Protect Yourself From Overexposure

Who has more privacy, Kim Kardashian and Kanye West, or long-term care physicians? That depends on how you define privacy. Kim and Kanye’s relationship is scrutinized within a 24/7 news cycle, but at least they have some degree of control over what parts of their personal lives are exposed. However, since March 2014, the professional Medicare services rendered by physicians and other Medicare Part B providers in 2012 has been posted online and freely available 24/7. It is only a matter of time before providers’ Medicare information from 2013 is released and posted online.

With just the name of a physician or other prescriber or provider, anyone can go online and determine:

- National Provider Identifier (NPI) number.
- 2012 Medicare patient count.
- 2011 Medicare Part D prescribing history.
- Current practice locations.

Most providers are unaware of their degree of exposure to the public. This month’s column explores publicly exposed raw data about providers. Then I’ll introduce you to some of the published analytics that claim to create a provider profile. Finally, I’ll offer strategies that providers can employ to improve their ratings and identify the negative elements we can’t engineer out of our profiles.

Background

Historically, physicians and other providers were sheltered by a broad umbrella of privacy in their transactions with third party payers. For the readers of Caring For The Ages, our primary payers are Medicare, Medicare Advantage Plans, and Medicaid. Commercial payers typically represent less than 10% of our post-acute/long-term care patient population.

The concept of privacy for transactions between providers and government payers began eroding in 2012. That’s when ProPublica, a public interest reporting group, successfully argued that there was a legitimate policy reason to compel the Centers for Medicare & Medicaid Services to release recent Medicare Part D claims history. That resulted in the 2007-2011 Medicare Part D claims payment database, which included the prescriber’s name, ID number, medication prescribed, and so on, for every prescription paid by a Medicare Part D plan. The patient’s identity and diagnoses were removed from the released data. A discussion of the information is available on the ProPublica website (bit.ly/WDbmAM).

This ground-breaking data release emboldened other journalists. In 2013, the Wall Street Journal (WSJ) secured limited access to 2011 Medicare Part B billing information. This information was more restricted than the Part D data – patient-level information was de-identified, as were the provider’s name and NPI number. Researchers at the WSJ were quickly able to reverse engineer the data using procedure codes and geographic locations to identify providers with frequencies and charges that were significantly above average. Data showed some of the providers exhibited behavior so egregious that Centers for Medicare & Medicaid Services (CMS) initiated criminal investigations.

Finally, in March 2014, Health and Human Services’ Kathleen Sebelius announced the Obama administration was releasing the full Medicare Part B claims dataset for physicians and other providers to the public.

Finding the Data

ProPublica doesn’t limit itself to revealing data from Part D providers; the organization is active in a range of investigations. Learn more in their series “Examining Medicare” (www.propublica.org/series/examining-medicare). Their Medicare 2011 Part D payment database is available as a sidebar to the main article (www.propublica.org/article/part-d-prescriber-checkup-mainbar).

Of particular interest to PA/LTC prescribers is this caption from a picture accompanying the article: “Dr. Daniel J. Hurley talks to patient William Sanders at his outpatient clinic in Beech Grove, Indiana. Hurley was credited with writing more than 160,000 prescriptions in Medicare Part D in 2010, the most of any provider in the country.”

Hurley said descriptions by others in his practice were credited to him by nursing home pharmacies, but that Medicare has never asked him about his numbers. “Why wouldn’t they call us up and ask us?” he said.

Dr. Hurley is a perfect example of why long-term care physicians need to better understand how they appear in these public profiles. Dr. Hurley leads a large group that serves multiple facilities. The dominant regional long-term care pharmacy listed Dr. Hurley as the attending physician regardless of who was signing the patient orders and refill orders.

The 2012 Medicare Part B payments to providers, which CMS calls Public Use Files, are available through this link: bit.ly/1xUKPmp. You can find a simple look-up tool that shows one provider at a time through this link: 1.usa.gov/1upG4Dm.

The New York Times created a more user-friendly version of CMS data, available at nyti.ms/1n8X3X.

Data Analysis

I can personally attest to the value of this vast trove of data. We’ve used this data to develop internal benchmarks, analyze markets, and screen prospective candidates. The last time I looked, the CMS Public Use Files had been downloaded more than 10,000 times. Significant database tools are necessary to make sense of the available information, but for those of us who understand how to build queries, it is extremely useful.

One of my colleagues in the National Society of Certified Healthcare Business Consultants is Frank Cohen. Mr. Cohen is the dean of physician practice consultants and is a wizard at analyzing claims data. He took the Public Use Files, merged some additional CMS data, and developed an online tool he called “Risk Based on Medicare Utilization by Providers,” available at bit.ly/1qAEamR. Using this tool, anyone with access to a provider’s NPI (available from CMS at 1.usa.gov/1p1K4P) can get a snapshot of the provider’s Medicare utilization.

Mr. Cohen’s analysis is designed to help physicians understand how they compare to their peers, and alert them to possible Medicare administrative contractors (MAC) audits based on higher than average utilization.

Third party payers are already conducting similar analyses using their own versions of the data. According to a 2013 WSJ article, United Healthcare was shrinking its provider network between 10%-15%. Other Medicare Advantage providers are following suit.

Some PA/LTC physicians in Florida reported in the article of being excluded from Medicare Advantage panels – they have to check plan enrollment before accepting a new patient.

Management Strategies

When this information started becoming publicly available, we began looking at our own providers. One feature was quickly apparent: physicians who worked on their own – that is, without an extender – had a significantly higher risk profile in Mr. Cohen’s model. In retrospect, that’s obvious – those physicians have the same number of encounters as their colleagues, but they serve a smaller patient census. In that situation, my recommendation is to always work with an extender. Does that translate to better care? I don’t know, but it is a better risk profile.

Physicians and extenders can bury their heads in the sand or choose to manage their public profile.

Do you rely on medications that are on the Beers List? That’s your professional choice, but know that prescribing information will show up in your profile. Medicare and the Part D plans track the rate you prescribe one or more medications on the Beers List. I expect it to become public on the Medicare Physician Compare website (www.medicare.gov/physiciancompare) in the future. We received that score as part of our first-year feedback report from the Value Based Payment program’s Quality and Resource Use Reports. CMS has already announced plans to publish all Physician Quality Reporting System data for large groups on the Physician Compare website starting in 2015. Data from 2013 is already there for accountable care organizations.

Physicians and extenders can bury their heads in the sand or choose to manage their public profile. If you work in PA/LTC you are already joined at the hip to Medicare and the Advantage Plans. The actions of payers like United Healthcare in reducing their provider panel are harbingers of the future. We are more exposed than any celebrity – you should be conscious of that fact and manage your practice accordingly.

There is no way to independently verify that all Part D prescriber history was included. However, there are data on 1.6 million prescribers and that includes 1.2 billion prescriptions. Accuracy is limited by the quality controls created in the pharmacy’s claims management system. We know that in some cases, pharmacies submitted claims with the name of a long-term care group’s founding physician instead of the primary care physician or nurse practitioner who actually approved the prescription.

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