Consumer-Purchaser
DISCLOSURE
PROJECT Improving Health Care Quality through Public Reporting of Performance

November 30, 2010

Donald Berwick, MD, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: Implementation of the Physician Compare Website
Comments from National Consumer, Labor, and Employer Organizations

Dear Dr. Berwick:

The 34 undersigned organizations representing consumer, labor and purchaser interests appreciate the opportunity to comment on the development of Physician Compare. Through Physician Compare, CMS will have the opportunity to help millions of Medicare beneficiaries make better decisions about who they choose to be their physicians. For far too long, consumers have been making these choices with little or no meaningful information regarding how well physicians care for their patients. Beyond facilitating consumer decision-making, public reporting promotes accountability and stimulates improvement. To achieve these aims, CMS should:

- Provide only information that meets consumer needs, including performance measures that help consumers make decisions on doctor choice and treatment;
- Report information at the individual clinician level, where variation in performance is most evident, and not just the practice group level, whenever feasible;
- Show differences in physician performance and not allow variations across physicians to be unduly obscured;
- Balance the desire for methodological perfection with consumers' immediate need for information about how their physicians care for their patients; and
- Support the availability of comprehensive physician performance information for the website by fostering the growth of all-payer data.

In this fiscally challenging time, the agency must ensure that the significant investment in Physician Compare truly enables consumer decision-making and accountability. To do so, the agency will also need to chart a course for Physician Compare that is dramatically different from those of the existing Compare websites, which still struggle to be effective despite incremental efforts to improve them. We would like to see the design and content of the Physician Compare website bypass these issues and be built from the ground-up with a consumer orientation. To do so, we strongly encourage CMS to adopt the standards outlined in the *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs*[1] (the Patient Charter), which have been agreed upon by a wide range of stakeholders and balance fairness to physicians with consumer need for information. Many health plans and regional collaboratives are adhering to these standards.

[1] Consumer-Purchaser Disclosure Project, Patient Charter for Physician Performance Measurement, Reporting and Tiering, April 2008, http://healthcaredisclosure.org/docs/files/PatientCharter040108.pdf>

C/O National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650
Washington, DC 20009
202.986.2600 • 202.986.2539 (fax) • healthcaredisclosure.org

What follows are detailed recommendations on making Physician Compare a credible and usable source of information for Medicare beneficiaries.

SELECT PERFORMANCE MEASURES THAT ARE MEANINGFUL TO CONSUMERS

CMS should populate Physician Compare with measures that matter to consumers. The agency must avoid relying on measures of process and center its work on high-value measures that are meaningful to consumers. Below are recommendations on how CMS can achieve this objective.

Ensure the wide range of measures required by the Affordable Care Act (ACA) are reported

The ACA mandates that the website be populated with information on: patient health outcomes; functional status; care coordination and transitions; resource use; efficiency; patient experience; and patient, caregiver and family engagement. CMS should publicly report this information as soon as possible because it reflects what matters most to consumers and offers the greatest potential for accelerating health system improvements. To support this work, CMS must make it a priority to guarantee that measures have been developed to assess provider performance on these critical facets of care and ensure that the measures are rapidly implemented within federal and other programs to generate the needed data. We also encourage – in the measure selection process – that the agency heavily weigh the advice of leaders of consumer organizations with the most direct experience in helping consumers compare goods and services via quantitative methods.

Use a core set of measures that applies across *most* professionals

To facilitate comparability, Physician Compare should include a core set of measures that applies to all relevant professionals. A core set of measures should include patient experience among other high-value measures. However, CMS should also add performance measures beyond those in the core set even where such measures may not apply to all health care professionals. For example, not all physicians will participate in the *Meaningful Use* program, but this should not preclude CMS from reporting information on how well participating physicians are using HIT to improve patient care.

