

# AFROC



ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

*Our Voice in Washington*

# The Source

Volume 22, Issue 13

March 2004

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## ISSUES AT THE TOP OF CONGRESS'S AGENDA IN 2004

Following in the wake of Medicare reform in late 2003, other health care issues are at the top of Congress's agenda in 2004. Among them are Medicaid reform, medical malpractice reform, and appropriations. The last issue of the Newsletter featured a detailed description of the major provisions of the prescription drug legislation impacting AFROC members, such as the physician fee schedule. This issue will focus on the regulatory reform provisions enacted as part of the bill and the legislative outlook for CY 2004-2005.

### Medicare Reform Bill Enacted in December 2003 – Regulatory Reform Spotlight

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 was signed into law in early December of last year and included major reforms to CMS's regulatory, contracting, and appeals structure. The following is a summary of the major revisions to laws governing CMS regulations, how it will contract with carriers and fiscal intermediaries, and the appeals structure.

## 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](http://www.afroc.org)

Register now for the  
**16<sup>th</sup> Annual AFROC  
Conference**  
on  
**May 23 and 24, 2004**  
at the  
**Grand Hyatt  
Washington, DC**

*(More information inside.)*

**Regulatory Reform**—The Medicare law enacts basic protections on the introduction of new rules by CMS, which, on occasion has frustrated health care providers participating in Medicare. Specifically the law enacts a prohibition on the introduction of new material in final rules without an opportunity for public comment and it prohibits the retroactive application of new regulations and policies. Furthermore, the law prohibits sanctions by CMS if a provider follows written, erroneous guidance from the government and its agents. Ultimately these new protections will spare providers from unanticipated changes in reimbursement or potentially unfair allegations of fraudulent billing practices even though CMS guidance was followed.

**Contracting Reform**—Currently CMS contracts with carriers and fiscal intermediaries to provider Parts A and B Medicare claims. Although it is unclear when CMS will implement these sections, the agency will combine administrative and claims contracting into new, combined entities called MACs, or Medicare Administrative Contractors. CMS will also implement a competitive bidding system for contracting for Medicare administrative functions, such as the processing and paying of claims. The law also allows CMS to expand the potential pool of contracting entities by allowing companies besides insurance companies to compete for contracts. It is unclear at this point what direct impact these new practices will have on claims processing and AFROC will monitor such actions by CMS as appropriate.

**Appeals Reform**—Many changes were made to the appeal rights CMS must follow with respect to beneficiary and provider claims. In a move that could impact the impartiality of Administrative Law Judges (ALJs), who adjudicate Medicare claims when internal Medicare appeals have been exhausted, the law transfers Medicare ALJs from the Social Security Administration to the Department of Health and Human Services. Additionally, the law provides for expedited access to judicial review for legal issues that cannot be resolved administratively, and requires expedited review of certain provider agreement determinations.

The law allows providers up to three years to repay overpayments in cases of hardship (five years if extreme hardship) and enacts a prohibition on recovery of overpayments until after evaluation by an independent party. CMS may no longer use extrapolation of overpayments from a small sample of claims to initiate an enforcement action; educational intervention to the provider would be required prior to the action. Furthermore, billing mistakes can be corrected by supporting documentation prior to settlement or appeal of an overpayment dispute. And

finally, notification to the provider must be made when a provider is possibly overusing a particular Medicare billing code.

## **THE ADMINISTRATION'S HEALTH CARE AGENDA FOR 2004**

The President's State of the Union Address outlined many of the Administration's other health policy priorities. During the January 20<sup>th</sup> speech, President Bush called for expansion of the Health Savings Accounts, enacted in the Medicare bill, to all Americans. Health Savings Accounts would allow individuals to put aside savings, tax-free, to help pay for medical expenses prior to insurance coverage with a high-deductible health plan. Bush showed his faith in the program by proposing that individuals be able to deduct the full cost of their high deductible or catastrophic health insurance policy from their HSA. Supporters believe that such an expansion would make coverage more affordable for those who do not receive coverage through their workplace. Opponents fear that such a policy could prove to be insensitive to low-income patients by favoring high deductible policies and potentially causing other traditional health insurance providers to increase their coverage costs or employers to drop existing low-deductible coverage.

Also addressed in the State of the Union was a proposal for a refundable tax credit for low-income workers in order to help them purchase health insurance. These tax credits, which have been proposed at up to \$3000 per family, enjoy bipartisan support; however, efforts to enact them have proven unsuccessful to date. More recently, in a February 13<sup>th</sup> hearing, House Ways and Means Committee Chairman William Thomas (R-CA) stated that these health care tax credits might not be appropriate due to the current budget deficit and the potential drain an effective program would have on the government.

