

AFROC



ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

Our Voice in Washington

The Source

January 2009

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21st AFROC Annual Conference
April 19-20, 2009
Grand Hyatt, Washington, DC

Visit the Website for full conference details
as well as Exhibit and
Sponsorship opportunities.
See the registration form
on page 7 of this newsletter.

Look forward to seeing you in Washington, DC!

LEGISLATIVE NEWS

AFROC Sponsors New Practice Expense Survey of Freestanding Radiation Oncology Facilities

The contractor retained by AFROC, ASTRO, and ACRO to survey freestanding radiation oncology centers is now analyzing the results, and preliminary indications suggest that the survey is likely to meet CMS statistical standards. The last practice expense survey of freestanding radiation oncology centers was sponsored by AFROC, and likewise met CMS statistical standards, resulting in a substantial increase in the amounts paid radiation oncologists for their practice expenses, over the amounts that had been proposed. Thank you to all AFROC members and other centers that participated in this important effort!

AFROC Office Relocation Reminder

New Mailing Address and contact information:

AFROC
12100 Sunset Hills Road, Suite 130
Reston, VA 20190
Phone: (703) 234-4050

FOR MORE INFORMATION,
CONTACT:
Robin Turner or Heather Hassell
Info@afroc.org

2009 DUES

First notice for 2009 AFROC dues were mailed in early December. To assure that your name will remain on our mailing list, please let us hear from you.

It is estimated that 95% of your dues can be taken as a business expense.

Check out
AFROC's website
www.afroc.org

AFROC Comments on Medicare Physician Fee Schedule

The Medicare Physician Fee Schedule released in November included a number of unhappy surprises for freestanding radiation oncology centers. First, as the result of Congressional action that changed the “budget neutrality” methodology used to determine relative value units (RVUs), the conversion factor was reduced by over 5%, instead of being increased by 1.1%, as many providers had anticipated. Because this modification of the budget neutrality formula was favored by almost all of organized medicine, including the AMA and all of the medical associations representing primary care physicians, there is virtually no chance that this change can be reversed.

In addition, the final Medicare Physician Fee Schedule for 2009 announced unanticipated and substantial reductions in the technical component of high dose rate (HDR) brachytherapy services. As the result of the introduction of three new CPT codes for HDR brachytherapy services (and the deletion of the four prior CPT codes for these services, new RVUs were introduced. Overall, Medicare payment for HDR brachytherapy treatment would be reduced from 46% to 67% if the payment rates established in the Final PFS Rule are implemented on January 1, 2009. The breast brachytherapy catheter placement codes also decrease between -15.0% (CPT 19296) to -17.6% (CPT 19298).

AFROC actively participated in a coalition of concerned organizations opposed to these reductions, and filed extensive comments requesting that CMS maintain current payment

levels pending further study. A copy of AFROC’s comments is available upon request. AFROC’s comments also request an increase in Medicare payment for superficial radiation treatment.

Implications of New Anti-Mark-Up Rule for Freestanding Radiation Oncology Centers

Historically, Medicare has limited payments to physicians and other suppliers for “purchased diagnostic tests” (other than clinical laboratory tests) if the physician purchased the technical component (TC) from an outside vendor. This was known as the “purchased diagnostic test rule” and limited the amount the purchasing physician could charge Medicare for such tests to the physician’s acquisition cost.

In the 2009 Final Physician Fee Schedule Rule, CMS substituted a new “anti-markup rule” test for the “purchased diagnostic test rule.” The new “anti-markup” rule instead focuses on the concept that there is no anti-markup prohibition if the performing or supervising physician “shares a practice” with the ordering physician. If a diagnostic test is performed or supervised by a physician who does not “share a practice” with the billing practice, the payment from Medicare is limited to the lesser of the performing physician’s charge or the Medicare Physician Fee Schedule amount.

Under the new anti-markup rule, CMS permits two alternative approaches to demonstrate that a physician “shares a practice” with a group. The anti-markup restrictions will not apply if physician/supplier can meet *either* of the following two alternatives:

AFROC Past President Position Vacant!

If you are interested in filling this position, please e-mail your interest to the AFROC office at: info@afroc.org. Thank you.

