

AFROC



ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

Our Voice in Washington

The Source

February/March 2005

THE BOARD

Peter Blitzer, MD <i>President</i>	Plantation, FL
Gabriela B. Masko, MD <i>Vice President</i>	Providence, RI
Paul Williams, MSPH <i>Secretary/Treasurer</i>	Charlotte, NC
Mary W. Conti, MD	St. Louis, MO
Arve Gillette, MD	Carmel, IN
Bob D. Hesselgesser, MD	Thousand Oaks, CA
Michael J. Katin, MD	Fort Myers, FL
Uma B. Mishra, MD	Cornwall, NY
Dhirendra J. Patel, MD	Prescott, AZ
David J. Rice, MD	Port Charlotte, FL
Wayne T. Spears, MD	St. Louis Park, MN
Diane Millman, JD	<i>Counsel</i>
Sheila Gell, MA	<i>Executive Director</i>

Medicare Announces Expansion of Diagnostic and Chemotherapy Services; Medicaid Reform, Insurance Coverage Proposals Emerge in the President's 2006 Budget

While Congress has been on recess in January in anticipation of the President's fiscal year 2006 budget, the Centers for Medicare and Medicaid Services (CMS) announced enhanced coverage for diagnostic tests and chemotherapy services. The new coverage, which will be published in draft form later this year, is clearly a benefit to cancer patients and freestanding centers.

Meanwhile, on February 7, 2005, President Bush released his Fiscal Year 2006 budget proposal to Congress. Among the austere spending proposals included in the budget is a Medicaid reform proposal that proposes to cut up to \$60 billion from the federal program that pays for

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.

Second invoices for 2005 dues have been mailed. 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

*It is Not Too Early to Register
for the*

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

*at the
Grand Hyatt
Washington, DC*

many services to low-income beneficiaries and people with disabilities. Differing from the Administration's 2004 Medicaid proposal that proposed a capped, consolidated "block grant" Medicaid reform scheme, the 2006 proposal would concentrate on what the Administration calls "waste, fraud and abuse" to rein-in Medicaid spending. The Medicaid proposals in the budget are likely to generate lively debate in Congress on the future of the Medicaid program and, ultimately, could lead to legislation that would systemically restructure the program later this year.

The President's FY 2006 budget proposal also contains market-based proposals targeted toward the uninsured with a total of \$142 billion marked for various coverage initiatives that aim to reduce the 45 million Americans without health insurance and promote what the Bush Administration refers to as "ownership" of consumers' health care. Among these proposals are the promotion of tax incentives for the creation of Health Savings Accounts, which were enacted in the Medicare Modernization Act of 2003, association health plans for small business to pool insurance risk, and tax credits for the purchase of individual health insurance policies. Though there are significant cuts to Medicaid, the president proposes to spend \$15 billion on Medicaid-related programs such as expanded children's health coverage through the State Children's Health Insurance Program (S-CHIP) and funding for the New Freedom Initiative for people with disabilities.

Coverage Expansion for Diagnostic and Chemotherapy Services

On January 28, 2005, CMS issued two national coverage decisions (NCD) that hope to improve care for cancer patients by expanding coverage for diagnostic tests and chemotherapy treatments for Medicare beneficiaries. CMS is working with the National Cancer Institute (NCI), the oncology community and cancer patient advocates to ensure that patients "get the care they need and to develop the evidence needed by doctors and patients to make informed decisions about their treatment" stated CMS Administrator Mark B. McClellan, M.D., Ph.D., on the day of the two NCDs' release.

In addition to providing more comprehensive care to cancer patients, CMS and the oncology

community hope that medically necessary care is enhanced with a broader range of treatment options and that better scientific evidence can be gathered. This marks one of the first times that coverage has been linked to the collection of clinical data and it may set a precedent for future coverage determinations.

