

AFROC



ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

Our Voice in Washington

The Source

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AFROC Urges Congress to Fix SNF Rules Precluding Separate Payment for Freestanding Facilities, Protect TC Payments from Possible Future Reductions

Over the past several months, AFROC has urged Congress to enact legislation that would authorize separate billing for radiation oncology services provided by freestanding facilities. Under current Medicare payment rules, hospital-based facilities, but not freestanding facilities, may bill the Medicare Program separately for services rendered to Skilled Nursing Facility inpatients. AFROC has appealed to CMS to modify this payment policy; however, because CMS claims that it is not authorized to fix the problem, AFROC has turned for help to Congress. At this stage, AFROC's efforts have involved approaching key members of the Senate Finance Committee to request them to support a legislative solution to the problem. AFROC has also requested that CMS support such legislation.

AFROC also has been urging Congress to include a provision in this year's Medicare bill that would ensure that radiation oncology and other technical component services are not disproportionately affected by modifications in the methodology used to pay for medical oncologists' technical component costs. Under the current methodology applicable to technical component payments, the amounts paid for all technical component services are affected by changes made in any of them. For this reason, if Congress modifies the methodology applicable to medical oncology practice expenses to compensate for possible

2003 DUES

AFROC is the only organization that solely focuses on the regulatory, legislative, and socioeconomic issues of freestanding radiation centers and is your only voice in Washington. Your continued participation is critical to its future and to the future of your freestanding radiation center.

If you have not already done so, please send in your 2003 dues. It is estimated that 95% of your dues can be taken as a business expense.

Thank you.

Check out
AFROC's website
www.afroc.org

INCLUDE AFROC'S 16TH ANNUAL CONFERENCE ON YOUR 2004 CALENDAR

The 16th Annual AFROC Conference will be held on
May 23-24th 2004 at the
Grand Hyatt in Washington, DC.

The meeting is already in the planning stages. If you have any suggestions for topics and speakers, please contact Sheila Gell at (888) 334-4542 or by email at sgell@PPSV.com.

reductions in payment made to medical oncologist for chemotherapy agents, this modification may adversely affect the allowances for all other TC services, including radiation oncology.

AFROC has written to all of the key legislators requesting that any legislation that affects medical oncologists' allowances for chemotherapy drugs also include a provision that ensures that radiation oncology and other TC services are not inadvertently affected.

In the interim, AFROC has continued its discussions with the Lewin Group, a CMS consulting group, to formulate a practice expense survey that would be acceptable to CMS. We will keep you apprised of further developments.

AFROC is also preparing comments on proposed CMS rules that would significantly modify the enrollment procedures for radiation oncologists' and other physicians' practices and that would for the first time impose re-enrollment requirements. It is anticipated that the AFROC comments will stress the need to streamline the process and avoid unnecessary new bureaucratic requirements.

Senate Finance Leaders Announce Deal on Medicare Reform and Prescription Drugs; Markup Scheduled for June 12

The Senate Finance Committee Chairman Charles Grassley (R-IA) and Ranking Member Max Baucus (D-MT) reached an agreement on a \$400 billion, 10-year Medicare reform proposal. The agreement represents the framework for a bill to be considered during committee markup on Thursday, June 12, and eventually on the floor by June 16th for a two-week debate. This bipartisan agreement greatly increases the likelihood of passage of a bill in the Senate. It also increases the possibility of enactment of a comprehensive bill this year.

Congressional and Administration Reaction

Overall, the plan makes a large concession that Democrats have been pushing thus far—equal access to a drug benefit in both traditional (fee-for-service) Medicare and the private, managed care administered plan. Although President Bush and some other Republicans would prefer a reform proposal that would include a more generous drug benefit in the private plan option to encourage seniors to join such plans, an administration official yesterday stated the Finance Committee plan represents "real progress" and has "a good shot" of attracting bipartisan support in the Senate. CMS Director Thomas Scully stated in a Finance Committee hearing on Friday, June 6, that the Bush administration has not determined whether to fully back the Senate plan. He praised aspects of the plan, particularly the use of a Medicare managed care model, stating that "all beneficiaries would be better off" under it.

Senate Minority Leader Tom Daschle (D-SD) stated the Finance Committee's plan "falls significantly short" of Democrats' goals for Medicare reform adding that Democrats do not favor a plan that has a gap in drug coverage, allows insurance companies to set prices or does not guarantee equal access for beneficiaries in rural areas. Daschle further commented that Democrats will attempt to amend the Finance Committee proposal when it comes to the Senate floor. Some Democrats have complained that the Finance Committee proposal does not include enough details for them to offer their support.

Senator Edward Kennedy (D-MA) surprised many observers by offering tentative support for the proposal by stating that the plan "assures every elderly American that they will have reliable coverage for the exorbitant cost of their prescription drugs, without being forced to give up the Medicare they love."

