The Medicare Data Release Conundrum

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As almost every physician in the country is now aware, the Centers for Medicare & Medicaid Services (CMS) published data in early April 2014 that showed detailed information on the $77 billion that 880 000 health care practitioners billed for some 6000 types of Medicare Part B services in 2012 (1). The data release came as a result of a Freedom of Information Act request made by *The Wall Street Journal* and a court decision that allowed it. The decision reversed an earlier federal court injunction that the American Medical Association had secured 35 years ago preventing the release of Part B Medicare payments made to individual physicians. Rather than respond to each request for the data, such as the one *The Wall Street Journal* made, the CMS released a public-use data file that contained all of the 2012 information on utilization, payment, and submitted charges by provider identification number, procedure code, and place of service. The CMS redacted data that involved fewer than 11 patients because of patient privacy concerns.

Although many consumer advocates, employers, and insurers supported the data release for providing greater and much-needed transparency to the Medicare program, many physicians reacted with anger, indignation, and resentment at reports showing how much they had billed Medicare. Part of the response came from a sense of exposure at having their individual Medicare billings listed on the Internet and discussed in local newspapers. However, at least part of the frustration came from physicians who were generally in favor of sharing information but viewed this data release as providing potentially misleading information because it did not indicate how many physicians or other health care professionals may have billed Medicare by using a single provider number or how much of the charge might be for overhead expenses, such as injectable chemotherapy or other types of drugs.

The American Medical Association had also raised concerns about potential errors in the data. It had requested that physicians be allowed to review the data before they were released but should not have been surprised that the request was not granted. The relevant institutional providers had never previously reviewed prior data releases, such as those for hospital payments or the hospital mortality statistics that were released in the 1990s. Furthermore, because these data were the basis for payments made to physicians and other Part B providers in 2012—unlike other reporting data—assuming accuracy was not unreasonable.

Where Could the Data Be Helpful?

The purported purpose of the data release is 2-fold: To help detect and ferret out fraud and abuse, and to help consumers or patients make more informed choices about which physicians they should choose. It is easy to see how the data might help identify "targets of opportunity" for further fraud or abuse investigations, and at least 3 of the top 20 billers are already under investigation for fraud. Being a high biller, even an extraordinarily high biller, is not necessarily a sign of fraud or abuse, but a high total of particular procedures that far exceed the norm should at least suggest opportunities for further exploration. There are many legitimate explanations for greater use, such as sicker patients or large groups of physicians or other health care professionals billing under a single provider number.

The data may also help further our understanding of variations in health care use and spending. One of the major conclusions of the recently released Institute of Medicine report on geographic variations, "Variation in Health Care Spending: Target Decision Making, Not Geography," is that use and spending vary almost as much within geographic areas as across them and that to reduce inappropriate variation requires focusing on the level at which decisions are made (that is, the hospital or physician practice) (2). Analyses at the physician level could help document the extent of this type of variation.

What Is Missing?

The area that is most in need of better data and is perhaps least well-served by the payment data release—described by some physicians as "nothing more than a huge data dump"—is help for patients who are trying to find out which physicians might be best for treating their conditions. The data could help patients identify the physicians who do substantial numbers of certain types of treatment. Although this information is not always important, the quantity of procedures done is frequently a good predictor of better patient outcomes for some complex procedures, such as coronary artery bypass grafting.

However, even in terms of procedure volume, the data could be misleading. They include only Medicare data and not the procedures covered by Medicaid or private-sector payers. The data also may attribute volumes to a single physician when, in fact, they reflect the experience of multiple physicians in the same practice.

However, the most serious limitation with the data is the absence of any quality metrics or any risk or case-mix adjustment to indicate the illness levels of the patients being seen. Fortunately, more sources of this information are being made available. Many major insurers are providing their enrollees with information on the probable cost of a particular procedure, depending on the physician seen and

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the quality metrics associated with various physicians and hospitals in the insurer's network that do such procedures.

The government is also starting an official Physician Compare Web site that should help consumers make more informed choices (3). It will include such factors as demographic characteristics and individual-level quality metrics for program participation and will be a companion Web site to the existing Hospital Compare site that provides information on how well hospitals provide recommended care to their patients. It currently provides information for group practices of 25 or more on performance metrics for diabetes and coronary artery disease.

What Is Next?

The emphasis on transparency in pricing and quality in health care is here to stay. Such metrics have been increasingly available for hospitals and managed care plans but rarely for physicians. Making accurate and relevant physician information available will be changing and remain a work in progress for years to come. The physician groups that are willing to take leadership positions in developing useful and accurate information at the individual practice level will be doing their fellow practitioners a great service—even if it is not always perceived that way.

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Note: Dr. Wilensky is a former administrator of the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) and a former chair of the Medicare Payment Advisory Commission.

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