

AFROC



ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

Our Voice in Washington

Volume 20, Issue 11

November 2003

THE BOARD

Peter Blitzler, MD <i>President</i>	Fort Myers, FL
Douglas J. Olson, MD <i>Vice President</i>	Edina, MN
Paul Williams, MSPH <i>Secretary/Treasurer</i>	Charlotte, NC
Kathryn Kepes, MD, MBA <i>Immediate Past President</i>	Tampa, FL
Mary W. Conti, MD	St. Louis, MO
Robert D. Hesselgesser, MD	Westlake Village, CA
Michael Katlin, MD	Fort Myers, FL
Gabriela B. Masko, MD	Providence, RI
Dhirendra J. Patel, MD	Prescott, AZ
Wayne T. Spears, MD	St. Louis Park, MN
Diane Millman, Esquire	<i>Counsel</i>
Sheila Gell, MA	<i>Executive Director</i>

Proposed IMRT Payment Reductions Reversed But Final Physician Fee Schedule Signals 4.5% Cut in 2004 Unless Congress Acts

CMS published on November 7, 2003, the final physician fee schedule for 2004. The good news is that, at the request of AFROC and a number of other organizations, CMS reversed its proposal to slash Medicare payment for IMRT. CMS's withdrawal of its proposal resulted from the concerted efforts of freestanding radiation oncology centers throughout the country who submitted comments objecting to the 35% reduction in IMRT payment that was proposed for public comment in August. Thanks to the many AFROC members who participated in the initiative.

The bad news is that, barring Congressional action on a provision in the Medicare bill to ameliorate a projected cut in physician payments for 2004, the cut will take effect January 1. The payment cut, which was originally projected to be 4.2 percent in 2004 has been revised by CMS to be 4.5 percent.

The cut, which marks a trend in decreasing Medicare payments, results from a statutorily imposed formula used by CMS that adjusts physician payments

2004 DUES

AFROC is the only organization that solely focuses on the regulatory, legislative, and socioeconomic issues of freestanding radiation oncology 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.

It is now time to pay your dues for 2004. 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

*Save the Date for the
16th Annual AFROC
Conference*

on

May 23 and 24, 2004

at the

Grand Hyatt Washington, DC

each year to a targeted rate of growth. Many health care observers agree that the formula is flawed because it unfairly reduces physician reimbursement in future years because of overpayment mistakes brought on by CMS in the late 1990s. AFROC has been very active along with other physician groups to pressure Congress to adopt a provision that would boost physician payments in 2004 and in subsequent years. Under the current formula, cuts will continue through 2006—possibly longer—if Congress does not act.

Congressional negotiators have signaled an interest in a House provision that would revise physician payments up 1.5 percent in 2004 and permanently reform the payment formula, averting future cuts as well. The Senate bill has a similar provision, but it does not have statutory effect. Conferees have debated how to prevent an immediate reduction in physician payments while debating long-term solutions to the formula. At the time of writing, it appears that a long-term fix is not in the cards due to a very high score from the Congressional Budget Office. A more modest, but short-term fix appears to be in the offing that builds upon the 1.5 percent increase, but details are as yet unavailable as negotiators continue to spar on other parts of the bill.

It should be noted that the proposed 1.5 percent increase is predicated on passage of the entire Medicare reform and prescription drug legislation. If the bill does not pass by the end of the year, it is unlikely that Congress will attempt to reform physician payments before the scheduled cut on January 1, 2004.

The Big Picture on the Medicare Bill

Congressional negotiators are working feverishly to complete work on a Medicare reform and prescription drug bill before the end of 2003. If they are successful in navigating through many contentious issues and partisan conflict, the enactment of a bill would be considered the largest reform of the Medicare program since its creation in 1965. Within the bill are broad provisions that promote a much greater reliance on private, managed care health plans to cover not only prescription drugs, but all Medicare services as well. In addition to the restructuring of Medicare itself, other provisions, such as the reform of the physician fee schedule, impact specifically on AFROC. The chances of final passage and enactment of the bill before the end of the year are high, but many potential issues could derail negotiations in the final stages.