Medicare Drug Benefit

The agreement is not yet in legislative language and the only available information on specifics is in summary form published by the committee and from press reports. Under the proposal, which would begin in 2006, Medicare beneficiaries wishing to remain in traditional, fee-for-service Medicare would pay a \$275 deductible and a \$35 monthly premium for the drug benefit. Participating private health plans would administer the benefit and could set premiums higher or lower than \$35 per month as long as the drug coverage they offer has the same overall

(actuarial) value called for under the proposal. Beneficiaries would be required to pay half of annual drug costs from \$276 to \$3,450 and all drug costs between \$3,451 and \$5,300. After \$5,300, beneficiaries would be required to cover 10% of drug costs, with Medicare paying the remainder.

New "Medicare Advantage" Plan

The agreement also calls for a new type of Medicare coverage, called "Medicare Advantage." Private plans would compete in 10 geographical regions (or on a national basis) to offer coverage for catastrophic health expenses and preventive care services, giving beneficiaries an incentive to move out of traditional Medicare and into a private plan. Medicare beneficiaries opting for this new coverage would pay a \$400 deductible for hospital and doctor visits, compared with \$840 for hospital stays and \$100 for doctor visits for beneficiaries remaining in traditional Medicare.

According to some press reports, the government itself would provide a drug benefit through a contractor in the event that private insurance companies decide not to participate in the plan.

Rural Provider Provisions

The agreement will include a rural provider provision similar to that which passed in the Senate during the tax debate. The provision would boost Medicare reimbursements to doctors and hospitals in rural areas. A recently released CBO score of the Senate amendment has revised the cost from \$25 billion up to \$38 billion over 10 years. The new score complicates the inclusion of the measure due to the increased level of offsets required to make the amendment budget-neutral. The offsets included in the tax bill amendment account for all but \$4.1 billion of the total. The offsets would have imposed a copayment on diagnostic laboratory services, reduced reimbursement for prescription drugs already covered under Medicare Part B, and frozen payments for durable medical equipment and orthotics and prosthetics for 10 years.

Committee staff have indicated that the offsets in the new agreement will be different from the previous offsets, but it is unclear whether the offsets will be substantively different or a revision of the previous offsets. Indications point toward offsets similar to the tax bill amendment. For instance, the durable medical equipment fee schedule will purportedly be frozen for seven years, not 10.

Interim Drug Discount Card

Beginning in 2004 and through the program's implementation in 2006, the federal government would authorize the use of drug discount cards to provide 10-25 percent discounts on drugs. Low-income beneficiaries would be eligible for a \$600-a-year drug subsidy in 2004 and 2005.

Physician Fee Schedule Update

In February, Congress enacted an omnibus appropriations bill (H.J. Res. 2) that contained a provision providing legal protection to CMS to correct data errors in the fee schedule for past fiscal years, thereby permitting an administrative recalculation of the 2003 physician fee schedule. In accordance with the recalculation, physicians and other health care providers--effective March 1--received a 1.6 percent increase in their Medicare reimbursement rates for the remainder of 2003, instead of a 4.4 percent decrease that had been previously calculated. The Congressional Budget Office priced the provision at \$54 billion over the period 2003-2013. Nonetheless, in March CMS projected that for 2004, reimbursements would drop by an estimated 4.2 percent.

The House Ways and Means Committee is contemplating both short-term and long-term changes to the Medicare physician reimbursement formula, in light of the new CMS estimates. The Congressional Budget Office (CBO) has projected that a physician fee schedule provision being considered by the Committee would cost

approximately \$34 billion over 10 years. The physician fee schedule provisions would be in Medicare prescription drug and reform legislation slated to be marked up soon by the Committee.

After the formula is corrected for two years, under the Ways and Means proposal, it is likely that a phase-out will begin on some of the factors used to calculate physician payments using the sustainable growth rate (SGR). The SGR is the formula used by CMS to compute physician Medicare payments, such as tying payments in part to the gross domestic product.

Overall it is likely that some form of physician payment reform will be considered in the Medicare reform debate. Whether an overall Medicare bill is enacted, however, will determine how quickly such a provision is enacted. If Medicare reform does not pass, it is likely that there will be consensus to seek an alternative legislative vehicle.

Appropriations Bill Fails to Include Medicare Amendments

Not included in this year's HHS Appropriations package was an amendment passed originally in the Senate that would have boosted by \$25 billion (over 10 years) Medicare payments to rural hospitals and providers. The Medicare amendment would have been paid for by: 1) Limiting payments for durable medical equipment (DME) and orthotics and prosthetics by freezing the consumer price index through 2013 (a 10-year period); 2) Establishing copayments for clinical diagnostic laboratory services; and, 3) Cutting the Average Wholesale Price (AWP) for Medicare Part B drug reimbursement by 10 percent.