Be selective of measures in the Physician Quality Reporting System (PQRS) and broaden the focus of Physician Compare well beyond PQRS

Consistent with the ACA, CMS will post information on physician performance that includes information collected under PQRS. PQRS is a reasonable starting point and consumers and purchasers have long advocated for PQRS performance data to be made public. At the same time we encourage the agency to incorporate only high-value measures from PQRS. For example, CMS should not post performance information from PQRS measures (or any other source) that:

- Assess basic competencies of care.
- "Document" the presence of evaluation, assessment, and counseling. Documentation measures do not assess the quality of care provided and are often not evidence-based. Furthermore, there is a poor relationship between such measures and patient outcomes.[2]
- Reflect processes that are not linked to improved outcomes. A recent study by the University of Michigan found little correlation between patients' death and complication rates from surgery and how well hospitals complied with Medicare's process measures, which are posted on Hospital Compare.[3]

Given PQRS' current limitations (e.g., too few measures that resonate with consumers; consumer inability to compare performance across individual providers due to self-selection of measures to report on),

---

[2] Mark R. Chassin, M.D., M.P.P., M.P.H., Jerod M. Loeb, Ph.D., Stephen P. Schmaltz, Ph.D., and Robert M. Wachter, M.D. Accountability Measures, Using Measure to Promote Quality Improvement, New England Journal of Medicine, June 2010. <http://healthcarereform.nejm.org/?p=3580 >

[3] Wall Street Journal, Medicare Faulted on Surgery Evaluation, October 2010 <http://online.wsj.com/article/SB10001424052702303496104575560522424599924.html>.

Physician Compare should also include performance information from the *Meaningful Use* program and other ACA mandated initiatives, e.g. the value-based payment modifier, accountable care organizations (ACOs), medical homes, and pilots in the Center for Medicare and Medicaid Innovation.

Make publicly reported information on patient experience – an area where rich measures already exist – a top priority

Besides resonating deeply with consumers, measures of patient experience assess whether patients are receiving the kind of care that is most likely to improve their outcomes and are good indicators of care quality for those with complex conditions. These measures are therefore important to assessing care for the large and growing number of Medicare patients with multiple chronic conditions who use the health system the most, generate the most cost and are the most vulnerable to low quality, poorly coordinated care. Evidence also shows that consumers care about how physicians are viewed by others like themselves and are seeking physician-specific information, not practice or group level.[4] To facilitate the collection of patient experience data, we suggest that CMS create a place on the Physician Compare website that allows consumers (after validly logging in as a Medicare beneficiary), to rate their experience with specific physicians using validated surveys.

Don't let the perfect be the enemy of the good

The ACA calls for the website to use "scientifically sound measures." In defining this phrase, CMS must recognize that there is no such thing as a perfect measure and the desire for perfection must be balanced with the critical need to place information about physician performance in the hands of consumers. Consumers are currently making decisions about physicians virtually blind. They are far better served by making information from existing performance measures available now and adding more precise measures as they become available rather than waiting. Importantly, determining whether a measure is "scientifically sound" is a value-laden process, and the perspective of those who receive and pay for care should be effectively represented in these assessments.

Employ composites to improve information use

Composite measures help consumers quickly and easily evaluate a provider by providing an overall picture. This is helpful given that research shows that when people get too many pieces of information at once, their ability to pay attention to, think about, and remember the information is compromised; in other words, less is more.[5] Composites also have the benefit of improving reliability. We encourage:

- The use of the composites that assess whether patients received all appropriate care for their condition, treatment or procedure (i.e., composites that use a patient-centered all-or-none method). An example is the Minnesota Community Measurement's Optimal Diabetes Care Composite.[6]
- Composites to be constructed in a way that allows interested consumers as well as others to drill down to more detailed performance data.
- CMS to build on the expertise of other communities that are working on composite measures. In California, the Pacific Business Group on Health is researching how to best develop composite measures of physician performance on various clinical conditions to meet consumer needs.

