ASSOCIATION of CANCER EXECUTIVES

ACE update

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NOVEMBER 2012

Independent, yet integrated:
The increasing popularity of oncology PSAs

*By **Katy Reed** and **Katie Collings Ray,** ECG Management Consultants, Inc.*

A PSA can promote a more aligned partnership that will allow both parties to remain in business in an increasingly competitive environment.

For hospitals and oncologists alike, alignment can be an intimidating concept, particularly given the unique revenue streams associated with oncology services (e.g., infusion administration, radiation oncology treatments). However, an increasing number of organizations are pursuing stronger affiliations in an effort to better coordinate care, improve access, and ensure long-term oncology service line financial viability. While physician employment has received much of the recent press, the **Professional Services Agreement** (PSA) has gained prevalence as a mutually beneficial, high-integration alignment strategy. In some circumstances, hospitals are precluded from directly employing physicians (e.g., in the state of California), so a PSA is the most highly integrated option available. For many other organizations, a PSA is preferred over other alignment models because it allows for physician independence while still promoting a higher level of physician involvement in oncology service line planning and development. This article highlights the basic features and benefits of a PSA model and offers an explanation for their increasing popularity.

Although a PSA can be somewhat administratively complex compared to an employment model, there are a number of situations in which a PSA is typically the most successful and/or only viable approach to alignment. For example:

- The oncologists wish to remain independent and preserve some level of autonomy but recognize the benefits of increased hospital alignment.
- The physician group practices at several hospitals, and employment may provoke a competitive response.
- A hospital only requires part-time specialty services and cannot support a full-time physician (particularly for specialties such as gynecological oncology and breast surgery).
- The oncologists belong to a larger, multispecialty group that will remain intact.
- An intermediate step is needed to build trust prior to considering full employment.
- The hospital cannot employ physicians due to political or regulatory concerns.

Appropriately structured, a PSA can promote a more aligned partnership that will allow both parties to remain in business in an increasingly competitive environment, especially in light of a healthcare market that is demanding a higher quality of care at a reduced cost.

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ASSOCIATION of CANCER EXECUTIVES

Calendar

19TH Annual Meeting

JANUARY 23–26, 2013
SAN ANTONIO, TX
Grand Hyatt San Antonio

20TH Annual Meeting

JAN. 29 – FEB. 1, 2014
SAN FRANCISCO, CA
Palace Hotel

ACE MEMBER **SPOTLIGHT**

Norton Cancer Institute

*Submitted by **Tammy McClanahan,** RN, OCN, MHA, FACHE*
System Vice President, Cancer Service Line

How many years have you been an oncology executive?
Total of 24 years in healthcare, with the past eight years dedicated solely to oncology administration.

What type of organizational model is the center? Hospital based and defined by the American College of Surgeons Commission on Cancer as an Integrated Network Cancer Program. Norton Cancer Institute (NCI) is part of Norton Healthcare; a five-hospital system based in Louisville, Kentucky.

Annual new cancer cases?
4200 new analytic cancer cases projected for 2012.

Number of locations?
- 10 Medical Oncology clinics
- 3 Radiation Centers
- 3 Infusion Centers
- 3 Resource Centers

Physician environment
Total of 36 employed physicians:
- 20 Medical Oncologists
- 5 Radiation Oncologists
- 5 Gynecologic Oncologists
- 1 Orthopaedic Oncologist
- 2 Behavioral Oncologists
- 2 Prevention/ Early Detection Physicians
- 1 Survivorship Physician
- Surgical oncology services provided by both university and private practice physician groups.

Accreditations
- Only designated Integrated Cancer Program in Kentucky by the CoC, a division of the American College of Surgeons

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Does my patient have unintended weight loss?

Is my patient experiencing side effects?

When is the best time for a conversation about nutrition?

Does my patient have a caregiver?

Has my patient had a change in eating habits?

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- Improve treatment tolerance
- Improve quality of life
- Reduce unplanned hospitalizations

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References: 1. Dewys WD, et al. *Am J Med.* 1980:69:491-497. **2.** Halpern-Silveira D, et al. *Support Care Cancer.* 2010;18:617-625. **3.** Nayel H, et al. *Nutrition.* 1992;8:13-18. **4.** Isenring EA, Capra S, Bauer JD. *Br J Cancer.* 2004;91:447-452. **5.** Marín Caro MM, et al. *Clin Nutr.* 2007; 26:289-301. **6.** Odelli C, et al. *Clin Oncol.* 2005;17:639-645. **7.** Bauer JD, Capra S. *Support Care Cancer.* 2005;13:270-274.