Both the House and Senate passed competing versions of Medicare reform and prescription drug bills in late June, appointed “conferees” in late July to negotiate a

compromise bill, and now are awaiting a reconciliation of the bills this fall. Thus far, conferees on the Medicare bill have already exceeded several self-imposed deadlines for completion of a compromise bill. Although House and Senate leaders are optimistic that conferees can complete work on the 1000+ page Medicare prescription drug and reform bill, many Democrats and Republicans are expressing doubt as to whether such a compromise bill can actually pass both chambers before going to President Bush for his signature.

Several very contentious issues remain to be decided that could endanger a final compromise, including the “800-pound gorilla” of Medicare competing with private plans similar to the Federal Employees Health Benefits Program, otherwise known as “premium support.” Senate Democrats have circulated a letter with enough signatures to block consideration of a bill with such provisions, but Congressional Republicans have stated that they will not support a bill that does not have the premium support provisions included in it. Premium support could very well be the straw that breaks the camel’s back in the Medicare debate.

Conferees have been hard at work resolving various elements of the Medicare bills, including a basic design for the drug benefit, a “federal fallback” that would ensure a Medicare drug plan if private plans do not enter a particular market, and a host of provider payment provisions that include increased rural Medicare and hospital payments. (See below for details on these compromises.) However, as the political rhetoric over the Medicare conference report heats up, conferees are now hoping to resolve remaining issues—including those issues in addition to premium support that have deadlocked talks so far—early in November in the hope of having a final package by Thanksgiving that is ready for a vote.

Medicare conferees are at an impasse over several key issues, with each political party taking the opportunity to blame the other for the continued delays. Nonetheless, Senate Finance Committee Chairman Charles Grassley (R-IA), who is helping to lead negotiations, stated that lawmakers crafting the conference report plan on tackling the bill’s dozen-or-so outstanding issues in the early part of November and should have a document ready to begin a difficult two-weeks of drafting and completing the final Congressional Budget Office “scoring” to ensure that the bill does not cost more than the \$400 billion allocated in the budget.

Of the outstanding issues, Grassley stated that the three crucial provisions are cost containment (such as reimportation of drugs from Canada or use of private health plans to hold down costs among others), health

savings accounts, and premium support. It is on these issues, Grassley stated, that conferees need a "magic wand" to write them so that "there's cover to get through the House but not lose so many Democratic [Senate] votes."

The three issues are the most politically charged elements of the entire Medicare bill. How the conferees resolve them will determine the political future of the bill, as they represent fundamental disagreements between House GOP conservatives and Democrats. Key Democrats have stated that proposals under consideration by conferees in the three areas are "showstoppers"—a message that provoked congressional GOP leaders to essentially challenge Democrats to block passage of a Medicare drug benefit. The big unresolved question is when, and how, the White House will weigh in to break the deadlock. Thus far, President Bush has remained relatively silent on Capitol Hill in attempts to break the legislative logjam.

Unlike the landmark bipartisan Senate compromise in June on Medicare reform engineered by Senator Ted Kennedy (D-MA), conference negotiations continue to be dominated by Republicans, with only two Democrats, Senators Max Baucus (D-MT) and John Breaux (D-LA), allowed to participate in the formal conference talks. The exclusion of the other Democratic conferees has fueled increased partisan bickering in recent weeks. Kennedy and other Democrats charged that the conferees are moving too much in the direction of the House bill, which is anathema to Kennedy and other Senate Democrats who supported the bipartisan Senate bill in June. But House conservatives are concerned that the GOP leadership may try to rush a compromise through Congress, possibly one that removes many of their "key" provisions such as premium support and health savings accounts. Such health savings accounts would allow beneficiaries to invest their own funds in a tax-free personal account to pay for routine health care with a catastrophic plan to cover major medical expenses.

Medicare Bill Drug Benefit Compromise

Conferees have reached a tentative deal on the design for a prescription drug benefit.

The proposed Medicare drug benefit would call for beneficiaries to pay a \$275 deductible and a monthly premium of about \$35 before drug coverage begins. The Medicare drug package would cover 75 percent of beneficiaries' drug costs of up to \$2,200, leaving seniors to cover their own drug costs up to \$5,000. After this point the government would cover 95 percent of drug costs. This tentative agreement tweaks the

structure in the House bill, which has a \$250 deductible with a mandatory 20 percent coinsurance payment on expenses above the deductible up to \$2,000. The Senate bill calls for beneficiaries to pay 50 percent for expenses up to \$4,500.