The President has also asked Congress to support legislation that would permit Association Health Plans (AHP), which would give small and medium size businesses the opportunity to join with other similar businesses under umbrella, group health plans. Ideally, AHPs would increase coverage and lower health insurance costs. However, negative reaction to this legislation points to the possibility that without regulation, AHPs could be free to exercise risk selection, thereby leaving high-risk individuals with exorbitant premiums and deductibles.

Resurrecting the issue of medical malpractice reform, which failed in the Senate last year, the President blamed rising health care costs, in part, on "wasteful and frivolous" lawsuits against physicians. While medical malpractice legislation is high on the priority list for many physician groups, including AFROC, many, including consumer and disability groups, aim to oppose the bill. Despite large support for such legislation, which would cap non-economic damages at \$250,000, Senate leaders do not anticipate passage of the bill this year and it is not expected to be enacted this year.

### **FISCAL YEAR 2004 APPROPRIATIONS AND THE PRESIDENT'S 2005 BUDGET PROPOSAL**

On February 2, 2004, President Bush released his FY 2005 budget proposal that funds all federal government programs. This came very soon after the final appropriations for FY 2004 were enacted on January 27, 2004.

The total FY 2005 Administration request is for \$2.4 trillion. Not counting mandatory spending such as Medicare, Medicaid, and Social Security, the portion of the budget which is subject to annual appropriations totals \$818 billion, an increase of 4.1 percent over FY 2004. This, however, does not include the costs for ongoing operations in Afghanistan and Iraq. If the 2005 budget is adjusted for those additional factors, the Administration is actually proposing a 6.3 percent cut in discretionary spending. Further, the FY 2005 request does not include the incremental amounts generally expected to be required for the Middle East conflicts.

Total spending for the Department of Health and Human Services would increase 5.8 percent to \$580 billion under the FY 2005 budget proposal. However, discretionary funding—which excludes the 85 percent dedicated for mandatory Medicare, Medicaid, and SCHIP funding for all HHS programs would decrease 1.6 percent to \$68.2 billion. Although the budget does not officially mention a Medicaid reform plan, the one described in last year's budget is still up for consideration this year. Likely to be the subject of an ongoing effort by House and Senate leaders to craft a Medicaid reform vehicle, The Bush proposal would generally offer greater "flexibility" and cap federal funding to states. The Budget does propose this year to end Medicaid's "upper-payment limit," or the maximum amount that states may pay local government-owned hospitals through Medicaid.

Under the 2005 budget, the National Institutes of Health (NIH) would receive a 2.7 percent increase, which is

much lower than 6 to 7 percent increases in previous years. The NIH was funded at \$28.044 billion in FY 2004 and the FY 2005 budget proposes funding at \$28.773 billion. Funding for CDC would drop to \$4.1 billion from \$4.5 billion, but with the increase in biodefense spending. HRSA funding also took a cut from \$6.7 billion to \$6.0 billion, mostly from health professions and public health improvement programs.

The Agency for Healthcare Research and Quality (AHRQ) is proposed to receive level funding at \$327 million in the President's FY 2005 Budget. Although AHRQ is slated to receive level funding, funding for projects related to the Medicare bill has lowered the budgets for other AHRQ programs in general.

Over the past several appropriations cycles, only defense and military construction bills have typically been approved under regular order. Given that 2004 is an election year and that the Bush budget calls for many cuts in popular programs, it is unlikely that enactment of FY 2005 appropriations will occur prior to the election and could possibly stretch into calendar year 2005.

### **MEDICAID REFORM EXPECTED TO BE CONSIDERED IN 2004**

While the overall consensus on Capitol Hill is that Medicaid reform legislation is not likely to be enacted this year, consideration of a wide-ranging Administration-endorsed reform proposal will occur and there is lack of Medicaid issues occurring outside of Congress. As evidenced in the State of the Union speech and in the past two budgets, the Administration continues to express their concern over the rising costs of the Medicaid program and seems to be making quiet moves toward the highly controversial system of block grants and Medicaid caps. These initiatives would eliminate the current system of federal matching funds that states receive for Medicaid expenditures. Although Medicaid reimbursement is now often abysmally low, a consolidated block grant system could potentially require states to fund more of the cost.

Rumors that now appear valid, have floated around for months that New Hampshire, likely followed by Florida and possibly Colorado, have made agreements with the Federal government involving forgiveness of Medicaid debts in exchange for agreeing to a block grant system. This type of back-door-approach bypasses Congress and often state legislatures, allowing the Bush Administration to quietly negotiate directly with the governors and state Medicaid directors.