The first coverage determination relates to positron emission tomography (PET) scans for certain uses in evaluation of patients with of brain, cervical, ovarian, pancreatic, ovarian, and testicular cancers, as well as for a broad range of other cancers. The expansion in PET scan benefits makes this test available to patients when the patient and doctor participate in high quality clinical studies or submit information to a PET database. CMS hopes that data collected as part of this policy will help ensure that the PET information is used accurately and appropriately in patient management and will also help doctors and Medicare beneficiaries make better-informed choices about their health care.

With regard to new off-label uses for certain cancer drugs, the proposed cancer drug policy will ensure that all Medicare contractors pay for the four anti-cancer drugs in selected clinical trials sponsored in part by the NCI. Off-label uses mentioned in certain drug compendia will continue to be covered, and contractors will continue to have the authority to pay for off-label use of the drugs for patients not enrolled in these trials. Medicare currently provides coverage for physician-administered cancer drugs for FDA-approved indications or indications listed in certain drug compendia. Medicare does not routinely pay for drug costs for off-label indications that are not listed in these compendia, although Medicare does pay for the routine services provided to beneficiaries in federally funded trials.

In addition to these positive coverage decisions, CMS will shortly announce a proposed decision that will maintain current policies for the use of Ibritumomab Tiuxetan and Tositumomab. This decision will propose to maintain the existing requirement for coverage of these agents as outlined in current law and regulations. Under current policy coverage of off-label use is based on local coverage policy. Federal law requires that all off-label uses listed in specific compendia must be covered, and other unlisted uses are at contractor discretion.

The CMS Council on Technology and Innovation will now begin to develop a draft guidance document on this policy approach in order to make the process more systematic, predictable and transparent. Initial draft guidance will be issued by March 31, 2005, at which time additional public feedback will be solicited.

Budget Proposal Released, Medicaid and Uninsured Targets for Reform

Medicaid Cuts in the President's Budget—

According to the budget documents released on February 7, the president proposed to reduce Medicaid spending by \$60 billion over 10 years through the reduction of "waste, fraud and abuse." The biggest proposals among these cuts are limits in the use of Intergovernmental Transfers (IGTs) and the Upper Payment Limit (UPL) that many states use to draw down additional federal dollars. The use of IGTs and the UPL have long been legal mechanisms states have used to bolster Medicaid funding and provide for coverage expansions for "optional" populations that are not federally entitled to Medicaid services.

All states cover such optional beneficiaries or provide optional benefits like prescription drugs. But with a flagging economy and a federal spending crunch some in Congress, along with the Bush Administration in the budget, are seeking to curb these quasi-legal practices in order to stem what many observers consider a looming budgetary crisis in Medicaid spending. Though only 32% of *federal* health care spending is comprised of Medicaid (compared with 63% for Medicare), Medicaid is the largest government-sponsored health care system in total dollars when *state* expenditures are included.

The president's budget also seeks to "close loopholes" on asset transfers from aging parents to younger children for the purpose of securing Medicaid coverage for long-term care eligibility and limit the Targeted Case Management reimbursement to a 50% matching rate neither from the FMAP matching rate used for non-administrative services. The case management reimbursement proposal was floated in 2004 as a means to pay for the "Family Opportunity Act," which would provide Medicaid coverage to lower and middle-income families with children with developmental disabilities. The bill ultimately snagged over this controversial cut in matching funding. Despite

bipartisan support for the Family Opportunity Act in Congress, the president's budget does not propose the Family Opportunity Act and the matching cut for case management stands alone as strictly a cut in Medicaid funding.

Private Health Insurance Coverage Initiatives—

The president's budget includes new market-based health insurance coverage initiatives which would total about \$126 billion in funding over 10 years. These initiatives include \$74 billion for health insurance tax credits, \$4 billion for grants to states to establish insurance purchasing pools for small businesses (otherwise known as Association Health Plans, or "AHPs"), \$28.5 billion for tax incentives for Health Savings Accounts (HSAs), and \$19.2 billion for rebates to small employers contributing to HSAs.

