

Physician Profiling Concerns Loom in Courts

BY BRUCE JANCIN

SAN FRANCISCO — You won't believe who's seeking access to your Medicare claims data—and what they want to do with it.

A little-known consumers group aiming to force the Health and Human Services department to provide Medicare billing data with physician identifiers recently was rebuffed by a narrow margin in federal appeals court. Meanwhile, another federal court has ruled in favor of a similar Freedom of Information Act request by another organization, setting the stage for a likely legal showdown with major implications for physicians.

"I think given the disagreement in these two cases, this is likely to be a higher court issue. We might actually see this going to the Supreme Court," Dr. Jack S. Resneck Jr., predicted to a full house at a special "Issues Impacting Your Practice" session held at the annual meeting of the American Academy of Dermatology.

Consumers' Checkbook, a small non-profit group, sued HHS seeking data on

Medicare payments to physicians for the express purpose of reporting on the volume and appropriateness of procedures individual physicians were performing as a guide to quality of care.

In 2007, the group prevailed in U.S. District Court. The American Medical Association then joined HHS in appealing the verdict, with the American Academy of Dermatology and other medical organizations filing friend-of-the-court briefs on their behalf. AARP was among the groups that did the same for Consumers' Checkbook.

In late January, the U.S. Court of Appeals for the District of Columbia reversed the lower court decision on a 2-1 vote, awarding victory to HHS and the AMA.

Consumers' Checkbook is expected to ask for reconsideration of the decision by the full appeals court.

Meanwhile, a similar Freedom of Information Act-based lawsuit filed by Jennifer Alley, owner of a small company called Real Time Medical Data, had a very different outcome. A U.S. District Court in Alabama ruled in her favor and ordered HHS to provide Medicare

claims data with physician identifiers for five southern states so Real Time Medical Data could sell it to hospitals, insurance companies, and pharmaceutical companies. The HHS and AMA have appealed. Ms. Alley has asked the 11th U.S. Circuit Court of Appeals in Atlanta to hold HHS in contempt for not releasing the data.

Legal scholars have framed the core issue in these two cases as a fundamental conflict between the public's right to know how federal tax dollars are spent as expressed in the Freedom of Information Act versus physicians' right to privacy. However, Dr. Resneck has an additional practical concern: Using Medicare billing data to characterize quality of care is like-

ly to create a misleading picture.

"Volume is just one tiny piece of measuring physician quality. This is a little scary. These folks [at Consumers' Checkbook] have no experience with evidence-based quality measures, no experience with risk adjustment, and have no access through these claims data to outcome measures," said Dr. Resneck, a dermatologist at the University of California, San Francisco, and chair of the AAD Council on Government Affairs, Health Policy and Practice.

"And remember, Medicare is a big payer, but it's just one payer. So ... depending on somebody's patient mix you could miss the vast majority of what they're doing," he noted. ■

Medical School Leaders Get Set for Future Challenges

BY CHRISTINE KILGORE

Fresh from their successful efforts to persuade Congress and the president to dramatically increase federal biomedical research funding, the nation's medical school deans are now working to prioritize which issues to tackle over the next several years.

The menu of issues is huge: There are crises in access to and cost of health care, an inadequate emphasis on preventive and primary care services, wide variations in health care utilization and quality of care, and a pace of translational research that many believe is much too slow.

"We're asking ourselves, what should we take on in the next 3-5 years, and how can we as medical school leaders maximize our value and contribution?" Dr. E. Albert Reece, who chairs the Association of American Medical Colleges' Council of Deans, said in an interview. The council identifies issues affecting academic medicine and develops strategies to deal with them.

When Dr. Reece assumed the council chairmanship last October, biomedical research funding was the top issue. Since 2004, the budget of the National Institutes of Health had been reduced by 13% after factoring in inflation—a trend that leaders at the AAMC argued was slowing progress on critical research programs and creating a backlog of unfunded and underfunded biomedical research projects.

"Our approach with Congress and with the Obama transition team, and then the administration, was to point out how academic medical centers create a huge amount of economic activity," said Dr. Reece, vice president for medical affairs at the University of Maryland and dean of the university's school of medicine in Baltimore.

The combined economic impact of the nation's 130 academic medical centers exceeded \$450 billion during 2005, according to the AAMC, with academic medical centers responsible for the creation of more than 3 million jobs.

"That's 1 out of 48 wage earners in the U.S.," said Dr. Reece, also the John Z. and Akiko K. Bowers Distinguished Professor at the university.

In their meetings with legislators and other national leaders, Dr. Reece and his colleagues from other medical schools emphasized the "ripple effect" of declining funding—how it thwarts the careers of young scientists and physicians interested in bench-to bedside research, slows the amount and pace of such translational research, and ultimately adversely affects patient care.

The \$787 billion Recovery Act, formally called the American Recovery and Reinvestment Act of 2009, directed \$10 billion in new funds to the NIH—equivalent to a third of the institute's \$29.5 billion annual budget and an amount higher than the deans and other supporters of increased funding had expected. Sen. Arlen Specter (R-Pa.) championed the new funding.

Now, said Dr. Reece, in addition to sustaining ongoing research, the deans will continue to explore and implement other ways of attracting more physician-scientists to academic medicine—a need identified by the Institute of Medicine's Clinical Research Roundtable (CRR) that, from 2000 to 2005, studied the challenges facing clinical research.

Easing loan repayments was among the many ideas examined by the CRR, said Dr. Reece, who served on the roundtable.

In an interview before an early April retreat of the Council of Deans, Dr. Reece said other questions for the medical school deans—questions that could drive the choice of issues for new or renewed focus—involve "maximizing the impact of research" and better preparing graduates for the future.

Deans have played a "very active role" in securing more biomedical research funding, Dr. John E. Prescott, chief academic officer at the AAMC, said in an interview. They are now "leading efforts" on access to treatment and the quality of care. ■

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