---

[4] Kaiser Family Foundation, AHRQ, Harvard School of Public Health, *National Survey on Consumers' Experiences With Patient Safety and Quality Information,* November 2004 <http://www.kff.org/kaiserpolls/upload/National-Survey-on-Consumers-Experiences-With-Patient-Safety-and-Quality-Information-Survey-Summary-and-Chartpack.pdf>. Conversation with Dr. Judith Hibbard on November 5, 2010.

[5] Ellen Peters, Nathan Dieckmann, Anna Dixon, Judith H. Hibbard, C.K. Mertz, *Less is More in Presenting Quality Information to Consumers*, Medical Care Research and Review, Vol. 64, No. 2 (2007): 169-190. <http://mcr.sagepub.com/cgi/content/abstract/64/2/169>

[6] http://www.mnhealthscores.org/?p=our_reports&sf=clinic&search_phrase=&category=1&name_id=&compare=

Include NQF endorsed measures as well as non-endorsed measures if certain standards are met

To better ensure that measures reflect accepted standards of health care quality, the federal government and others look to the National Quality Forum (NQF) to evaluate and endorse measures for use. However, NQF's current portfolio of physician measures does not include the full range of measures that matter to consumers and purchasers. Therefore, non-endorsed measures should be permitted to be used in Physician Compare if they meet certain criteria such as those outlined in the Patient Charter:[7]

- The primary source of measures should be measures endorsed by NQF. However, when non-NQF measures are used because NQF measures do not exist or are unduly burdensome, they should be used with the understanding that they will be replaced by comparable NQF-endorsed measures when available.
- Where NQF-endorsed measures do not exist, the next level of measures that should be considered (to the extent practical), should be those endorsed by national accrediting organizations, federal agencies, and others.
- Supplemental measures are permitted if they address areas of measurement for which national standards do not yet exist or for which existing national standard measure requirements are unreasonably burdensome on physicians or program sponsors. Supplemental measures should reasonably adhere to the NQF measure criteria (importance to measure and report, scientific acceptability, feasibility, and usability).

REPORT INFORMATION AT THE INDIVIDUAL PHYSICIAN LEVEL

For Physician Compare to be useful for consumers and help spur individual physician-level improvement, information must be reported at the level of the individual physician. The law supports this goal and the science is in place to facilitate it. And in addition to helping consumers make decisions, information on individual physician performance also better equips physicians in choosing their teammates and making referrals.

The ACA reinforces reporting at the level of the individual physician

The ACA states that Physician Compare will provide "comparable information for the public on quality and patient experience measures with respect to physicians enrolled in the Medicare program." Research has shown that individual-level measures are what consumers need and want.[8] Consumers need to select individual physicians to be a part of their care team, even where team-based practice occurs. Consumer focus groups have revealed that consumers want information at the level of the individual physician, not at the practice group level.[9] And the growth of independent sites such as HealthGrades, RateMDs.com and Angie's List speaks to the growing desire of consumers to access information about specific physicians.

The ACA also states that information must be a "robust and accurate portrayal of a physician's performance." Practice group level data is not always representative of an individual physician's performance as the way physicians within the same group practice care for their patients can vary significantly, and individual physicians greatly impact the care that a patient receives. For example:

- In the area of patient experience, research shows that individual physicians account for the largest proportion of explainable system-level variation across all patient experience measures, as well as the most variation in measures assessing the quality of physician-patient interactions.[10]

---

[7] Consumer-Purchaser Disclosure Project, Patient Charter for Physician Performance Measurement, Reporting and Tiering, April 2008 <http://healthcaredisclosure.org/docs/files/PatientCharter040108.pdf>
[8] Conversation with Dr. Judith Hibbard on November 5, 2010.
[9] Conversation with Dr. Judith Hibbard on November 5, 2010.
[10] Rodriguez et al, Attributing Sources of Variation in Patients' Experiences of Ambulatory Care, Medical Care, Vol. 47, No. 8, August 2009.