- The “substantially all” test. The physician supervising the TC or performing the PC performs “substantially all” (at least 75 percent) of his or her professional services for the billing physician or other supplier; OR
- The “site of service” test. The TC or PC is performed by an employee or independent contractor physician in the same building where the office of the billing (ordering) physician or other supplier is located.

The new anti-markup rule became effective on January 1, 2009.

While the anti-markup rule is intended primarily to restrain physicians’ offices from providing diagnostic imaging and other diagnostic services, the new rule may impact freestanding radiation oncology centers that own or operate PET/CT or CT facilities for the purpose of providing radiation treatment. For example, a freestanding center that utilizes the services of an outside radiologist to provide the professional component of a PET/CT, CT or other diagnostic test may be affected if the radiologist does not dedicate at least 75% of his or her time to the freestanding facility, and if the diagnostic service involved is located in a space separate from the radiation oncologists who order the service.

Where a freestanding facility utilizes the services of an outside radiologist to provide the professional component of PET/CT, CT, or other diagnostic services and the radiologist dedicates less than 75% of his or her time to the freestanding facility, consideration should be given to requiring the radiologist to bill for his or her professional component services separately. This avoids application of the anti-markup rule with respect to the professional component services.

To avoid application of the anti-markup rule with respect to the diagnostic test’s technical component, the diagnostic service should be provided at the same office as the radiation oncologists who order the diagnostic tests.

Alternatively, a physician who dedicates at least 75% of his time to the freestanding facility should supervise the technical component of the diagnostic services involved.

Health Care Reform and Its Implications for Medicare and Medicaid

While the economic crisis is on the top of the agenda for the incoming Obama administration, it is clear that reform of the Medicare and Medicaid programs are likely to be a key component of any effort to institute broader health care reforms. Medicare Advantage plans are a clear target for cost savings, and it is anticipated that the new Administration and Congress will focus on wide-scale reforms in the Part D program, including consideration of price rebates. While comprehensive changes in fee-for-service Medicare are less likely in light of the multitude of conflicting interests involved, speculation about the possibility of overhauling the system continues, and, at the very least substantial Medicare payment reductions are likely to be considered when Congress addresses overall Medicare reform closer to the end of 2009.

Some health care issues, however, almost certainly will be addressed as part of the stimulus package that Congressional Democrats are pushing to pass by the President’s Day break in mid-February. These include, for example, increases in the Federal Medical Assistance Percentages (FMAP), under the Medicaid Program, reauthorization and funding for the SCHIP program, and certain health IT issues.

The outlook beyond that will depend to a large degree on the success of the economic stimulus package and changes in the economic tides. While there is broad consensus that Congress will not let a 21 percent decrease in Medicare payments go into effect on Jan. 1, 2010, it is still possible that plans for a Medicare bill and a health reform bill could be scuttled if the economy continues to contract.

Part A

The coming year is likely to bring with it continued emphasis on “value based purchasing” despite continued resistance from the hospital industry, which has significant concerns over the science and methodologies underlying the increasing requirement that hospitals meet an ever expanding list of new quality measures in order to obtain their full market basket update. The hospital industry has been particularly concerned about the lack of established and transparent criteria for determining which measures are adopted by CMS.

Despite hospital industry objections to the way in which CMS has chosen to exercise its discretion in linking quality and payment thus far, it appears that Congress may take further action to align payment incentives using “value based purchasing.” While the term “value based purchasing” is sufficiently amorphous to serve as an umbrella for a number of different types of health care reforms, many on Capitol Hill are intrigued by the possibility of combining payments to hospitals and physicians in a manner that makes it easier to assign accountability for health care outcomes. For better or worse, however, pursuing this concept would entail reexamination of many legal and regulatory issues, including the physician self-referral law (the “Stark Law”) which generally complicates financial interactions between hospitals and physicians.

In addition, it is likely that Congress will consider reallocating funds currently used to support medical education (the Indirect Medical Education (IME) funds) and obtain funds from other sources to create an incentive pool for hospitals.

Part B

New directions for Medicare Part B are less clear. While CMS will continue focusing on “quality” through the Physicians Quality Reporting Initiative (PQRI) program, decreasing utilization of imaging and other rapidly growing services, and implementing Congressional directives related to

preventive health care, no clear “favorite” for systemic reform of Medicare Part B has emerged – yet.