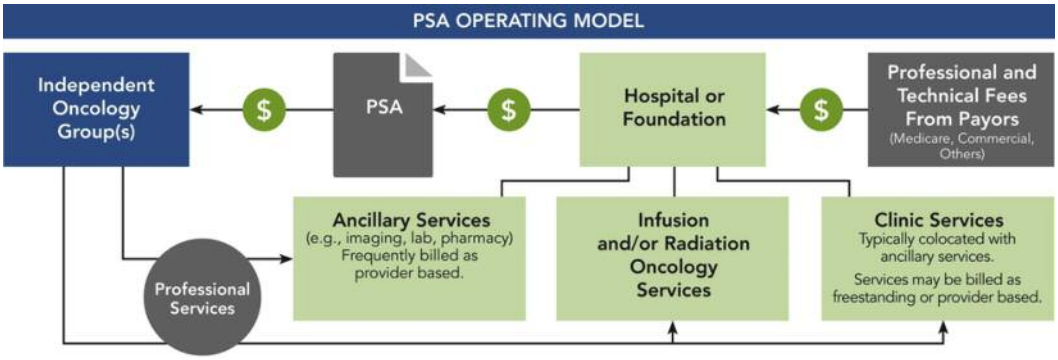
Abbott Nutrition

The Increasing Popularity of Oncology PSAs

> *Continued from page 1*

PSA Model Overview

Under a PSA, the physician or medical group is an independent entity that, according to the agreement, provides professional services in a clinic owned by a hospital (or foundation).[1] The hospital typically retains all rights to the associated professional and technical fees from payors and, in exchange, furnishes the physician or group with a PSA payment (as shown in the figure on the front). In many cases, the practice management functions also remain with the physician group through an accompanying Management Services Agreement (MSA). If the hospital owns all associated revenue streams, it may have the option to bill for services as "freestanding" or "provider-based." The designation is ultimately contingent upon the clinic's setup because a provider-based clinic must meet additional regulatory and operational requirements; however, if a clinic is converted to provider-based status, select services will then be eligible for hospital-based reimbursement rates, which are typically higher than freestanding rates. In oncology, organizations that are eligible for the 340B Drug Pricing Program will also typically choose to convert to a provider-based clinic to participate in 340B savings and reduce their medication expenses.[2] The complexity of provider-based status and 340B savings can be intimidating, but the rewards are potentially great, and we recommend that organizations evaluate their eligibility for both programs as part of their broader planning efforts.[3]



Management and Governance

Regardless of clinic ownership (hospital, foundation, or other), the oncologists may continue to manage day-to-day operations. If a practice is well functioning, this arrangement can be beneficial to both parties, so long as costs are reasonable and services are clearly defined. However, if the clinic is converted to a provider-based department, there are a number of decisions that will require hospital input, guidance, and/or approval. For example, although the physicians may be accountable for select functions, such as staff hiring and firing, the hospital should ultimately be responsible for issues related to finances, compliance, and clinical protocols. Further, although the physicians remain independent, healthcare organizations that utilize PSAs are increasingly choosing to incorporate some form of shared governance, such as a Joint Operating Committee (JOC), for making key decisions. Defining accountabilities up front is a vital step in developing a successful arrangement and could help organizations to avoid significant conflicts in the future. A sample of collaborative governance and authority is shown in the table below.

	JOC	Hospital	Physicians
JOC Membership	Select JOC Leaders	Appoint Members	Appoint Members
Strategic Planning and Development	Approve	Develop	Develop
Physician Recruitment	Approve	Advise	Responsible
Budgeting/Capital Requests	Approve	Develop	Develop
Quality Program Monitoring & Implementation	Be Informed	Responsible	Responsible
Payor Contracting	Be Informed	Responsible	Advise
Practice Standards & Clinical Protocols	Approve	Advise	Responsible

