HHS/CMS Release of Physician
Medicare Reimbursement Claims Data

Position Statement

April 10, 2014

The Community Oncology Alliance (COA) strongly disagrees with the release of physician-specific Medicare reimbursement claims data and the manner in which the Centers for Medicare & Medicaid Services (CMS) released the data. The data is incomplete, biased, without context, and an unrepresentative sample of Medicare reimbursement to oncologists. Supporting documentation of that is listed below. Further, CMS did not allow physicians an opportunity to confirm the accuracy of individual data and did not conduct any studies to assess how the data will potentially influence consumers, especially senior beneficiaries, about their medical care decision-making.

CMS has stated that "this data release will help beneficiaries and consumers better understand how care is delivered through the Medicare program." That is impossible given that the data is simply an unscientific and inconsistent sample of reimbursement claims data — it provides no metrics on quality and value. COA believes that the data may well confuse seniors and others with cancer, adding unnecessary angst to an already emotional situation. As physicians we are first taught to do no harm to our patients. The release of Medicare physician reimbursement claims data may possibly result in inaccurate, misunderstood, and even harmful conclusions by cancer patients.

COA strongly supports identifying physicians who may be fraudulently billing Medicare, which should be a top priority of CMS independent of releasing Medicare reimbursement claims data to the general public. COA also equally supports more transparency and accountability in medical care, especially in measuring the quality and value of cancer care. This is evidenced by COA's Oncology Medical Home initiative and associated payment reform model based on quality and value metrics. Community oncology practices across the country are providing cost-effective cancer care that substantially reduces spending by Medicare and seniors, as documented by numerous national studies. CMS should be empowering cost-effective cancer care in the community setting and providing consumer-friendly quality and value data that will truly help in more informed decision-making. The release of Medicare reimbursement claims data is not a step in that direction.

Specific facts supporting the COA position are as follows:

- Medicare pays for approximately half of cancer care because cancer is a disease that is weighted towards older individuals. As a result, oncologists will have more Medicare reimbursement claims relative to other specialties that treat a lower percentage of Medicare patients. This precludes comparisons with other specialties.

- Oncologists are required to administer chemotherapy and other anti-cancer drugs under close supervision in their clinics, given the potentially toxic nature of these drugs. These typically expensive drugs can account for 70-80% of the dollar amount of Medicare reimbursement claims, thus substantially increasing a community oncologist's Medicare reimbursement relative to other specialties. This further precludes comparisons with other specialties.

- CMS has released Medicare reimbursement claims data that is unrelated to the associated costs of Medicare reimbursement for drugs and services. In many cases, especially with CMS applying the Medicare sequester cut to the underlying cost of cancer drugs, Medicare reimbursement is less

than cost. As a result, reimbursement claims data is virtually meaningless in isolation without the associated data on underlying costs, including those relating to materials, labor, procurement, and facilities. In fact, those costs are increasing while CMS is actually cutting reimbursement to community cancer clinics, thus fostering the consolidation of cancer care to the more expensive hospital setting.

- The types of cancer that an oncologist treats, as well as the demographic mix of patients, determines what drugs and associated treatment are provided by an oncologist. Those variables preclude valid comparisons among oncologists using reimbursement claims data.

- Medicare regulations dictate that Medicare billings be under the name of the supervising physician when chemotherapy is administered. The supervising physician is not necessarily the treating physician. The result is inordinately higher Medicare reimbursement attributable to some oncologists who are designated as supervising physicians. This further precludes valid comparisons among oncologists.

- Community oncologists in private practice bill for all the drugs and services provided, whereas hospital employed physicians do not. Typically, hospital oncologists who see outpatients will only bill for office visits. Chemotherapy, advanced imaging, pathology, and radiation will all be billed by and attributed to the hospital. Therefore, comparisons between community oncologists and hospital oncologists using Medicare reimbursement claims data are apples to oranges.

- Community oncologists in integrated cancer clinics receive reimbursement for services such as advanced imaging, radiation, and other ancillary services, in addition to chemotherapy administration. This will result in higher reimbursement to cover those services for oncologists in integrated clinics versus for oncologists in clinics administering only chemotherapy. This precludes meaningful comparisons even among community oncologists because the data does not identify specific services provided by each oncologist.

- Mid-level providers can bill under the oncologist. Greater use of mid-level providers will increase Medicare reimbursement for some community oncologists, thus further clouding comparisons among community oncologists.

- The data released by Medicare is only a sample covering the 30 most common outpatient Part B billing codes. Additionally, this is Medicare fee-for-service data only, which does not account for Medicare Advantage and private insurance. The percentages of both vary greatly by oncologist, depending on their location. Due to the differences stated previously, this makes the data released an unrepresentative, unscientific sample that has specific sample selection biases.

As always, our first concern relates to cancer patients, especially seniors, and how Medicare reimbursement claims data can confuse or cloud their decision-making. For example, a patient might incorrectly infer that an oncologist with lower Medicare reimbursement has less experience treating certain cancers, or erroneously fear that seeing an oncologist with higher reimbursement will lead to higher out-of-pocket costs. Medicare reimbursement claims data, especially in its current state based on specific Medicare billing regulations, cannot be used effectively to "help beneficiaries and consumers better understand how care is delivered through the Medicare program" — especially in the case of cancer care.