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ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS
Our Voice in Washington

The Source

January/February 2005

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LEGISLATIVE NEWS

The 109th Congress kicked off its first session of 2005 on January 4 in what is likely to be a contentious and partisan year. Featuring prominently will be President Bush's signature health issue, medical malpractice reform. Medicaid reform and a major budget fight will likely ensue as well. The Senate, which saw the GOP gain 4 seats to a 55-seat majority, will face a confirmation battle over current Environmental Protection Agency Administrator Michael Leavitt as the new Secretary of Health and Human Services. For freestanding radiation oncology providers in 2005, the largest issue will likely be an effort to increase physician payments, which are expected to decrease if Congress or the Centers for Medicare and Medicaid Services (CMS) do not intervene.

2005 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.

Now is the time to pay your 2005 dues. It is estimated that 95% of your dues can be taken as a business expense.

Thank you.

It is Not Too Early to Save the Date for the

17th Annual AFROC Conference on June 5 and 6, 2005

at the

Grand Hyatt

Washington, DC

Check out AFROC's website *www.afroc.org*

Skilled Nursing Facility Reimbursement

http://www.cms.hhs.gov/manuals/pm_trans/R412CP.pdf

CMS has recently issued a Transmittal that clarifies the rules applicable to SNFs when services that are subject to SNF "consolidated billing" (such as radiation oncology technical component services) are furnished to SNF Part A beneficiaries. A link to the Transmittal is set forth above.

Significantly, this Transmittal clarifies that a SNF may not refuse to pay a radiation oncology center (a "supplier", in Medicare terminology) for technical component services simply because there is no written agreement between the center and the SNF. Specifically, the Transmittal states:

However, it is important to note that the absence of a valid arrangement does NOT invalidate the SNF's responsibility to reimburse suppliers for services included in the SNF "bundle" of services represented by the SNF PPS global per diem rate. As the SNF has already been paid for the services, the SNF must be considered the responsible party when medically necessary supplier services are furnished to beneficiaries in Medicare Part A stays. This obligation applies even in cases where the SNF did not specifically order the service; e.g., during a scheduled physician's visit, the physician performs additional diagnostic tests that had not been ordered by the SNF; a family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

Hopefully, the issuance of this Transmittal will assist freestanding centers in getting paid for technical component services rendered to SNF Part A patients, when the SNF refuses to enter into a written agreement for these services.

If you have any questions regarding this issue, please do not hesitate to e-mail Diane Millman (dmillman@ppsv.com) or Justin Hunter (Justin.Hunter@ppsv.com).

MedPAC Recommends Increase in Physician Payments

In a move heralded by many physician groups in Washington, DC, the Medicare Payment Advisory Commission (MedPAC) on December 10, 2004, released a preliminary recommendation for a 2.7 percent raise in physician reimbursements for 2006. Although Congress does often follow MedPAC recommendations, the recommendation, is not binding and does not force Congress or CMS to act.

MedPAC, which advises Congress on Medicare issues, based its update recommendations on estimated changes in input prices for physician services, minus an adjustment for productivity growth. The formal recommendation for the payment update will be voted on by the commissioners in January 2005, which will be in time for their annual report in March. That report is highly anticipated in Congress and will likely form the basis for debate on a possible Medicare bill later in the year. The Medicare Modernization Act of 2003, which established the Medicare drug benefit, requires CMS to recommend "technical" changes to the law by 2005. Some in Congress hope to use such a technical corrections bill to add substantive Medicare provisions, such as an increase in the physician payment formula.

Despite what will likely be a positive recommendation, physician payment updates are based by law on the sustainable growth rate (SGR) formula. Under current law, the SGR would have led to cuts in Medicare reimbursements in 2004 and 2005 had Congress not provided a statutory 1.5 percent increase in each of the two years. Cuts are also expected in 2006.

Bush Nominates Leavitt to Head HHS

On Monday, December 13, former Governor of Utah and current Environmental Protection Agency (EPA) Administrator Mike Leavitt was nominated to replace outgoing Secretary of Health and Human Services Tommy Thompson. Thompson's resignation from the Department is effective February 4, 2005, or earlier if his successor is confirmed by the Senate prior to that date.

Thompson has served as Secretary of HHS since February of 2001. Perhaps Thompson will be best remembered for shepherding through the largest reform of the Medicare program since its inception in 1965. He took a very active role in the enactment of the legislation, taking the unusual step of lobbying members of Congress on the House floor during the vote on final passage in December of 2003.

Leavitt graduated with a Bachelor's degree in Economics and Business from Southern Utah University. After earning his degree, he eventually became president and Chief Executive Officer of a regional insurance firm, establishing it as one of the top insurance brokers in America. Since he left the insurance industry in 1990, Leavitt served as Utah's governor for 11 years before being tapped to head the embattled EPA, which saw the departure of controversial Administrator and former New Jersey Governor Christie Todd Whitman. Leavitt has been highlighted by the Bush Administration as a national leader on homeland security, welfare reform and environmental management issues. However, some consumer advocates point to a poorly managed child welfare system and controversial Medicaid waiver proposals in his state during his governorship. Despite these issues, his confirmation is expected to be successful.