Funds Flow Structure

PSAs can utilize a variety of funds flow models, from fixed monthly payments to pure productivity-based plans. If considering a PSA payment model based on productivity under a provider-based arrangement (typically measured by WRVUs), it is important to note that medical oncologists' productivity levels will likely decrease from historical levels because infusion administration would no longer produce WRVUs. Depending on the arrangement, this situation could apply to radiation oncologists as well. In these instances, there are several methods to compensate physicians for infusion and/or radiation suite management (e.g., WRVU credits, fixed management fees) that could be incorporated into the broader funds flow structure. Regardless of the selected funds flow model, and in contrast to the typical employment arrangement, the hospital normally provides a payment to the group as a whole rather than to each individual physician. The group is therefore free to maintain its own income distribution plan. While oncologists generally prefer the increased level of autonomy associated with this arrangement, it is important to ensure that the group's overarching incentive structure is aligned with its individual compensation plan. For example, physician groups' compensation distribution models tend to be productivity-based in focus; however, in anticipation of value-based payment methodologies, an increasing number of hospitals are incorporating service incentives related to quality, care coordination, and efficiency into their PSA funds flow structures that may not tie to the group's individual compensation plan. Additionally,

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The Increasing Popularity of Oncology PSAs

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any structure will have to comply with federal and local regulations by not inadvertently creating incentives to reduce patient care or correlating payments to hospital referrals. Regardless of these potential complexities, it is important to engage physicians in the development of the PSA funds flow structure and work toward physician consensus for any proposed incentives.

Conclusion

With benefits to both parties, PSAs are increasingly becoming an optimal alignment model for hospitals and oncologists. While hospitals desire access to more coordinated care and physician-integrated oncology service lines, the physicians welcome the increased autonomy that this model can provide. Structured correctly, PSAs can also create mutual financial benefit, a rarity in today's healthcare economy. In summary, a PSA, like employment, is a high-integration alignment model that enables hospitals and oncologists to advance their program services and be more sustainable in an ever-challenging market. ■

REFERENCES

1. In California, where hospitals cannot employ physicians, health systems may form a medical foundation, which in turn contracts with an independent medical group(s) to provide clinical services. For the purposes of this article, the focus will be on hospital-owned clinics; however, many of these same PSA trends also apply through a foundation arrangement.
2. NOTE: The U.S. Department of Health and Human Services' Health Resources and Services Administration Office of Pharmacy Affairs manages the 340B Drug Pricing Program. Only select organizations (e.g., federally qualified health center, freestanding cancer hospital, children's hospital) are eligible for the 340B discount. Source: www.hrsa.gov/opa/introduction.htm.

*This article was written by **Ms. Katy Reed,** Senior Manager, and **Ms. Katie Collings Ray,** Manager. To learn more about this article and issues related to PSAs, please contact Ms. Reed or Ms. Collings Ray at kreed@ecgmc.com or kcollingsray@ecgmc.com, respectively.*

***About ECG Management Consultants, Inc.** ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to healthcare providers. As an industry leader, ECG is particularly known for providing specialized expertise regarding the complexities of the academic healthcare enterprise, strategic and business planning, specialty program development, and hospital/physician relationships. ECG has offices in Boston, San Diego, San Francisco, Seattle, St. Louis, and Washington, D.C. For more information, visit* **www.ecgmc.com**.