- A study conducted for CMS by Acumen, LLC, found that "generally speaking, care for a patients' episode is primarily influenced by just one provider, as indicated by a majority of episodes constructed from [Medicare Part B] claims submitted by a single provider."[11]
- Individual physicians write the orders that account for 89% of total expenditures.[12]

Reporting at the individual level is ready for primetime

Some may say that the science behind assessing individual physician reporting is not ready for consumer consumption. However, the science has been continuously improving. A number of techniques can be applied to identify reliable and valid performance information on individual physicians:

- Aggregate data across payers. The California Physician Performance Initiative and others have achieved reliable and valid individual level performance data through this method.[13]
- Employ composites.[14]
- Use multi-year data.

Determining whether information is good should be something left up to consumers, as consumers have a different threshold for precision than other stakeholders.[15] For instance, where performance strata depend on statistical confidence intervals, individual Medicare beneficiaries should be allowed to select what level of confidence is appropriate for their decision-making rather than have CMS make this determination on behalf of all beneficiaries.

Other users can also benefit from individual physician performance information

Performance information is helpful to physicians who are making referrals or choosing other physicians to be a part of a patient's care team. Some specialists are requesting that their information not be reported at the individual level because they are assigned to patients and cannot be selected by patients (e.g., anesthesiologists, hospitalists), however information on these specialists will still be valuable to other physicians. Similarly, hospitals would also find this information helpful because they contract with individual physicians.

Link to existing websites that display individual physician performance information

Physician Compare should include links to other sites that provide individual physician performance information, such as Consumers' CHECKBOOK's "What Patients Say About Their Doctors."[16] Federal and state portals for Health Insurance Exchanges may also contain information on individual physician performance. If they do, their links should be included. The agency should also vet linked sites to ensure that they are credible.

SET STANDARDS FOR REPORTED DATA THAT DO NOT OBSCURE VARIATIONS IN CARE

The ACA requires that publicly reported data be "statistically valid and reliable" through mechanisms that include risk adjustment. In fulfilling this requirement, CMS should ensure that variation across measured providers is not obscured in public reporting, a concern that consumers have voiced regarding the reporting of outcome measures in Hospital Compare. This may result from over-adjusting for risk and/or applying standards for statistical confidence in reporting that are too high. Standards that are applied to

---

[11] MaCurdy T, Theobald N, Kerwin J, et al., Prototype Medicare Resource Utilization Report Based on Episode Groupers, Burlingame, CA: Acumen; 2008. Available at www.cms.gov/reports/downloads/MaCurdy2.pdf.
[12] A. Sagar and D. Socolar, Health Costs Absorb One-Quarter of Economic Growth, 2000-2005, page 30, Exhibit 10.
[13] California Physician Performance Initiative Methodology for Physician Performance Scoring, Cycle 4, June 2010 <http://www.cchri.org/programs/documents/FINALMethods_Document_Cycle4_Final6_10_2010.pdf>.
[14] SH Scholle, J Roski, J Adams, D Dunn, EA Kerr, DP Dugan, R Jensen: Benchmarking Physician Performance: Reliability of Individual and Composite Measures. Am J Managed Care, December 2008, Vol. 1414(12):829-38.
[15] Matthew M. Davis, Judith H. Hibbard, Arnold Milstein. Consumer Tolerance for Inaccuracy in Physician Performance Ratings: One Size Fits None. Center for Studying Health System Change, March 2007. <http://www.hschange.com/CONTENT/921/>
[16] Consumers' CHECKBOOK, What Patients Say About Their Doctors <http://www.checkbook.org/patientcentral/>.

improve statistical validity and reliability should reflect the needs of those who receive and pay for care as well as the needs of providers to be represented accurately. Patients and purchasers need information that distinguishes performance within their local market areas.

In the same vein, we also encourage the agency to employ data display techniques that show variation in performance among physicians. This could include using deciles or quartiles, or including benchmarks that identify physicians who are best-in-class or in the top 10%. These techniques will help propel consumers toward physicians who supply high-quality and high-value care, and allow them to more easily make decisions by using the site.