Although this drug plan is a compromise between the two bills, beneficiaries would still be faced with a gap in coverage between \$2,200 and \$5,000 in total drug expenses. Catastrophic expenses—when drug costs exceed the \$5,000 threshold—require beneficiaries to pay either 5 percent coinsurance or nominal cost sharing depending on the cost projections from the Congressional Budget Office. The Senate bill would require 10 percent coinsurance above the catastrophic threshold, whereas the House plan picked up all the expenses.

Conferees have tentatively agreed to adopt the Senate bill's proposal to extend coverage through the gap in coverage for low-income beneficiaries. Seniors whose incomes are up to 135 percent of poverty would face no cost-sharing or deductibles for their coverage and all of their catastrophic drug costs would be covered. They would, however, be required to make a \$2 copayment on generic drugs and \$5 for brand names. Beneficiaries whose incomes are between 135 and 150 percent of poverty would pay more for drugs—a \$50 deductible and \$35 monthly premiums, for which they would receive financial help on a sliding scale.

Provider Payment Compromises Abound in Medicare Conference

Medicare conferees made significant progress on several key provider payment issues. Reimbursement formulas covering hospitals and home health agencies and reform of the payment system for physician-administered drugs are among those that have been tentatively agreed upon by conferees. Any tentative provider deals are subject to scoring of the final bill and could be revisited if the bill exceeds the targeted \$400 billion budget, however. At this point in negotiations, the tentative agreements that have been reached are as follows:

- **Indirect medical education payments (IME):** Conferees have agreed to improve the language in the Senate Medicare bill relating to indirect medical education payments by adjusting teaching hospitals' IME "conversion factor" to 6 percent—a 0.5 percent increase over Senate language. The deal brings the IME increase up to around \$500 million, \$200 million more than in the original Senate bill.

- **Hospital inpatient payments:** Hospitals would receive a full market basket update for FY 2004, followed by market basket minus 0.4 percent for FY 2005 through 2007.
- **Ambulatory surgical centers:** House language to cap Medicare inflation updates to ambulatory surgical centers (ASC) was tentatively agreed upon. The proposal generates \$2.1 billion by setting the ASC update at the consumer price index minus 2 percent from FY 2004 through 2008.
- **Rural hospitals:** Conferees decided to adopt similar provisions in both Medicare bills that would boost payments for rural hospitals, agreeing to the House bill's 2004 start date for a change to the labor share of the reimbursement formula for hospitals in low wage areas. The estimated total over 10 years is \$5.4 billion. In addition, the \$7.9 billion provision to increase the standardized inpatient payments for rural and small city hospitals was tentatively agreed upon.
- **Disproportionate share hospital payments (DSH):** According to a bulletin released by the American Hospital Association (AHA) Wednesday, conferees have agreed to adopt the House bill's FY 2004 20 percent boost in disproportionate share hospital payments. This provision resolves the sharp drop in DSH payments under current budget rules, as well as leveling the payment in future years. The tentative deal also incorporates a provision from the Senate bill, which would allow states with low DSH payments—currently capped at one percent—to receive as much as 3 percent of DSH funds.
- **Average Whole Price (AWP):** A tentative outline of the agreement calls for the establishment of a reimbursement system for drugs provided in a physician office setting based on the average sales price (ASP). A one year phase-in period, beginning in 2004, would lower the current payment from 95 percent of AWP to lower than 85 percent of AWP or the widely available market price (WAMP) as determined by CMS review of prevalent prices. CMS will begin to pay for drugs in the Part B setting based on the average sales price (ASP) plus 4% no later than 2005. The conferees have also discussed adding \$300-\$400 million per year in practice expense reimbursements to oncologists and other physicians who lose out on the AWP cuts—an increase from the \$190 million included in both Medicare bills. The House provision excluding drugs for patients with end stage renal disease, hemophilia along with vaccines and radiopharmaceuticals was also adopted.

Co-payment for home health services: Conferees have agreed to drop the House bill's proposed co-payment for home health services, however deepening the cuts by 0.9 percent for FY 2004-2005 to market basket updates for home health agencies. The House bill proposed a 0.4 percent cut during that time with a 5 percent rural add-on in FY 2005; the Senate bill called for no co-pay, no update cuts, and a 10 percent rural add-on for FY 2004-2005.

