**The Medicare Physician-Data Release — Context and Rationale**


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.

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**The Medicare Physician-Data Release — Context and Rationale**


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...
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spending and physicians’ practice
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Ultimately, we concluded that
were submitted identifying po-
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comment on the matter; in re-
gust 2013, we issued a request
spect to disclosure of individual
information to a
large size of the data set restricts
the data release, arguing that the
concern regarding the format of
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 in-
junction lacked a legal basis for
continued enforcement. CMS then
proceeded in a deliberative and
open fashion to determine the
most appropriate policies with re-
spect to disclosure of individual
physicians’ payment data. In Au-
gust 2013, we issued a request
for information seeking public
response, more than 130 comments
were submitted identifying po-
tential benefits and concerns.6
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 pos-
ively,2 we are aware of the con-
cerns 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 be-
cause they reflect only fee-for-
service Medicare claims; that al-
though 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 under-
standing, on the part of a diverse
community of policymakers, data
entrepreneurs, and consumers,
about the way in which Medi-
care 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 indepen-
dent quality-measurement organ-
izations 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

Finally, some health care pro-
viders have claimed that the data
set is not representative of their
practice or that certain informa-
tion, such as their specialty or
practice address, is not accurate.
Since these data are based on
paid claims, we remain confi-
dent that the data are accurate,
although they may fail to reflect
services because of the
suppression of data on services
(as coded using the Healthcare
Common Procedure Coding Sys-
tem) that a given physician has
delivered to fewer than 11 bene-
ficiaries. We have found that phy-
sicians in geographic areas that
have high utilization of Medicare
Advantage plans tend not to dis-
tinguish between patients in fee-
for-service Medicare and those in
Medicare Advantage, and they
may initially view the released
fee-for-service data as nonrepre-
sentative of their Medicare prac-
tice. If a physician truly believes
that the volume of services and
procedures reported is too high,
it is possible that his or her Na-
tional 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 prac-
tice 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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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.4 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