President Lays Groundwork for Passage of Malpractice Legislation

During a speech in Illinois on Wednesday, January 5, 2005, President Bush reiterated his support for medical malpractice legislation that would cap non-economic damages at $250,000. The president will likely make this issue his top health care priority in 2005, though the chances of enactment are still mixed.

Medical malpractice reform legislation was passed by the House in the 108th Congress; however, Senate leaders were unable to find the necessary votes during the last Congress to send the bill to the President's desk. The president's proposal, which is loosely based off of the failed Congressional proposals, would cap non-economic damages in malpractice lawsuits, possibly at $250,000. The Bush approach would also place restrictions on the scope of class-action lawsuits and limit lawsuits against manufacturers and marketers of products that contain asbestos. In addition, Bush hopes to eliminate non-economic damages in malpractice lawsuits except in "egregious cases where they are justified" and allow defendants to pay jury awards in malpractice lawsuits over time, rather than as a lump sum.

However, new controversy regarding the issue has arisen as a leading proposal in Congress would prevent consumers from seeking punitive damages from pharmaceutical companies such as Merck and Pfizer for claims resulting from dangerous side effects associated with their medications. Senate Minority Leader Harry Reid (NV) as well as Senators Byron Dorgan (D-ND), Edward Kennedy (MA), and Patrick Leahy (VT) have all issued statements opposing such malpractice legislation.

Study Says False-Positive Cancer Screening Can Cost Patients More

According to a study released in the December issue of Cancer Epidemiology, Biomarkers & Prevention, cancer screening tests that produce false-positive results can cost patients an extra $1,000 in the year after screening, largely because of the cost of additional, more definitive tests to rule out cancer. The study, which was led by Jennifer Elston-Lafata, director of the Center for Health Research at the Henry Ford Health System, involved some of the 154,000 participants in a National Cancer Institute study designed to determine the value of cancer screening tests.

Participants in the study received chest X-rays and a flexible sigmoidoscopy, as well as ultrasound and blood tests for ovarian cancer in women and PSA blood tests and digital rectal exams for prostate cancer in men. Elston-Lafata and colleagues then focused on 1,087 participants for whom insurance records were available on follow-up care following the initial screenings. They compared costs incurred in the year after a false-positive test with costs incurred by people whose tests were accurately negative. The researchers found that men with false positives spent an extra $1,171 in the year following the false positive, compared with $1,024 for women. Additional procedures performed on the participants included prostate biopsies in men and laparoscopic surgeries to rule out ovarian cancer in women.

Some have criticized the study for its classification of costs for false positives, noting that if follow-up testing by colonoscopy returned a negative result, the initial test was considered a false positive and the colonoscopy tests were regarded as excess. They also said that the tests were productive because polyps are removed during colonoscopy, helping prevent cancer and thus saving money in future years.

Abarelix Subject of CMS Coverage Determination

In a draft coverage determination, CMS has proposed that the drug Abarelix be covered by Medicare for the palliative treatment of beneficiaries with advanced prostate cancer who have a variety of other symptoms.

The proposed decision would make available an alternative cancer drug for beneficiaries with advanced symptomatic prostate cancer who may experience some medical difficulties using the currently recommended course of treatment. Specifically, Abarelix would be covered for patients for whom hormone therapy is not appropriate, who refuse surgical castration, and who have one or more of the following: 1) risk of neurological compromise due to metastases; 2) ureteral or bladder outlet obstruction due to local encroachment or metastatic disease; or 3) severe bone pain from skeletal metastases persisting on narcotic analgesia.

Praecis Pharmaceuticals Inc., which makes the drug Abarelix under the brand name Plenaxis, had requested a national coverage determination to define the appropriate coverage indication, coverage in certain defined trials, and specific non-coverage for other indications.

Conclusion

With President Bush expected to make health care a priority issue, 2005 will be an active year on issues relating to freestanding radiation oncology centers and health care more broadly. Medicaid reform and a possible Medicare "corrections" bill will feature prominently and require Medicare beneficiaries and oncologists to be active participants in the reform process. AFROC will continue to monitor and respond to issues relating to the physician fee schedule and other major issues impacting freestanding centers as the Congressional agenda becomes clearer following the State of the Union and the release of the President's budget.

MEMBERSHIP:

- ☐ New Member Application
- ☐ Renewal Application
- ☐ Updated Information

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- ☐ **AFROC annual dues are $500 per applicant. Funds are earmarked for legislative and regulatory issues relating to freestanding centers**
- ☐ **Mail application form with check (payable to AFROC) or Visa / MasterCard information to: Sheila Gell, 1875 Eye Street NW, 12th Floor, Washington, DC 20006**
- ☐ **Fax application form with Visa / MasterCard information to Sheila Gell, fax # 202-466-5938**

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