Given the high cost of many new drugs, the DHHS's approach to patient-assistance programs will strike many people as cold and insensitive, but I believe that the DHHS is absolutely right to limit the scope of these programs. Patient-assistance programs help individual patients but are associated with hidden costs for insurers and taxpayers. Cost sharing will accomplish nothing more than cost shifting if assistance programs shield patients from costs.

Drug companies could maximize the benefits and reduce the harms associated with patient-assistance programs by targeting their assistance to low-income patients; providing assistance for all medical expenses, not just expenses for a specific drug; and limiting assistance to patients whose out-of-pocket costs have exceeded a threshold, similar to what is done when an out-of-pocket maximum is used in an insurance plan. Programs constructed along these lines would expand patient access without undermining the beneficial aspects of cost sharing.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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1. Provenge financial coverage. Seattle: Dendreon (http://www.provenge.com/reimbursement.aspx).
2. Vistante. How copay coupons could raise prescription drug costs by $32 billion over the next decade. November 2011 (http://www.pcmanet.org/images/stories/uploads/2011/Nov2011/visante%20copay%20coupon%20study.pdf).
3. Pavenik N. Do pharmaceutical prices respond to potential patient out-of-pocket expenses? Rand J Econ 2002;33:469-87.
4. Office of Inspector General, Department of Health and Human Services. Publication of OIG special advisory bulletin on patient assistance programs for Medicare Part D enrollees. Fed Regist 2005;70:70623-28.
5. Sebelius K. Letter from the Secretary of Health and Human Services to Rep. Jim McDermott, October 30, 2013 (http://op.bna.com/hl.nsf/id/etor-9czj72/$File/case.pdf).

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The Medicare Physician-Data Release — Context and Rationale

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On April 9, the Centers for Medicare and Medicaid Services (CMS) released detailed information on utilization by more than 880,000 physicians and other health care providers who care for Medicare beneficiaries. This data release was unprecedented in its size and scope: it included nearly 10 million records accounting for more than $77 billion in Medicare payments. The data have been downloaded or accessed more than 300,000 times from the CMS website since their release. But because the release has also come in for some criticism, it may be helpful to clarify its context and rationale.

In one of his first acts in office, President Barack Obama issued a memorandum calling for more open, participatory, and collaborative government, and in May 2013, he issued an executive order mandating implementation of an open-data policy in all federal departments. We at CMS have embraced this directive and worked to identify information and data that could be made publicly available even as we maintain safeguards to protect the privacy of our beneficiaries. We believe that greater transparency in the health care system can drive improvement in health and contribute to the delivery of higher-quality care at lower cost and that CMS can play an important role in stimulating a vibrant health-data ecosystem. By making data files available as "raw material," we aim to enable innovators and entrepreneurs to maximize the data's value for a wide array of users.

Examples of this commitment to open data include the Medicare Geographic Variation Public Use File and the Medicare Provider Utilization and Payment Data inpatient database — the former includes information on fee-for-service Medicare spending, utilization, and quality at the state, hospital referral region, and county levels, and the latter contains information on individual hospital utilization, submitted charges, and payments for the 100 most frequently occurring diagnosis-related groups in the Medicare program. The release of these data in 2013 sparked a national conversation about the appropriateness of hospital charges and about the large variation in charges for the same service, often in the same geographic area. These data sets are just two of the many that CMS and the Department of Health and Human Services have released over the past several years. Users can find these publicly available data sets and others by visiting the CMS Data Navigator (http://dnav.cms

.gov/), Data.CMS.Gov (https://data.cms.gov/), and HealthData.gov (http://healthdata.gov/).

Until May 2013, however, CMS was prohibited from disclosing information on total Medicare payments to individual physicians, owing to a 1979 court injunction declaring that such disclosures would constitute unwarranted invasions of physicians' personal privacy. On May 31, 2013, a Florida federal district court issued an order vacating the 1979 injunction. In its decision, the district court did not address whether physicians' privacy interests in their payment information had diminished since 1979; instead, the court concluded that the injunction lacked a legal basis for continued enforcement. CMS then proceeded in a deliberative and open fashion to determine the most appropriate policies with respect to disclosure of individual physicians' payment data. In August 2013, we issued a request for information seeking public comment on the matter; in response, more than 130 comments were submitted identifying potential benefits and concerns.[1] Ultimately, we concluded that these data were essential for shedding light on health care spending and physicians' practice patterns in Medicare.

Although this data release has, in general, been viewed positively,[2] we are aware of the concerns of certain stakeholders, particularly physicians, regarding the accuracy or meaning of the data. Specific criticisms include that the data are not reflective of a physician's overall practice because they reflect only fee-for-service Medicare claims; that although utilization data presented in isolation do not reflect the quality of care being delivered, patients may assume they do; and that the data do not account for differences in the severity of illness. All these points have some merit, but we concluded that these issues did not outweigh the overall benefit of releasing the data. In particular, we view this data release as an important first step in building greater understanding, on the part of a diverse community of policymakers, data entrepreneurs, and consumers, about the way in which Medicare pays physicians and other providers.