Politically, these proposals enjoy some popular appeal. However, Democrats in Congress have expressed growing concern with these proposals. When similar proposals were raised in past Congresses, they were often unsuccessful—with the exception of HSAs, which were tacked on to the larger, and politically more viable, Medicare reform law in 2003. For cancer patients especially, there are many potential pitfalls within these proposals for people with chronic health conditions. Catastrophic deductible insurance coverage combined with a health spending account is often a good choice for healthier beneficiaries but can be very costly for those with high medical costs. AHPs raise the potential for nefarious insurance practices that could cause consumers to lose coverage because insurance companies would be exempt from state insurance regulations. Tax credits, though clearly a new source of revenue to assist in covering the uninsured, could be relatively ineffective for beneficiaries with chronic conditions whose private health insurance costs are far greater than the annual benefit provided by the tax credit.

Conclusion—AFROC continues to monitor Congressional reaction to these proposals and stands to work with others in the health care community as Congress prepares to debate these proposals. 2005 is clearly a very likely year for a possible Medicaid restructuring bill or possibly a package of initiatives targeted at the lack of coverage among the nation's 45 million uninsured. But most significantly for cancer patients and freestanding centers is the expansion of

coverage for PET under Medicare. Though this proposal does not have all the information available on how it would be implemented, overall it is expected to be a positive development. AFROC will continue to monitor and act appropriately as details emerge.

MEDICARE PHYSICIAN PAYMENTS HEARING - 2/10/05

Sustainable Growth Rate

The general consensus on SGR was that it was an inaccurate method of determining physician payment rates and that the time to fix the formula had come and gone. Chairman Johnson opened the hearing by noting that she thought the system's problems were irreparable and that it needed to be rebuilt from the ground up. Congressman Stark was a bit more skeptical, noting that doctor's incomes continued to rise despite alleged declines in payment rates. However, he agreed the SGR formula had been made worse by Congress over the years and now needed to be corrected. He asked both the GAO and MEDPAC witnesses which of the varying proposals presented by the physicians community each would recommend and what each would cost. Neither witness endorsed any specific plan, but both acknowledged that the SGR was unrealistic in its baseline, causing low rates, and that any plan Congress chose to fix the formula would have an enormous cost. Congressman Thompson led the questioning as to whether lower payment rates would have an impact on access to care if SGR was not fixed. Hackbarth noted that while they had not yet seen any access to care issues arise, they would be inevitable in the future if doctors felt that the Medicare rate was unable to cover their costs of care. The GAO witness noted that their studies of access to care issues had not shown any problems but rather Medicare beneficiaries had increased utilization in every state and had a very high satisfaction rate, even in the one year where Congress allowed the scheduled 5% rate cuts to be executed.

As to the advocacy from the various physician group witnesses, Ms. Nielsen from the AMA emphasized the flaw of using GDP as a measuring stick in the SGR formula and noted the formula was also flawed because CMS failed to account for changes in NCDs in its calculations. Congressman Lewis and others expressed concern that extraneous factors, such as the NCDs and prescription drug advertising, were putting unanticipated pressure on the system. The

GAO witness responded by noting that the formula used measures such as GDP to try to make up for those market changes but that they may not be adequate. The AMA also suggested that CMS revise the definition of physician services to exclude outpatient drugs, noting that they had a legal opinion that CMS had the authority to do so prospectively as well as retrospectively. Other witnesses, including GAO, agreed about prospective authority but thought CMS' retrospective authority may be a bit more speculative. Congressman Stark responded by noting that doctors were always asking for increases, and that in cases where there was a large learning curve so that procedures became less expensive as time went on, physicians should be willing to take a rate cut. Overall, the physician witnesses at the hearing seemed to agree that SGR desperately needed to be replaced, that the GDP measure should be replaced with a more accurate indicator, such as MEI, and that the new formula needed to better account for the development of new technologies. All in all, the consensus of the hearing seemed to be agreement that it would be difficult to fix SGR by simply tweaking the current formula and that the necessary overhaul would have a large price tag.