In the interim, efforts to increase revenue to primary care physicians are likely to continue through initiatives such as the “patient-centered medical home” and payment for “care coordination.” The primary question appears to be whether this revenue is taken from other physician specialties or whether the cost of increasing payments to primary care physicians is added to the federal deficit.

Bundling Part A and Part B services is also the subject of experimentation in the Acute Care Episode (ACE) demonstration. CMS announced the five sites chosen for the demo Jan. 7, 2009. They are: Baptist Health System in San Antonio, Texas; Oklahoma Heart Hospital LLC in Oklahoma City, Okla.; Exempla Saint Joseph Hospital in Denver, Colo.; Hillcrest Medical Center in Tulsa, Okla.; and Lovelace Health System in Albuquerque, N.M.

Part C

Whatever vehicle Congress uses, Medicare managed care (Medicare Advantage) payments are likely to be on the chopping block. The trick for Congress will be to obtain the needed savings without triggering a withdrawal of Medicare Advantage plans from rural and medically underserved areas. To further complicate matters, Medicare Advantage Plans are likely to face rate reductions at a time when they are also experiencing increased costs as the result of the push toward “value-based purchasing.”

Part D

Reforms to the Medicare Part D benefit are widely expected, including stepped up CMS oversight and imposition of a minimum rebate for drugs covered by prescription drug plans (PDPs) or Medicare

Advantage PDPs. According to the Congressional Budget Office, the rebate proposal would net savings of \$33 billion over five years beginning in 2011 or \$110 billion over 10 years beginning the same year.

Another big question is whether Congress will take on the issue of price negotiation, which is currently precluded under existing legislation.

Medicaid

Increasing federal matching funds (potentially up to \$100 billion) likely will be included in the stimulus package. However, the distribution method of the federal assistance is still being debated. Congress must determine whether to provide additional FMAP across the board like the model used in 2003, or by using a more targeted method based on state-specific fiscal indicators.

Other Medicaid changes are also anticipated. The Obama Administration is likely to take a hard look at the Medicaid waiver program, especially to the extent that Medicaid waivers are being used as a vehicle for state efforts to provide universal access to health insurance. The waiver program has allowed states liberty to implement health care coverage reform using Medicaid as a vehicle, as long as the programs remain budget neutral compared with traditional Medicaid.

Health Care Workforce

It appears that increasing the health care workforce is likely to be another focus of attention. On December 11, Sen. Herb Kohl (D-WI) introduced a bill entitled "Retooling the Healthcare Workforce for An Aging America Act." The bill would massively expand education and training programs aimed at geriatrics health care professionals by increasing funding for the country's geriatric education centers (GECs) to let them offer short-term intensive courses in geriatrics, chronic care management and long-term care to medical school faculty and other members of health professional schools. These

grants would require the GECs to either develop new courses or to incorporate appropriate training into other classes.

Sen. Kohl's bill would also expand the geriatric academic career awards (GACA), a training program that supports the career development of junior medical school faculty in nursing, clinical psychology, social work and other fields. Among its other provisions is an expansion of the Nursing Comprehensive Geriatric Education Program to support additional avenues for training.

In addition, it appears that a coalition is now forming to pursue additional resources for physician training, to address the physician shortage in some specialties. There is also a push to include workforce provisions for both physicians and nurses in the economic stimulus package currently under development, though inclusion of such provisions might be fought by President-elect Obama who desires a focus on jobs before all other considerations.

Health IT and privacy

Privacy issues are viewed as roadblocks for health information technology; nonetheless, it is widely anticipated that the stimulus bill will include health IT provisions and subsidies for small physician practices and other providers to adopt health IT.

Medicaid, COBRA, Health IT, Comparative Effectiveness Included in House Stimulus Package

The \$825 billion House stimulus package includes \$87 billion for state Medicaid programs, a \$30.3 billion subsidy and extension of COBRA health care coverage, \$20 billion for health information technology, \$4.1 billion for preventative care, and \$1.1 billion for comparative effectiveness efforts. The package would also create new health-related jobs. More specifically, the Federal Medical Assistance Percentage (FMAP) rate would increase by 4.8 percent the federal share of

Medicaid costs through the end of 2010. Additional Medicaid assistance would be provided based on unemployment figures. The House plan also includes \$8.6 billion for Medicaid coverage of unemployed up to 200 percent of the federal poverty level (FPL) through 2010.