Compliance Deadline for HIPAA Electronic Transactions Extended

The Centers for Medicare and Medicaid Services (CMS) announced in September that it will accept noncompliant electronic transactions after the October 16, 2003 compliance deadline. CMS has implemented a contingency, or back up plan to ensure that claims not meeting the new transaction standards will continue to be paid after the October 16 deadline. Thousands of providers who were unable to meet the original deadline are provided with additional transitional time without having their current noncompliant Medicare claims rejected.

The HIPAA Administrative Simplification Compliance Act (ASCA), signed into law on December 27, 2001 provided a one-year extension to HIPAA "covered entities" to meet HIPAA electronic and code set transaction requirements. The Act allows the Secretary of HHS to prohibit Medicare payments to providers if their claims, submitted by paper rather than electronically, are received after October 16, 2003. After reviewing statistics showing a very low number of claims properly submitted under the new system, CMS made the decision to implement its contingency plan.

CMS Administrator Tom Scully explained that the implementation of such a contingency plan will move "us toward the dual goals of achieving HIPAA compliance while not disrupting providers' cash flow and operations, so that beneficiaries can continue to get the health care services they need."

Many question whether the money put forth to comply with the new transaction rule is being used properly. Senate Special Committee on Aging Chairman Larry Craig (R-ID) worried that such an effort may be "diverting resources from quality patient care." The estimated cost of complying with the privacy rules is \$17.6 billion over 10 years, but HHS contests that an estimated savings of \$30 billion over 10 years to the healthcare system from this transaction standard will offset the complying costs. CMS will reassess the providers' progress in transitioning to the new system to

determine how long the contingency plan will be in effect.

HCA Expands Access to Freestanding Centers and Diagnostic Imaging

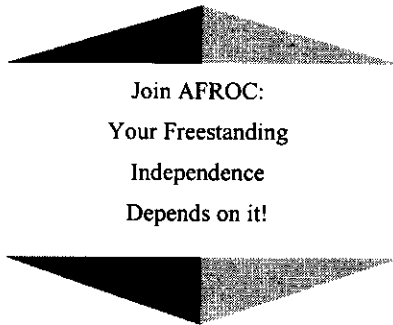
In a move that could expand access to AFROC members, HCA of Nashville, announced that it will look to freestanding outpatient centers for growth as the number of uninsured and the poor economy continues to impact patient volume. The company will increase its investment in freestanding outpatient facilities. HCA also plans to organize a separate outpatient services unit to be headed by a senior manager.

HCA stated that the Medicare outlier policy that went into effect October 1, 2003, will cost it \$144 million in revenue annually, which HCA explains, would have the same effect of its new policy on collecting from self-pay patients. In response to these trends and soft patient volume, HCA announced that it will reduce capital expenditures from \$2 billion this year to \$1.8 billion in 2004 and \$1.6 billion in 2005, but no currently approved projects will be canceled.



Volume 20, Issue 11 November 2003

1875 Eye Street, NW
Twelfth Floor
Washington, DC 20006-5409
Phone: 888-334-4542
Fax: 202-466-5938
Email: sgell@ppsv.com



Join AFROC:
Your Freestanding
Independence
Depends on it!

Gold Practice Members:

- .Costal Radiation Oncology
Medical Group
Santa Maria, California
 - .Mathews Radiation Oncology,
Inc.
Charlotte, North Carolina
 - .Minneapolis Radiation Oncology
Physicians
Minneapolis, Minnesota
 - .Poudre Valley Radiation Oncology
Denver, Colorado
 - .Radiation Medical Group, Inc.
San Diego, California
 - .Radiation Oncology Associates*
 - . Providence, Rhode Island
 - .Radiation Therapy Medical Group
 - . Riverside, California
 - .Regional Radiation Oncology*
 - . Rome, Georgia
 - .Southeast Radiation Oncology
Group
Charlotte, North Carolina
 - .Tacoma Radiation Oncology
Tacoma, Washington
 - .Tri State Regional Cancer Center
Ashland, Kentucky
 - .21st Century Oncology
Fort Myers, Florida
- * New Gold Members