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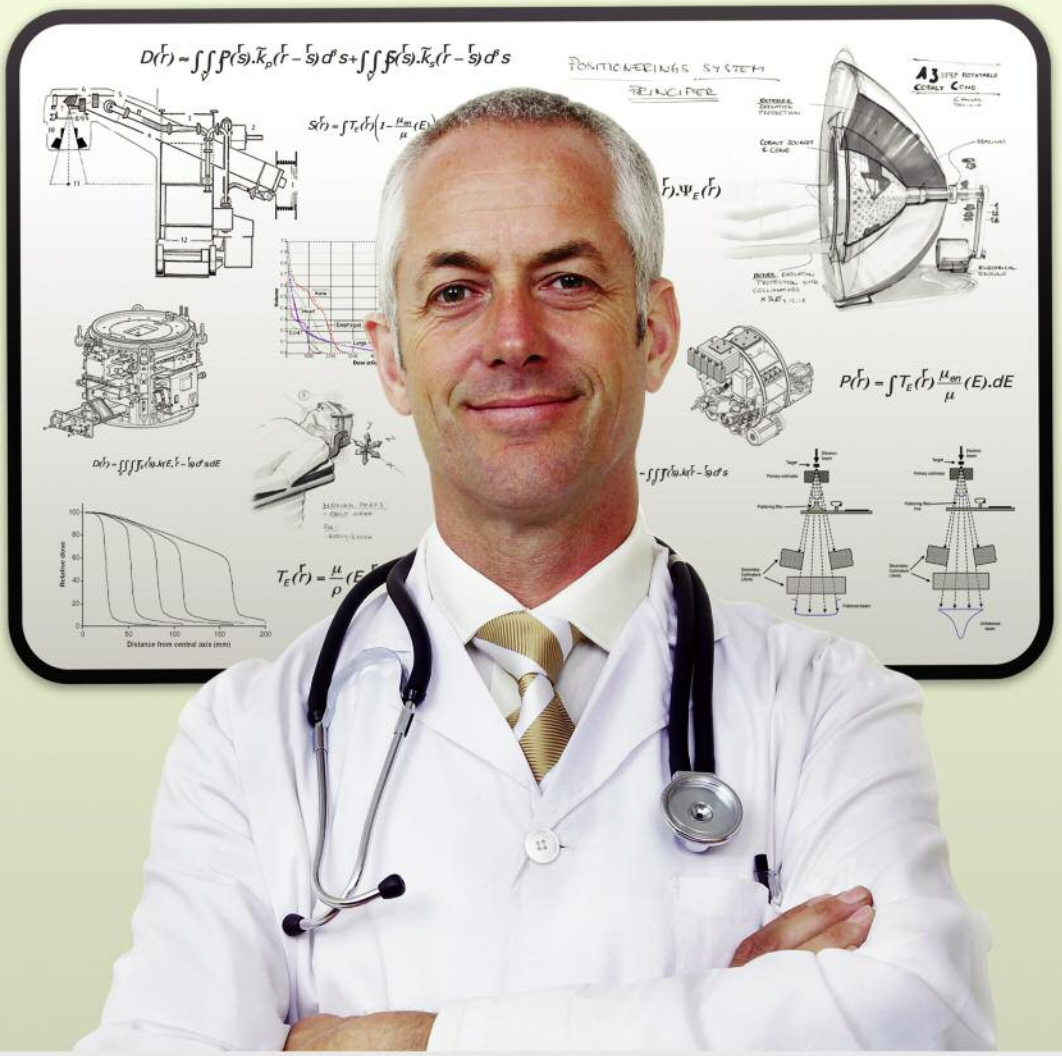

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ACE Member Spotlight > *Continued from page 1*

- Only site in Kentucky to be selected as one of only 21 in the nation to participate in the National Cancer Institute Community Cancer Centers Program (NCCCP)
- National Accreditation Program for Breast Centers (NAPBC)
- American Society of Clinical Oncology's Quality Oncology Practice Initiative (QOPI) Certification Program, a 3-year certification for outpatient hematology-oncology practices
- Recognized by *U.S. News and World Report* as a leading provider of cancer services in Louisville, KY
- Press Ganey Summit Award Winner for three consecutive years

Unique or recently developed programs/services

- Multidisciplinary Clinics: Brain Tumor Center, Liver Cancer, Sarcoma, Endocrine, Lung Cancer, and Survivorship Clinics
- Nationally recognized Behavioral Oncology Program
- Lymphedema Program
- Genetic Counseling
- Resource Centers offering support groups, massage, music and art therapies, nutritional counseling, comprehensive lending library
- Patient navigation program offering access to eleven oncology-certified nurses specializing in various disease sites: breast, hepatobiliary, lung, gastrointestinal and neurological
- $1 million mobile prevention unit providing free routine screenings to members of the community
- Private retail pharmacy services
- Novalis Tx linear accelerator providing stereotactic radiosurgery
- Four (4) daVinci robotic surgery systems
- Research and clinical trials program with more than 400 active/follow-up patients enrolled in various stages of study or enrollment

Lessons learned: Communication and follow through is key. Building trusting relationships with staff, co-workers, and physicians is important to successful outcomes.

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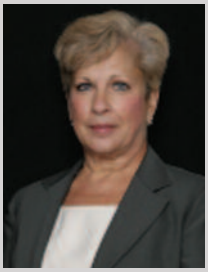
SPOTLIGHT ON OMC GROUP'S EXPERTS - SUSAN SHAFER, MT, CMM, CPC, RMC



Susan Shafer is a Senior Consultant with Oncology Management Consulting Group and brings over 25 years of experience in the healthcare field. Sue served for well over two and a half decades as practice administrator of a very active and successful oncology practice in Pennsylvania and continues to provide sales and technical support for a medical billing software program. Her responsibilities included oversight of all operations including staffing, purchasing, billing and collections, and payer contract negotiations. She also enjoys considerable experience in practice management of a free standing radiology facility as well as family practice. Susan has also specialized in instituting Physician Quality Reporting Initiative (PQRI), Quality Oncology Practice Initiative (QOPI), and E-prescribe programs into practices. Specific areas of her focus for OMC Group include billing, coding, and accounts receivable management, lost receivables and inventory management of chemotherapeutic agents to avert revenue loss.

