdt=2&as_vis=1&oi=scholarr (Accessed September 3, 2013), The Florida Star v. B. J. F., 491 U.S. 524 (1989). http://www.caselaw.lp.findlaw.com/scripts/getcase.pl?court=us&vol=491&invol=524 (Accessed September 3, 2013), Smith v. Daily Mail Publishing Co., 443 U.S. 97 (1979). http://www.caselaw.lp.findlaw.com/scripts/getcase.pl?court=us&vol=443&invol=97 (Accessed September 3, 2013), and Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 (1975). http://www.caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=420&invol=469 Accessed September 3, 2013).

not have Fourth Amendment protections for personal information in records maintained by third-parties, such as businesses or the government.[6]

Moreover, previous attempts at the state-level specifically aimed at restricting disclosure of information about the professional practices of physicians under the guise of protecting physician privacy have been rejected. The Supreme Court ruled in *Sorrell v. IMS Health* that a Vermont state law that restricted the disclosure of the prescribing practices of individual physicians was unconstitutional.[7] Specifically, the majority found:

> "...the State cannot engage in content-based discrimination to advance its own side of a debate. If Vermont's statute provided that prescriber-identifying information could not be sold or disclosed except in narrow circumstances then the State might have a stronger position. Here, however, the State gives possessors of the information broad discretion and wide latitude in disclosing the information, while at the same time restricting the information's use by some speakers and for some purposes, even while the State itself can use the information to counter the speech it seeks to suppress. Privacy is a concept too integral to the person and a right too essential to freedom to allow its manipulation to support just those ideas the government prefers."[8]

While (as with all comparisons) there are obvious differences with the *Sorrell* case, many of the broad lessons still apply. Most notably, detailed Medicare payment information is already being shared with a subset of entities, such as through CMS claims feeds to Accountable Care Organizations and through the Blue Button Initiative.[9]

CMS SHOULD MAKE TIMELY, ACCURATE DISCLOSURES OF PHYSICIAN PAYMENT DATA

Patients benefit when timely, accurate information is made available to them whether this information is about their personal health records or the overall functioning of the health care system. As HHS has found from its projects such as the Health Datapalooza conference, the demand for high quality health care data is strong across the public, research and private sectors.

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[6] California Bankers Assn. v. Shultz, 416 U.S. 21 (1974). http://www.caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=us&vol=416&invol=21 (Accessed September 3, 2013).
[7] Sorrell v. IMS Health Inc., No. 10-779 131 S.Ct. 2653 (2011). www.supremecourt.gov/opinions/10pdf/10-779.pdf (Accessed September 3, 2013).
[8] Ibid.
[9] Tavenner, Marilyn and Niall Brennan. HHS.gov Digital Strategy. "CMS Progress Towards Greater Data Transparency." August 6, 2013. www.hhs.gov/digitalstrategy/blog/2013/08/cms-data-transparency.html (Accessed September 3, 2013).

Health Datapalooza has seen rapid growth since its inaugural event in 2010, with over 1,900 attendees in 2013. Eighty organizations offered demonstrations of their data-driven applications this year, including several that used CMS data to enable financial and other business analytical tools. Granular paid claims data would be a crucial asset to such applications and would enable the development of more patient- and provider-facing analytical tools in the future.

CMS's own recent efforts have also received enthusiastic responses. The 2012 Blue Button initiative, which allows Medicare beneficiaries to access and download their personal health data on a website or mobile device, has already spurred patient-facing app creation, and was the focus of a recent app contest on the federal crowdsourcing platform Challenge.gov.[10]

Granular paid claims data would lend itself to a broad range of use cases, including efficiency and performance measurement beyond what has been implemented among qualified entities and Accountable Care Organizations.[11] The ability to compare providers along paid claims could also be a valuable addition to care coordination schemes, both for patients and health systems.[12]

In addition, the data could be used to inform physician recommendations in the Health Insurance Marketplace, a resource for individuals seeking health care under the Affordable Care Act.[13]

To these ends, CMS should streamline its internal formatting and reconciliation processes to facilitate daily or weekly public releases. It should strive for completeness by default, and avoid releasing only subsets of data to the extent possible, in order to maximize the versatility of the data for use in future applications. Making complete data available publicly in a machine-readable format and in a timely manner will allow for reuse by businesses, researchers, non-profit organizations, and citizens.