SUPPORT THE AVAILABILITY OF COMPREHENSIVE PERFORMANCE INFORMATION BY FOSTERING THE GROWTH OF ALL PAYER DATA

The ACA requires that Physician Compare use "data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance." To support this provision, CMS should make Medicare data available, in the implementation of section 10332 of the ACA, at the individual patient level to make it possible to link information on how the patient was cared for across different providers. At the same time patient identifiers should be encrypted to maintain privacy, permit lawful release, and avoid HIPAA complications while permitting appropriate linking of patient-level records for longitudinal analyses. Doing so will foster the growth of all-payer databases which will allow CMS to gain greater access to the data needed to populate Physician Compare with information that comprehensively assesses how physicians cares for all their patients. All-payer databases will also give regional collaboratives better information with which to populate their physician selection tools. Regional collaboratives across the nation are laboratories for innovation, leading the way in developing and communicating physician performance information. They can help CMS achieve its goal of advancing transparency and consumer choice with greater speed. Encouraging more public-private collaboration on ACA initiatives (e.g., ACOs, medical homes, pilots from the Innovation Center) will also facilitate data aggregation across payers.

However, CMS should not wait until all-payer data becomes available to publicly report Medicare data. CMS should start with Medicare data and broaden the number of measures that can be reliability scored over time by including private payer data.

MAKE THE WEBSITE EASY FOR CONSUMERS TO UNDERSTAND AND NAVIGATE

We encourage CMS to make the website easy for consumers to use by:

- ***Including decision-support tools:*** Helping consumers make the best choices for their characteristics and preferences will require the website to have good decision-support tools (e.g., frame the decision context, use summary performance indicators while still offering detail by allowing users to drill down, permit sorting of information based on patients' values and preferences, provide step-by-step search instructions, contain language that is simple and jargon-free, etc.).
- ***Being mindful of the consumers' diverse needs*:** Medicare beneficiaries have varying literacy levels, language preferences, and health needs. Physician Compare should take these differences into account.
- ***Leveraging lessons learned from existing physician reporting sites and research.*** CMS should build on the experiences of regional collaboratives (e.g., Aligning Forces for Quality and Chartered Value Exchanges), states, and others with a history in communicating provider performance information.[17] Entities such as the Aligning Forces for Quality collaboratives have conducted extensive focus groups to assess consumer understanding of physician performance information.

[17] Minnesota Community Measurement, Minnesota HealthScores (http://www.mnhealthscores.org/); State of New Jersey, Cardiac Surgery in New Jersey 2006 (includes a section on individual surgeon performance) (http://www.state.nj.us/health/healthcarequality/documents/cardconsumer06.pdf); Consumers' CHECKBOOK, What Patients Say About Their Doctors (http://www.checkbook.org/patientcentral/).

CMS can also tap into resources that provide guidance on communicating with consumers such as its *Toolkit for Making Written Material Clear and Effective*, AHRQ's *Talking Quality website*, and work by Dr. Judith Hibbard and Dr. Shoshanna Sofaer.[18,19 ,20]