Further Medicaid controversy has surfaced as CMS has signaled an interest in "predetermining" states' Medicaid budgets. The new policy, if implemented, would require states to receive prior federal approval for each source of revenue that would be used to cover the states' share of Medicaid costs. Currently, states collect federal matching funds for Medicaid costs after their budget has been established. Health care observers have speculated that additional administrative burdens associated with the potential CMS predetermination policy could be used as an effort to frustrate states to the point of agreeing to limits on federal Medicaid funding; i.e. block grants. Over the short term, the policy could also place states in the position of potentially receiving less Medicaid matching funds than they would otherwise receive under the current budget reporting policy.

### **CIGNA SETTLES RACKETEERING LAWSUIT INVOLVING TEXAS PHYSICIANS**

On February 9, 2004, U.S. District Court Judge Federico Moreno gave final approval to a settlement involving the Texas Medical Association (TMA) and other state societies negotiated with Cigna in an ongoing class-action antiracketeering lawsuit against the country's major HMOs. The settlement includes a guaranteed cash payment of \$85 million and business practice changes of \$400 million that are expected to save physician practices hundreds of millions more. Outside lawyers estimate the gross value of the package at more than \$1 billion. Like a similar Aetna settlement in 2003, the agreement requires CIGNA to create a foundation to foster a broad range of public health improvement initiatives through state medical societies. The trial of the remaining HMO defendants is scheduled to begin in September.

The settlement agreements with Aetna, and now CIGNA, include the following: a better medical necessity definition, payment of vaccines and vaccine administration, reduced downcoding, fairer payment rules, fewer contract changes, disclosure of payment rules, faster credentialing, capped arbitration fees, no required use of electronic transactions, and better mental health coverage.

### **NATIONAL PROVIDER NUMBER OFFICIALLY ANNOUNCED BY CMS**

According to a final rule issued by CMS, health care providers will be required to use a unique national provider identifier (NPI) for filing and processing all health care claims by May 23, 2007. The effective date is May 23, 2005, at which time providers may begin to apply for their NPIs. Providers will be assigned one NPI for all health care transactions, whether federal (such as Medicare), state-administered (such as Medicaid), or private. The NPI will replace so-called legacy identifiers, which insurers currently use depending on the destination of data. The identifier was mandated in by Congress in the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

**AFROC 16th ANNUAL CONVENTION**

May 23-24, 2004—Grand Hyatt Washington  
1000 H Street, NW • Washington, DC

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**AGENDA**

**Sunday, May 23rd**

**Farragut/Lafayette**  
7:00 to 8:30 am

**Continental Breakfast**

8:30 to 8:45 am

***Introductory Remarks – AFROC, Now More than Ever***  
Peter Blitzer, MD – AFROC President – **Conference Theatre**

**Session 1**

**Conference Theatre**  
8:45 to 9:30 am

***Ethical Considerations in Cancer Treatment & Research***  
Kevin T. Fitzgerald, SJ, PhD – Research Associate Professor, Dept. of Oncology  
Georgetown University Medical Center, Washington, DC

9:30 to 10:15 am

***Integrated Radiation Therapy***  
Charles Mayo, PhD – Assistant Director of Physics, University of Mass.  
Memorial Hospital Center, Worcester, MA

**Farragut/Lafayette**  
10:15 to 10:30 am

**Coffee Break**

**Session 2**

**Conference Theatre**  
10:30 to 11:30 am

***Respiratory Gating – Imaging & Treatment:***  
***Introduction to Respiratory Gating Analysis Software***  
Steve Kohlmyer, Global Manager, General Electric Medical Systems, CT Oncology  
Waukesha, WI

11:00 to 11:30 am

***Feasibility Studies of Respiratory Gating & Imaging in IMRT***  
Andrew Wu, PhD, Professor & Director, Dept. of Radiation Oncology,  
University of Pittsburgh, Medical Center – Cancer Center

11:30 am to 12:15 pm

***Quality of Life in Cancer Treatment***  
Margaret W. Wool, PhD, Social Worker, Private Practice, Providence, RI

12:15 to 1:15 pm

**LUNCH - Farragut/Lafayette**

**Session 3**

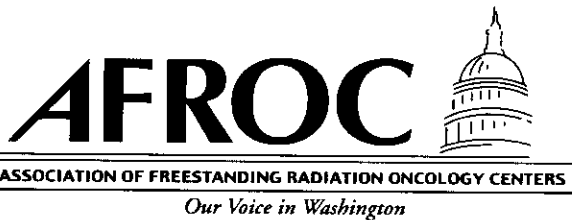
**Conference Theatre**  
1:15 to 2:00 pm

***New Concepts in the Design & Architectural Planning of Freestanding  
Radiation Oncology Centers***  
Paul Torp, AIA, Architecton, Louisville, KY

2:00 to 2:45 pm

***Reimbursement for New Techniques in Radiation Oncology***  
James E. Hugh III, MHA  
Senior VP, American Medical Accounting & Consulting (AMAC), Marietta, GA