Pay for Performance

The theme for the discussion of pay for performance (P4P) measures predictably focused on the marriage of quality and efficiency. Hackbarth noted that the current rate payment structure included no incentives for physicians to integrate new technologies into their practice that would allow them to improve quality of care while also improving efficiency. He cited a Dartmouth study that found enormous variation in the volume and intensity in care provided to different patients suffering from identical conditions, and emphasized the study found that increased costs did not necessarily correlate with improved quality of care. When asked whether he supported the new CMS P4P demonstration project he responded that it was very important but that he did not think Medicare should wait until it was completed before taking action to begin implementing across the board programs. Some members had concerns that the use of P4P would hurt rural areas where physicians were treating more poor patients and had less access to new technologies but the witnesses seemed to agree that any plan implemented would account for those differences.

The members' questions also indicated some skepticism as to how quality would be measured and

whether P4P would be able to measure quality and efficiency in relation to one another. Hackbarth noted that in the interest of implementing a system earlier rather than later, quality and efficiency would initially have to be measured in isolation, with the goal of eventually being able to gauge them together. He noted that because there was not the capability to measure quality in each case, the initial efforts would measure a physician's data collection and use, stating that the approach assumed that the physicians who were utilizing these new information technologies and data systems would be enhancing their care while streamlining the process.

On the physician side, the members' seemed particularly intrigued by the testimony of Dr. Lee of Partners Health System, who testified about the success of the P4P measures his system had implemented into its contracts with private insurers. He noted that their focus was also on the promotion of the use of technology systems to improve care since there were no current methods available to accurately measure actual quality. He explained that while their P4P program was a voluntary one, it had been largely successful and well received by their physicians. When asked whether he was in support of the P4P model proposed by MEDPAC, he said that he was, noting that while no proposal was perfect, there was a need to get a model they could live with up and

running. Congressman Stark commented that he thought it was dangerous to have Congress tie payments to quality as they were completely ill-equipped to start legislating in that policy area. He further commented that he disagreed with any system that would reward one doctor for being good without punishing another for being "less good". He suggested that we rely on board certifications as the measure of the quality we should expect from physicians. In contrast, Dr. Gee, a physician witness, emphasized that any proposed system should not be punitive in nature, which was echoed by the AMA. He also suggested that P4P measures should recognize differences by specialty areas and measures should be developed with input from the physician communities. His suggestion partnered well with Hackbarth's conclusion that performance should be measured based upon clinical standards of care that are based upon evidence based practice guidelines, which are developed mostly within the physician community. A few members on the committee and the physician witnesses seemed to agree that whatever P4P approach is chosen, it should be piloted first to work out its problems before being imposed upon the physician community at-large.

Piper Nieters, Esq.

Associate, Powers Pyles Sutter & Verville, P.C.

Message From Diane Millman on Skilled Nursing Facility Patients

We have continued to receive inquiries on billing for Skilled Nursing Facility (SNF) patients, and, in particular, questions about what can be done if a SNF refuses to enter into an agreement with a freestanding center to pay for technical component services rendered to SNF Part A patients. Please note that the most recent transmittal by CMS on this issue states that the SNF has an obligation to pay for technical component services provided by a freestanding center to a SNF Part A patient--regardless of whether or not there is a contract. The Transmittal goes on to say:

If a SNF elects to utilize an outside supplier to furnish medically appropriate services that are subject to consolidated billing, but then refuses to reimburse the supplier for the services, then there is no valid arrangement as contemplated under §1862(a)(18) of the Act. Not only would this potentially result in Medicare's noncoverage of the particular services at issue, but the SNF would also risk being found in violation of the terms of its provider agreement. Under §1866(a) (1) (H) (ii) of the Act (and the regulations at 42 CFR 489.20(s), the SNF's provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

This should provide you with some leverage in dealing with your local SNF. Also, please note that the prohibition on billing of radiation oncology TC services only applies if the patient is covered under PART A of the Medicare Program. Many SNF patients are covered under PART B, and the prohibition on billing TC services directly to Medicare does not apply.