Other components of the outline include \$4.1 billion to provide for preventative care and to evaluate the most effective health care treatments; \$1.1 billion for health care research and quality programs to compare the effectiveness of different medical treatments funded by Medicare, Medicaid, and SCHIP; \$3 billion in grants to fight preventable chronic diseases, the leading cause of deaths in the U.S., and infectious diseases (including hospital infection prevention; preventive health and health services block grant; immunization programs; and evidence-based disease prevention); \$1.5 billion, for community health clinics; \$600 million to address shortages of primary care providers including doctors, dentists, and nurses as well as helping pay medical school expenses for students who agree to practice in under-served communities through the National Health Service Corps; and \$550 million to modernize hospitals and health clinics and make health care technology upgrades to improve underserved rural populations.

Earmarks to Become More Transparent under New Appropriations Procedures

According to new transparency measures unveiled by the incoming House and Senate Appropriations committee chairmen, members seeking earmarks in the FY10 spending bills will have to post them on their Web sites, and lists of earmarks will be made available at the subcommittee markup instead of the later full committee markup. These measures are intended to reduce earmarks, increase public scrutiny, and enable members of Congress to have more time and access to more information before they vote on bills.

MedPAC Approves 1.1 Percent Boost to Physician Payments

In its public meetings held January 8-9, the Medicare Payment Advisory Commission decided to increase Medicare reimbursements for physicians in 2010 by 1.1 percent. To obtain the 1.1 percent pay hike, a "productivity goal" of 1.3 percent was subtracted from a forecast of input price inflation of 2.4 percent.

A continuing issue for overall physician reimbursement in 2010 is the sustainable growth rate formula which requires a 20 percent cut. In 2008 Congress enacted a law preventing a 10.6 percent Medicare pay cut for physicians, effective July 1, 2008, from being implemented and replacing it with a payment freeze for the rest of 2008 and a 1.1 percent pay hike for 2009 (which replaced a scheduled 5% cut for that year as well). As noted earlier, Congress is expected to consider again canceling a scheduled pay cut for physicians due in 2010 at the end of this year.

In addressing ongoing concern with inadequate payments to primary care physicians, MedPAC will also reissue an unimplemented recommendation from its June 2008 report in the March 2009 report. It will call for Congress to "establish a budget-neutral payment adjustment for primary care services billed under the physician fee schedule and furnished by primary-care-focused practitioners.



21st ANNUAL CONFERENCE
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 or
 Fax registration form to 703-435-4390, Attn: Heather Hassell

Full name: _____ Title: _____
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Registration includes: All conferences, continental breakfasts, refreshment breaks, lunches, and dinner. Guest fee for breakfasts, lunches and dinner – see below.

<u>Two Day Registration</u>	<u>Pre-registration</u>	<u>On-site registration</u>	<u>Payment</u>
<input type="checkbox"/> AFROC member	\$450	\$475	\$ _____
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- Any member organization paying a \$450 registration fee will be granted a \$50 reduction in registration fees per additional attendee. Please return forms for multiple attendees together.
- **Cancellation Policy:** The registration fee is refundable up to **March 27th, 2009**. All requests for a refund prior to **March 27th, 2009** will receive a full refund, minus a \$50 administrative fee. There will be no refunds on registration fees after **March 27th, 2009** although you can send a replacement from your organization or company. Please notify us if you plan to send a replacement to the conference.

Payment information:	Total amount due:
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<input type="checkbox"/> Enclosed is check # _____ (Payable to AFROC) <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard Card #: _____ Exp date: _____ Name as it appears on card: _____ Authorized signature: _____
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Call the Grand Hyatt Washington at (800-233-1234) for room reservations (AFROC).
 Reservations made before **March 17th, 2009** will be afforded conference rate
 of **\$259** single/double per night based on two night stay.



The Source

January 2009

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