Medicare Physician Payment Data: Is This Transparency?

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After reading the *New York Times* report of recently released data on Medicare payments to physicians (1), we used the accompanying "interactive tool" to see our own numbers and those of our colleagues. What we found confused and concerned us more than it clarified. Transparency in health care is greatly needed. The striking variation in physician payments makes these data both important and illustrative. More care is not necessarily better, but neither is less. Wide variations invite thoughtful discussion of how best to allocate finite resources. The amount of money in question and the potential for misuse demands it. However, comparing the annual Medicare payments to a physician or medical specialty without deeper consideration of the data represents misuse as well.

The interactive tool reduces 10 million lines of data on 880 000 physicians performing more than 6000 Medicare-covered services to 1 annual payment per physician (2). We both see patients, teach, conduct research, have substantial administrative roles at an academic medical center, and interact with physicians in myriad practice settings around the country. Our jobs necessitate facility not only with the practice of medicine but also increasingly the business of medicine. Still, we can only guess at explanations for the variability of these data. Our colleagues in health care finance had differing explanations. If persons involved in the daily practice and economics of medicine cannot decipher these figures, where does that leave patients?

First, everyone should avoid the impulse to view these data as quality indicators (3). Volume (and the costs it generates) and quality are not the same (4). In theory, the more procedures that individual physicians or hospitals perform, the better they should be at doing them. Although the Medicare data provide some measure of volume, they offer no information about appropriateness. Was a particular drug or test required? How did its use affect overall care? Was a choice made to use a less (or more) expensive therapy over other options? Most important, Medicare annual payment figures provide no insight into whether the patient benefited from the treatment.

Second, the data are imprecise measures of an individual physician's practice or income. For some physicians, Medicare beneficiaries represent a small proportion of their patient panel compared with other physicians who might see only Medicare patients. Further, these numbers represent more than physician services alone. Some numbers include drug costs (for example, for macular degeneration or cancer chemotherapy) or laboratory services, and their linkage to physician payments is an artifact of the system. Wrapping other reimbursements with physician services make the data confusing to decipher and can create perverse incentives for their interpretation (5).

Third, greater expense does not necessarily mean greater efficacy. The data highlight the demographics of health care for an aging population. Overrepresentation of payments to physicians who care for conditions of elderly persons (for example, cancer, cataracts, and macular degeneration) is no surprise and reflects implicit decisions about what patients demand and what the government agrees to pay for. Optimally, we will use this type of data to drive decisions that improve health care value. Do we sufficiently improve quality of life and other important end points to justify these costs? Higher payments may be appropriate for some services but inappropriate for others.

Fourth, physicians are only part of the story. Although $20 million in annual Medicare payments to 1 physician makes a sensational headline, physician services are just a sliver of health care spending. No doubt some rapacious physicians have pumped up billing unethically if not illegally, but a significant proportion of overall health care costs are not specific to physicians. Basing policies on physician reimbursement data without consideration of drug, testing, and facility fees is unlikely to move the United States ahead with regard to health care value.

These cautions aside, regional variation in costs of care is rampant and we must figure out why (6). Geographic variation clearly exists, but some differences are astounding. For example, total reimbursement to individual radiation oncologists ranged from $237 to more than $2.7 million in Philadelphia, where we practice; $206 788 to $802 627 in Des Moines; and $7437 to $33 177 in San Francisco. What could justify such substantial variation within and among these cities? A deeper review of the data provides some explanation. Examining 1 diagnostic code (77421, using stereoscopic x-ray guidance to guide radiation therapy) reveals that at 1 academic center in Philadelphia, a physician performed this service 616 times on 321 patients. The average amount billed was $63, and the average Medicare reimbursement was $15 per treatment. At a suburban private practice, this same service was done 1744 times on 51 patients; the average billing was $300, and the average reimbursement was $69 per treatment. The Philadelphia academic center's numbers are closer to those of an academic center in San Francisco (263 services on 14 patients; average billed, $82; and average reimbursement, $16). Thus, variation here may be determined more by practice type and not geography. Other reasons for variation may include geographic differences in cost of care and lack of evidence-based guidelines that offer credible, accepted reference standards. Recognition of such details is

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not new. The Institute of Medicine recently concluded that evaluations of variation in care based on regional-level assessments are not useful and indeed may be misleading because health care decisions are not made at that level (7). Care is decided on and provided by individual physicians and practices, and the Institute of Medicine opines that practice- and physician-level assessments will be needed to better understand variation because those are the levels at which health care decisions are made. These Medicare data, when appropriately evaluated, may provide a means to understand variation at the level that determines care.

The recent availability of these data is an important step toward the transparency needed to enable thoughtful analyses of variation in health care and its costs. Used carelessly, however, they may provide great headlines, gossip, and controversy but will offer little insight, thereby hindering—instead of promoting—efforts to improve health care value.

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