<b>Farragut/Lafayette</b> 2:45 to 3:15 pm	<b>Coffee Break</b>
3:15 to 4:30 pm	<b><i>Legislative and Reimbursement Update With Roundtable Discussion</i></b> Diane Millman, JD, Legal Counsel to AFROC, Washington, DC
6:00 to 10:00 pm	<b>Dinner Cruise on the Potomac on the Odyssey</b>
<b><u>Monday, May 24</u></b>	
<b>Farragut/Lafayette</b> 7:00 to 8:30 am	<b>Continental Breakfast</b>
<b>Session 1</b>	
<b>Conference Theatre</b>	
8:30 to 9:15 am	<b><i>Best Practices in Cash Flow Management</i></b> Claudia A. Murray, COO, Provider Practice Analysis, Baldwin, MD
9:15 to 10:00 am	<b><i>Updates in Brachytherapy Payment Policy &amp; Reimbursement</i></b> Wendy Smith Fuss, MPH, Director of Government Affairs, Computerized Medical Systems, Inc., Falls Church, VA
10:00 to 10:45 am	<b><i>How Expense Surveys are Likely to Impact Medicare Reimbursement for Practice Expenses in Freestanding Radiation Oncology Centers</i></b> Mark Hartstein, Health Insurance Specialist, Center for Medicare & Medicaid Services, Baltimore, MD
<b>Farragut/Lafayette</b> 10:45 to 11:00 am	<b>Coffee Break</b>
<b>Session 2</b>	
<b>Conference Theatre</b>	
11:00 to 11:45 am	<b><i>The Evolutional Nature of Radiation Research: An Update from The National Cancer Institute</i></b> Paul Wallner, DO, FACR, Chief, Clinical Radiation Oncology Branch Radiation Research Program, Division of Cancer Treatment & Diagnosis National Cancer Institute, Rockville, MD
<b>Farragut/Lafayette</b> 11:45 am to 1:00 pm	<b>Lunch and AFROC Business Meeting</b> <b><i>Government Day Orientation</i></b> Diane Millman, JD, Legal Counsel to AFROC
<b>Session 3</b>	
<b>Conference Theatre</b>	
1:00 to 1:45 pm	<b><i>Medicare Reimbursement for Treatment at Freestanding Radiation Oncology Centers: A View from the Hill</i></b> Madeline Smith, PhD Professional Staff Health Subcommittee, Committee on Ways & Means
1:45 to 2:30 pm	<b><i>Partial Breast Irradiation</i></b> Bradley Prestidge, MD, Radiation Oncologist, Cancer Therapy Research Center, San Antonio, TX
2:30 to 3:15 pm	<b><i>The SNF Consolidated Billing Requirement: A Continuing Problem for AFROC Members</i></b> Justin Hunter, JD, Associate Powers Pyles Sutter & Verville, Washington, DC
3:30 pm	<b>Visit to the Hill</b>



16th ANNUAL CONFERENCE

May 23 - 24, 2004

Grand Hyatt Washington

1000 H Street, NW

Washington, DC

Return form with check to AFROC,  
1875 Eye Street, NW, 12th Floor, Washington, DC 20006

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fax credit card information to 202-466-5938, Attn: Sheila Gell

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This is my first time attending an AFROC Conference.

Registration includes: All conferences, continental breakfasts, refreshment breaks, lunches, and dinner. Guest fee for breakfasts, lunches and dinner cruise.

	<u>Two Day Registration</u>	<u>Pre-registration</u>	<u>On-site registration</u>	<u>Payment</u>
<input type="checkbox"/> AFROC member		\$350	\$375	\$ _____
<input type="checkbox"/> Additional AFROC members*		\$300	\$350	\$ _____
<input type="checkbox"/> Non-Member		\$450	\$475	\$ _____
<input type="checkbox"/> Guest		\$125	\$150	\$ _____
<input type="checkbox"/> Dinner Cruise Only		\$75	\$100	\$ _____

	<u>One Day Registration</u>	<u>Pre-registration</u>	<u>On-site registration</u>	<u>Payment</u>
<input type="checkbox"/> AFROC member		\$200	\$225	\$ _____
<input type="checkbox"/> Additional AFROC members*		\$150	\$175	\$ _____
<input type="checkbox"/> Non-Member		\$275	\$300	\$ _____

• Any member organization paying a \$350 registration fee will be granted a \$50 reduction in registration fees per additional attendee. Please return forms for multiple attendees together.

<b>Payment information:</b>	<b>Total amount due:</b>
<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: _____	

Call the Grand Hyatt Washington at 800-233-1234 for room reservations (AFROC).

Reservations made before April 23, 2004 will be afforded conference rate of \$209/single, \$224/double per night based on two night stay.

1875 Eye Street, NW  
Twelfth Floor  
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