We agree that the value of these data would be enhanced with the inclusion of claims data from other sources, and we would welcome a dialogue about how Medicare Advantage plans, state Medicaid programs, and private health insurers could contribute their own provider-level utilization information in order to build a fuller picture of care. CMS is also committed to increasing the availability of data on the quality of care. The agency has already taken steps in this regard with the public release of a limited set of quality data for physician group practices on our Physician Compare website earlier this year and plans to expand this release of quality data to all large group practices in 2014 and to small groups and individual physicians in 2015.[3] CMS has also approved as "qualified entities" 12 independent quality-measurement organizations that combine Medicare data with data from other sources to create comprehensive provider-performance reports.[4]

Some critics have expressed concern regarding the format of the data release, arguing that the large size of the data set restricts the use of the information to a small group of users who have the tools to analyze and understand the data. We recognize the importance of making these data available to a variety of users. On April 23, 2014, we launched a user-friendly tool at Data.CMS.Gov that allows anyone to quickly and easily perform a search by physician or other supplier name. Other organizations have also launched tools enabling easier access to the data.[5]

Finally, some health care providers have claimed that the data set is not representative of their practice or that certain information, such as their specialty or practice address, is not accurate. Since these data are based on paid claims, we remain confident that the data are accurate, although they may fail to reflect certain services because of the suppression of data on services (as coded using the Healthcare Common Procedure Coding System) that a given physician has delivered to fewer than 11 beneficiaries. We have found that physicians in geographic areas that have high utilization of Medicare Advantage plans tend not to distinguish between patients in fee-for-service Medicare and those in Medicare Advantage, and they may initially view the released fee-for-service data as nonrepresentative of their Medicare practice. If a physician truly believes that the volume of services and procedures reported is too high, it is possible that his or her National Provider Identifier (NPI) number has been compromised; physicians who suspect that this has happened should follow CMS procedures for reporting suspected fraud. Information such as practice addresses included in the data release was obtained directly from the National Plan and Provider Enumeration System database,

which must be maintained and updated as needed by providers.

CMS is committed to producing and releasing high-quality data that permit as many users as possible to better understand the Medicare program. The physician data release is part of a broader strategy of data transparency, and we plan to continue to release additional data in the future. We believe that transparency will drive health system improvement.

The views expressed in this article are those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare and Medicaid Services.

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1. Centers for Medicare and Medicaid Services. Public comment on the release of Medicare physician data (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Public-Comment.html).
2. Disclosing Medicare payment data could be a boon for the nation. Washington Post. April 5, 2014 (http://www.washingtonpost.com/opinions/disclosing-medicare-payment-data-could-be-a-boon-for-the-nation/2014/04/05/822b9ce0-bb66-11e3-9a05-c739f29ccb08_story.html).
3. Quality data added to Physician Compare website. Press release of the Centers for Medicare and Medicaid Services, February 21, 2014 (http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-02-21.html).
4. Centers for Medicare and Medicaid Services. Qualified entity program. March 27, 2013 (http://cms.hhs.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/QEMedicareData/index.html).
5. How much Medicare pays for your doctor's care. New York Times. 2014 (http://www.nytimes.com/interactive/2014/04/09/health/medicare-doctor-database.html?_r=0).

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Caution Advised: Medicare's Physician-Payment Data Release

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On April 9, 2014, Health and Human Services Secretary Kathleen Sebelius announced the release of privacy-protected data concerning services provided to beneficiaries enrolled in the fee-for-service Medicare program in 2012; the services were provided by individual physicians and other health care professionals.[1,2] The release occurred 10 months after federal district court judge Marcia Morales Howard of the Middle District of Florida vacated a 33-year ban on the publication of such information in a legal victory for Real Time Medical Data and Dow Jones.[3] In her opinion, Morales Howard stated that the legal principles on which the previous injunction was based could no longer be sustained, citing case law that had narrowed the scope of the Privacy Act over the intervening three decades.[3] Medical professional organizations had opposed lifting the ban, in part because of concerns that the loss of members' individual privacy rights could be harmful, especially if the data released were inaccurate and wrongfully created an aura of suspicious or inflated payments when none existed.

Much has transpired over the past several years with respect to public reporting of physician performance, hospital outcomes, and health systems' population management. To impede the release of Medicare data concerning physician and facility payments in the current environment would create a treacherous dynamic for providers and place them in a defensive posture that would be widely seen as a futile effort to maintain the status quo at the expense of enacting meaningful health care cost reforms. The implications of the data release are more nuanced than a simple accounting of payments, and caution should be exercised in interpreting and using these data, lest patients and the public misunderstand their applicability.

The newly released data set contains information on more than 880,000 individual health care providers in all 50 states and on 6000 procedures and services for which Medicare Part B paid $77 billion in 2012. Individual providers can be identified by name, unique provider identification number, geographic location, practitioner type, and Medicare participation status. The available information includes the number of Healthcare Common Procedure Coding System (HCPCS) codes submitted, the number of unique Medicare beneficiaries seen, the Medicare charges submitted, and the total dollar amounts allowed and paid to the provider.

The data are indeed unprecedented in scope, yet their limitations must be recognized if we