Medicaid - A last-minute deal was struck between Senate leaders and Energy and Commerce Committee Chairman Billy Tauzin (R-LA) on the state fiscal relief provision to provide \$10 billion for a temporary increase in the Medicaid federal medical assistance percentage (FMAP) and an additional \$10 billion in general fiscal relief (\$6 billion to the states for other programs and services and \$4 billion to local governments for the same purposes). Chairman Tauzin had threatened to vote against any tax legislation that includes Medicare or Medicaid reforms because the provisions would not have passed through his House committee, which has jurisdiction over Medicaid and Medicare Part B. He ultimately compromised with several moderate Senators who had vowed to fight for its inclusion. The compromise included legislation clarifying the intent of the Senators to keep the provision as a "temporary" boost in state assistance, not, as Chairman Tauzin had feared, a substitute for his Committee's upcoming consideration of structural Medicaid reform.

Although the increase in funding will be a short-term boost for cash-strapped states, it does not preclude attempts by Tauzin and other House Republicans from seeking broader Medicaid reforms that ultimately could result in removal of federal oversight and block granting the program.

Medicare - It is still likely that Congress will act on Medicare issues in the very near future, including the rural reimbursement issues (See accompanying story on Senate Medicare package). President Bush, in his statements following a compromise on the tax legislation, reiterated his commitment to Medicare reform this summer and has vowed to make it his next priority. House Speaker Dennis Hastert (R-IL) has made a similar commitment.

Chairman Grassley is adamant about passing Medicare relief for rural hospitals and he may succeed in including such provisions in a Medicare reform and prescription drug bill, which is expected to be drafted early in June and considered in June and July. His plan was bolstered by a May 22 letter President Bush sent to him that stated, "I will support the increased Medicare funding for rural providers contained in your amendment as part of a bill that implements our shared goal for Medicare reform." White House support for the rural Medicare provider payment measure increases the odds for its inclusion in the House and Senate Medicare reform bills.

However, dropping the rural Medicare "giveback" package from the tax bill has in turn infuriated House Republicans who did not want to add a new complication to already sensitive efforts to craft a Medicare reform bill next month. This situation leaves House Republicans in a difficult position since they have indicated an intent to

follow the Medicare Payment Advisory Commission's (MedPAC) recommendations, which conclude that most providers should not get additional funding increases this year.

House Republicans are also upset, not just about how the funds would be distributed, but about how Grassley's amendment would have been offset by cuts in other providers' reimbursements. In addition, Bush's letter did not contain any mention of the offsets. Clearly in the House, and to some extent in the Senate, the question of how to pay for provider givebacks or, in turn, provide savings in the context of Medicare reform will fall along the same issues as passed by the Grassley amendment: AWP and DME. AWP and DME are often targeted for their perceived wastefulness or excess reimbursement. The concept of "competitive bidding" is set to be debated as a means to reduce costs for drugs and for DME, some orthotics, and medical supplies.

In last year's Medicare prescription drug legislation, which is expected to be a Model for this year's bill, competitive bidding was included for DME, some orthotics, and medical supplies. With the removal of the Grassley language from the tax bill, pressure will continue to mount to include competitive bidding in the House Medicare bill while pressure in the Senate will mount to impose a fee schedule freeze for DME and orthotics and prosthetics. The competitive bidding provision included in last year's House Medicare bill would save \$7.7 billion over ten years according to a Congressional Budget Office score. However, the Senate version of competitive bidding included in the Baucus/Grassley legislation last year has a major exemption for competitive bidding in rural areas by imposing competitive bidding only in Metropolitan Statistical Areas (MSAs) with over 500,000 people.

With regard to AWP, Chairman Thomas has proposed reforming AWP in a model similar to competitive bidding whereby the government would base its reimbursement on the lowest price bid. The Energy and Commerce committee, on the other hand, has explored AWP reform based on Average Sales Price. Last year, many attempts to compromise on a solution to the AWP formula failed. AWP reform is more likely this year as the Committees have worked to resolve their differences.

The inclusion of copayments for clinical diagnostic laboratory services was a new addition to potential offsets in a Medicare giveback bill. The addition of copayments and a deductible would not only reduce Medicare expenditures, but it would likely cause reduced utilization, which would save further money. This provision was not included in last year's reform legislation, but it would not be surprising to see its inclusion this year given the support it received from the Grassley amendment.

CMS Posts 2004 Managed Care Rates; Health Plans Challenge Payments as Too Low

On May 12, 2003, CMS posted the 2004 payment rates for managed care plans. Immediately following the release the managed care industry said the payment rates are too low. For the counties containing most of the nation's Medicare+Choice beneficiaries, the payment increase will be the minimum of 2.2 percent for calendar 2004. The remainder of the counties will see a higher increase in payment, about 5 percent.