AFROC'S 17TH ANNUAL CONFERENCE
June 5-6, 2005
The Grand Hyatt – Washington, DC

Speakers & Topics

Arve Gillette, MD

Director, Radiation Oncology
 Community Hospitals Indianapolis
 Indianapolis, IN 46219
 Cancer Care Group
 Carmel, Indiana

**Prostate HDR – Temporary Seeding at Freestanding
 Radiation Oncology Centers**

John Collins Harvey, MD, PhD

Center for Bioethics
 Georgetown University
 Washington, DC

**What to Do When Treatments Fail:
 Dealing with End-of-Life Issues**

Michael J. Katin, MD

21st Century Oncology, Inc.
 Fort Meyers, Florida

**Radioimmunotherapy at Freestanding Radiation
 Oncology Centers: Clinical & Business Rationale**

Jerome C. Landry, MD

Image Guided Intelligence, Inc.
 Decatur, Georgia
 Emory University School of Medicine
 Dept. of Radiation Oncology
 Atlanta, Georgia

Latest Trends in IMRT

Linda L. Lively, MHA

President & CEO, AMAC
 Marietta, Georgia

**An Effective Appeals Process:
 Best Practices Approach**

Diane Millman, JD

Powers, Pyles, Sutter & Verville
 Washington, DC 20006

**Legislative Changes Impacting Radiation
 Radiation Therapy at Freestanding
 Centers**

Cindy C. Parman, CPC

President Elect
 AAPC National Advisory Board
 Coding Strategies, Inc.
 Powder Springs, Georgia

**Tips and Traps in Coding & Billing
 for Freestanding Centers**

Stephen Phillips

Centers for Medicare & Medicaid Services
 Baltimore, Maryland

**Medicare Reimbursement
 What's New for 2005-2006**

Christopher M. Rose, MD, FACR

Technical & Associate Director
 Valley Radiotherapy Associates Therapy Group
 Providence Saint Joseph Medical Center
 Dept. of Radiation Oncology
 Burbank, California

**Strategies for the Independent
 Operator of Radiation Therapy
 Clinics**

Ajit Singh, PhD

President & CEO
 Oncology Care Systems Group
 Siemens Medical Solutions, USA
 Concord, California

**What is Adaptive Radiation
 Therapy?**

Mark L. Sobczak, MD

Director, Radiation Oncology
 21st Century Oncology
 Seaford, Delaware

**Bringing Adaptive Radiation
 Therapy into the Clinic**



17th ANNUAL CONFERENCE
June 5 - 6, 2005
Grand Hyatt Washington
1000 H Street, NW
Washington, DC

Return form with check to AFROC, 1875 Eye St. NW, 12th Floor,
 Washington, DC 20006
 or fax credit card information to 202-466-5938, Attn: Sheila Gell

Full name: _____ Title: _____

Company: _____

Address: _____ City _____ State _____ Zip _____

Phone: _____ Fax: _____ E-mail: _____

Non-attending guest's full name _____

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	\$ _____
<u>One Day Registration</u>	<u>Pre-registration</u>	<u>One-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.

Payment information:	Total amount due:
<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: _____	

Call the Grand Hyatt Washington at (800-233-1234) for room reservations (AFROC).
 Reservations made before May 5, 2005 will be afforded conference rate
 of \$209/single, \$224/double per night based on two night stay.



*The
Source*

February/March 2005

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:

- Coastal Radiation Oncology
Medical Group
Santa Maria, CA
- IRMT—Illinois Metro Radiation
Therapy
Illinois and Missouri
- Minneapolis Radiation Oncology
Physicians
Minneapolis, MN
- Radiation Medical Group
San Diego, CA
- Radiation Oncology Associates
Providence, RI
- Radiation Therapy Medical Group
Riverside, CA
- Regional Radiation Oncology
Rome, GA
- Southeast Radiation Oncology
Group
Charlotte, NC
- Tacoma Radiation Oncology
Tacoma, WA
- Tri State Regional Cancer Center
Ashland, KY
- 21st Century Oncology
Fort Myers, FL