- ***Taking inspiration from how other industries use the web to successfully reach consumers*.** The private sector successfully connects with consumers using inventive web-based mechanisms. For example, Amazon.com has built in capabilities to make recommendations to consumers based on their past behavior (and the behavior of people like them) and several major online retailers provide chat boxes that consumers can use to communicate directly with support staff. We encourage CMS to explore how to incorporate tools like these into Physician Compare to more effectively engage consumers.
- ***If reported, trending data should be presented in a way that is not burdensome for consumers.*** If trending data are available, CMS could include it on the website; however, this information should be displayed in a way that is not confusing or cumbersome for consumers (e.g., allow consumers to drill down to this information if they are interested in it, provide a high-level indicator of whether a physician's performance has been improving or getting worse).
- ***Testing the website while under development with consumers, and continue to solicit feedback once the website is live***. Testing will reveal areas consumers do not understand, specific misinterpretations, difficulty users have finding information within reports, and users' perception of the information's relevance. For example, until recently Hospital Compare was very difficult for consumers to navigate, particularly when it came to finding outcomes information or data on patient experience. The agency's recent work with consumer focus groups have resulted in significant improvements not only to the navigability of the site, but also to how the data is displayed and the contextual information that is provided to help consumers interpret the data. In developing Physician Compare, CMS should learn not only from the lessons of the Hospital Compare focus groups, but also follow this example and begin the process of designing the site by consulting with consumers from the beginning. Of course, the agency should also solicit feedback about the site once it has been launched to support continual improvement.
- ***Expand the Healthcare Provider Directory to meet consumers' broader information needs.*** We encourage the agency to consider how it might expand the Directory, in addition to the Physician Compare work, and provide information on other important physician attributes that consumers need to know about when selecting a physician, such as whether a physician is participating in a Maintenance of Certification (MOC) program. MOC programs require physician participation in lifelong learning and continuous professional development and include, among other things, assessment of physician practice performance that includes patient experience and improvement. It's also helpful for consumers to know whether physicians are accepting new patients.

FACILIATE DISSEMINATION OF PHYSICIAN COMPARE INFORMATION THROUGH OTHER CHANNELS

To maximize Physician Compare's impact and reach, CMS should identify regional and national organizations that patients reach out to and encourage these organizations to advertise the availability of Physician Compare (e.g., by providing a link to the website). The agency can also facilitate dissemination by making the performance information available in a way that allows it to be repurposed for distribution through other venues. Hospital Compare, for instance, allows any entity to download every hospital's score on every measure in either a Microsoft Access format or a CSV format.

MAKE INFORMATION CURRENT WHERE POSSIBLE

It's important to have current data to facilitate consumer-decision making. To give consumer access to the most recent information, physicians should be allowed to directly update their contact information, specialty, and other similar information. We do not, however, support allowing physicians to directly

[18] AHRQ, Talking Quality https://www.talkingquality.ahrq.gov/default.aspx.
[19] CMS, Toolkit for Making Written Material Clear and Effective <http://www.cms.gov/WrittenMaterialsToolkit>.
[20] *Judith Hibbard and Shoshanna Sofaer,* Best Practices in Public Reporting No. 1: How To Effectively Present Health Care Performance Data To Consumers, AHRQ <http://www.ahrq.gov/qual/pubrptguide1.htm>.

revise information on how well they care for their patients. As required by the Affordable Care Act (ACA), physicians will have an opportunity to review and correct their performance information before it is posted on the website, so there is no need for them to have the capability to update the performance website information on their own.

Also, while we believe that the Medicare physician performance data available at this time, despite its time lag, is a good starting point for Physician Compare, we encourage CMS to increase the speed at which Medicare data is collected and made available to consumers. To help consumers understand how current the information posted is, CMS should also document the date the information was last updated.

ALLOW A REASONABLE AMOUNT OF TIME FOR DATA PREVIEW THAT WILL NOT JEOPARDIZE GETTING TIMELY INFORMATION TO CONSUMERS.

We support providing those who are being measured and reported on with a reasonable amount of time to review and, where appropriate, correct information about their performance, as outlined in the Patient Charter.[21] A reasonable timeframe will not prevent getting timely information to consumers. Additionally, CMS must be nimble and efficient in making the needed corrections, as this will have implications on the currency of performance information. Before Physician Compare goes live, CMS should also launch a physician education campaign that impresses upon physicians that their Medicare claims data will be used to populate the website so physicians should ensure that data that they are submitting to CMS are complete and accurate. We also recommend that the review process be conducted electronically (e.g., through web portal), to promote a more efficient process.