Releasing this information will also allow citizens to become more involved in identifying fraud, waste and abuse in CMS programs. A 2012 special communication in the Journal of the American Medical Association estimated the cost of fraud and abuse in Medicare and Medicaid to be as high as $98 billion in

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[10] Brennan, Niall. HealthData.Gov. "Medicare Blue Button, More Data Than Ever Before!" June 22, 2012. www.healthdata.gov/blog/medicare-blue-button-more-data-ever (Accessed September 3, 2013).
[11] "CMS Progress Towards Greater Data Transparency."
[12] athenahealth, Inc. Making Care Coordination Work: A Sustainable Model to Benefit the Whole Community. February 2012. www.athenahealth.com/_doc/pdf/whitepapers/Making_Care_Coordination.pdf (Accessed September 3, 2013).
[13] HealthCare.gov. "What is the Health Insurance Marketplace? https://www.healthcare.gov/what-is-the-health-insurance-marketplace/ (Accessed September 3, 2013).

2011.[14] The HHS Office of the Inspector General has identified Medicare and Medicaid fraud as one of its top management and performance challenges, and has noted that data mining solutions to automated fraud detection are an area of increased focus. The public release of granular paid claims data could foster savings through greater involvement of data-driven private sector firms in solving these problems.[15]

The value of the data for fraud detection could be maximized in a number of ways. For one, CMS has proposed to modify the reward structure of the Medicare Incentive Reward Program which would encourage greater engagement with this data.[16] A similar reward increase to the IRS Incentive Reward Program has been a considerable success, with $592 million in collections attributed to whistleblowers in 2012, up from $61 million in 2003.[17]

Another approach to fostering automated efforts to detect fraud and abuse with this data could be realized through engaging existing civic hackathons and other app contests. In health care, these vary in size and scope from the Robert Wood Johnson Foundation's highly targeted Hospital Price Transparency Challenge to the Knight Foundation's broadly focused Knight News Challenge: Health.[18] Such contests are often designed to derive value from specific data sets, and could serve to accelerate the adoption of granular claims data in a variety of contexts, quickly putting the data to use in some applications and identifying potential future uses in others.

CMS SHOULD RELEASE DETAILED CLAIMS DATA

Under its new rule, CMS should endeavor to release granular physician claims data in a widely-accepted, non-proprietary file format. Details should include the amount paid to each unique health care provider, the items or services provided, and the location of the provider. In addition to the line item claim details, each entry should be accompanied by the provider's unique identifier (i.e. the National Provider Identifier).

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[14] Berwick, Donald and Andrew D. Hackbarth. "Eliminating Waste in US Health Care." *Journal of the American Medical Association* 307 (2012): 1513-1516. doi:10.1001/jama.2012.362 (Accessed September 3, 2013).
[15] Office of Inspector General, U.S. Department of Health and Human Services. "Management Issue 3: Preventing and Detecting Medicare and Medicaid Fraud." https://oig.hhs.gov/reports-and-publications/top-challenges/2012/issue03.asp (Accessed September 3, 2013).
[16] "Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment." Federal Register. https://www.federalregister.gov/articles/2013/04/29/2013-09991/medicare-program-requirements-for-the-medicare-incentive-reward-program-and-provider-enrollment (Accessed September 3, 2013).
[17] Internal Revenue Service. "Fiscal Year 2012 Report to the Congress on the Use of Section 7623." www.whistleblowers.org/storage/whistleblowers/docs/BlogDocs/2012%20irs%20report.pdf (Accessed September 3, 2013).
[18] "RWJF Hospital Price Transparency Challenge." Health 2.0 Developer Challenge. www.health2con.com/devchallenge/rwjf-hospital-price-transparency-challenge/ (Accessed September 3, 2013).
Knight Foundation. "How can we harness data and information for the health of communities." https://www.newschallenge.org/challenge/healthdata/brief.html (Accessed September 3, 2013).

Data should be released in a machine-readable format and be accessible to the public in a searchable online database at no cost.

CONCLUSION

CMS has an enormous opportunity to unlock a valuable data set for public benefit. To maximize the public benefit of releasing data, CMS should adhere to the principles of accuracy, completeness and timeliness. Ongoing efforts to release health care claims data and health care quality data have the potential to unleash new patient-friendly tools to make it easier for consumers to shop for health care and stimulate price competition among health care providers. In addition, releasing physician claims data may be particularly useful for fostering citizen-led efforts at combatting fraud, waste, and abuse within Medicare and Medicaid. Finally, releasing detailed physician claim data will help provide additional information for use by researchers, policymakers, and the private sector.

Sincerely,

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