CMS made no special announcement of the final capitation rates, but posted them on its website for Medicare+Choice in 2004. CMS issued a 45-day advance notice of the rates in late March. Medicare rates have been set, county-by-county, at the highest of three amounts: (1) a "blended rate" based on both national and local data; (2) a "floor" amount specified in statute; and (3) a 2 percent increase over the prior year's rate. Using a risk adjuster, the 2 percent change becomes 2.2 percent.

In a press release, the American Association of Health Plans (AAHP) said the government's payment rates to health plans threaten Medicare beneficiaries' access to this coverage option. "Although somewhat higher rates of increase apply in areas serving slightly more than one-third of beneficiaries in private health plans, improved funding for the program as a whole is critical to its future, AAHP said.

The industry group said more than 5 million Medicare beneficiaries "continue to choose private-sector Medicare health plans for access to high-quality care and needed benefits, including, in many cases, prescription drug coverage and disease management programs that are not available under fee-for-service Medicare."

In a May 7 letter to House Ways and Means Committee Chairman Bill Thomas (R-CA), CMS Administrator

Thomas Scully stated it was "important to preserve and strengthen" the Medicare managed care program. Scully said Medicare+Choice plans had suffered from payments that had not kept pace with the rising cost of care. "Due to changes in payments made in 1997, in many areas of the country, payments to Medicare+Choice plans have not kept up with the rising costs of providing health care," Scully said. "Thus, many health plans have withdrawn from Medicare+Choice, and enrollment has declined from 6.3 million beneficiaries in 1999 to 4.6 million in 2003."

Medicare Reimbursement Update for Prostate Brachytherapy in Ambulatory Surgical Centers

On March 28, 2003, CMS updated the list of Medicare covered Ambulatory Surgical Center (ASC) procedures. The list of procedures that are covered by the Medicare Program when provided in an ASC now includes CPT code 55859 (Transperineal placement of needles or catheters into the prostate for interstitial radioelement application, with or without cystoscopy). This CPT code for prostate brachytherapy was placed in ASC group 9, with a facility payment amount of \$1339. The physician's professional services are reimbursed separately.

Although this brachytherapy procedure is now covered in the ASC setting, some questions have emerged concerning reimbursement for the brachytherapy seeds and other issues related to physician purchase of seeds and delivery/storage of radioactive seeds in ASCs. While CMS has informally indicated that the seeds are to be provided by the physician and billed to the Medicare carrier, CMS has not publicly announced any details concerning the reimbursement methodology used to determine the amount of payment.

Also, while the final rule adds CPT Code 55859 to the ASC list, the radiation oncology and radiological guidance codes generally billed in conjunction with the performance of the procedure are not included on the list. It is unclear which entity is entitled to bill for these codes, when a procedure is performed in an ASC. It is possible, if not probably, that an ASC that bills for these services is required to obtain a billing number as an Independent Diagnostic Testing Facility.

Finally, if the ASC bills for radiological guidance or radiation oncology services performed in conjunction with prostate seed implants and if the referring urologist has an ownership interest in the ASC, the arrangement may raise issues under the federal self-referral statute, which have not been addressed.

GAO Says CMS Should End Local Coverage Policies In Favor of National Decisions

According to a General Accounting Office (GAO) study released on May 12, CMS should not allow contractors to shape local Medicare coverage policies for new procedures and devices, and should instead centrally manage coverage decisions to ensure all beneficiaries receive equitable care.

Medicare covered about 99 percent of all procedures and devices in 2001 that had been assigned payment codes by the American Medical Association or another national group. However, about a quarter of new codes were approved with no restrictions or rules governing coverage, another quarter were restricted by national coverage decisions, and the remaining 50 percent were affected by local coverage policies, GAO said in the report: *Medicare: Divided Authority for Policies on Coverage of Procedures and Devices Results in Inequities* (GAO-03-175).

Medicare rules allow contractors to establish local coverage decisions that affect only beneficiaries in their jurisdiction, meaning patients in some states may not be able to receive coverage for the same procedures or devices that are covered by Medicare in other states, the report stated. GAO also said that, although national coverage decisions apply equally to all beneficiaries, the determination process is not as open to doctor and patient input as it should be and coverage criteria should be clearer. In addition, it said that, while CMS has improved the amount of time it takes to make coverage decisions, the agency often still exceeds the 90-day timeframe, in some cases by several months.

GAO said CMS should evaluate all local policies to determine which ones should be adopted nationally and which ones ought to be rescinded. The national determination process should be more open and timely, GAO said.

HHS disagreed with most of GAO's recommendations, saying in part that CMS did not have the resources to make the changes. In addition, HHS argued that GAO did not prove that developing only national coverage decisions would fully benefit the Medicare program and would deviate from the original intent that Medicare be a



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