USE ELECTRONIC HEALTH RECORDS, CLAIMS, REGISTRY AND PATIENT-REPORTED DATA

Electronic health records (EHRs) will become an increasingly important source of information, especially in light of the federal government's investment in *Meaningful Use*. However, claims data are the most readily available source of information at this time and provide information to support measures of outcomes (e.g., mortality, complications, hospital readmission), process of care (e.g., immunizations, adherence to evidence-based guidelines on laboratory and medication orders), resource utilization, and cost-efficiency.[22] Even with the growing use of EHRs, claims data will continue to be a vital source of information on cost. While some individuals may argue that administrative data are incomplete and inaccurate, studies have shown that they are appropriate for many purposes and there is no assurance that information in an EHR is always complete and accurate.[23] Rather than dismissing data, those responsible for its generation should focus on improving accuracy and completeness. And the amalgamation of claims, pharmacy and laboratory data can at times be comparable to a good EHR. Undoubtedly, though, moving beyond the reliance on claims data to the use of other types of electronic data like EHRs will facilitate more comprehensive and efficient outcomes-based performance reporting. Additionally, access to EHR information is real-time and can support clinical decision-making where and when it is needed. Registry data are also readily available for some specialties and provide a longitudinal view of patient care that allows for reporting on patient outcomes.

While administrative and clinical data should be used to the maximum extent possible, patients are another important source of information. The beneficiary of health services is often in the best position to evaluate the effectiveness of those services. We therefore recommend that Physician Compare also use patient-reported data.

---

[21] Consumer-Purchaser Disclosure Project, Patient Charter for Physician Performance Measurement, Reporting and Tiering, April 2008, http://healthcaredisclosure.org/docs/files/PatientCharter040108.pdf>
[22] Consumer-Purchaser Disclosure Project, Using *Electronic Data for Performance Measurement*, October 2007 <http://healthcaredisclosure.org/docs/files/UsingElectronicDataOct2007.pdf>
[23] Ibid. Pacific Business Group on Health and Lumetra, *Using Administrative Data to Assess Physician Quality and Efficiency*, (2005). <http://www.pbgh.org/programs/documents/PBGHP3Report_09-01-05final.pdf>

We also encourage CMS to use data from any of these sources from reporting periods prior to January 2012. Although the ACA states that Physician Compare will use data from reporting periods beginning no earlier than January 2012, during the Physician Town Hall Meeting, CMS staff clarified that this ACA provision is subject to interpretation and the website could use earlier data. Including data from reporting periods before January 2012 will provide immediate access to multi-year data, which can be used to increase sample sizes and therefore expand the number of measures that can be reliably reported on, and supply trending data.

On behalf of the millions of Americans represented by the undersigned organizations, thank you for your efforts and your responsiveness to our comments. We look forward to seeing CMS translate its dedication to transparency and empowering consumers in their health into the effective and rapid implementation of Physician Compare. If you have any questions, please contact either of the Disclosure Project's co-chairs, David Lansky, President and Chief Executive Officer of the Pacific Business Group on Health, or Debra L. Ness, President of the National Partnership for Women & Families.

Sincerely,

The Alliance
American Benefits Council
American Hospice Foundation
Buyers Health Care Action Group
Childbirth Connection
Community Health Foundation of Western and Central New York
Consumers' CHECKBOOK
Consumers Union
Dallas-Fort Worth Business Group on Health
Employer's Coalition on Health
Employers' Health Coalition
The Empowered Patient Coalition
Health Action Council Ohio
Health Care Incentives Improvement Institute
HealthCare 21 Business Coalition
Health Policy Corporation of Iowa
HR Policy Association
Iowa Health Buyers Alliance
The Leapfrog Group
Louisiana Business Group on Health
Lowe's Companies, Inc.
Mid-Atlantic Business Group on Health
Midwest Business Group on Health
National Business Coalition on Health
National Family Caregivers Association
National Partnership for Women & Families
National Retail Federation
New Jersey Health Care Quality Institute
Northeast Business Group on Health
Oregon Coalition of Healthcare Purchasers
Pacific Business Group on Health
Puget Sound Health Alliance
PULSE of America
Texas Business Group on Health