Susan is one of the original founders and board members of the Premier Oncology Hematology Manager's Society (formerly Pennsylvania Hematology Oncology Manager's Society). She is also a former member of the Easton Hospital Office Manager's Steering Committee and since 2005 she has been a member of Amgen's Office Manager's speaker board.

Sue is a certified Medical Technologist, Certified Medical Manager with the Professional Association of Health Care Office Managers, Certified Professional Coder with the Academy of Professional Coders, and Registered Medical Coder with The American Association of Registered Health Care Professionals

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Targeted for Reductions: MPFS and Radiation Oncology

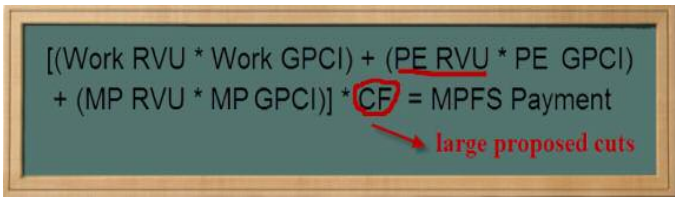
*By **Bridget Krueger, MBA, BSRT (T)** and **Kelli Weiss, R.T. (R)(T)***

Once again, the Medicare Physician Fee Schedule (MPFS) was targeted for cuts published in the proposed CY 2013 rule issued by the Centers for Medicare and Medicaid Services (CMS) on July 6th, 2012. On November 1st, 2012, CMS issued the CY 2013 MPFS final rule, which softened the proposed blow to some degree. The proposed rule called for the estimated impact on total allowed charges for Radiation Oncology to be -14% and Radiation Therapy Centers to -18%. The final rule called for the estimated impact for Radiation Oncology and Radiation Therapy Centers to be -7% and -9% respectively. Compared to other medical specialties, radiation oncology faces some of the most severe estimated impact on total allowed charges.

Whether you agree or disagree with the final rule issued by CMS or are completely unaware of the volatility the MPFS has been under, it is important to be informed as to where these reductions in reimbursement are coming from and how it could affect cancer centers across the country and the industry now and in the future. Your patient base is most likely in the 45-60% range for Medicare, so this matter should be very important to you.

To understand these issues at a higher level let us review how payments are established and how the cuts translate into payment decreases for the radiation oncology specialty. There are components to each CPT® code that make up a payment rate under the Medicare Physician Fee Schedule ("MPFS"). The large looming cut is in regards to the conversion factor ("CF"). The CY 2013 final rule conversion factor is $25.0008, roughly a 26% reduction from last year. This reduction to the CF affects EVERY physician and freestanding practice in the country accepting Medicare. The cuts to the conversion factor have been avoided every year since 2002. The additional proposed cuts to the practice expense relative value units ("RVU"s) also have a potential to largely decrease in some of the radiation oncology codes. The equation for determining payment rates under the MPFS is pictured at left.

Below, the equation for determining payment rates under the MPFS.



Understanding the components more in depth.

The terms and definitions in the bottom table will help you in understanding the MPFS equation and how the inputs affect the payment rate.

As mentioned, the conversion factor is a key component to our payment equation and once again is drastically reduced in the final rule. After years of facing drastic reductions, this important decrease sometimes gets glossed over. This year the reduction to the CF snowballs into a 26.5% reduction. As you can see from the table at right we are in essence chasing metastasis, but not curing the cancer. It is obvious that a cure to the conversion factor is needed to help stabilize the MPFS.

Continued >

Year	CF Pre-Legislation	CF Post Legislation
CY 2006	$37.8975	–
CY 2007	$35.9848	$37.8975
CY 2008	$34.0682	$38.0870
CY 2009	$30.1510	$36.0666
CY 2010	$28.3868	$36.0846 (Jan–May)
CY 2010	$28.3868	$36.8729 (June–Nov)
CY 2010	$28.3868	$36.8729 (Dec–Dec 31)
CY 2011	$25.4999	$33.9764
CY 2012	$24.6712	$34.0376
CY 2013	$25.0008	???

Input	Acronym	Definition
Relative Value Unit	RVU	Relative value units are assigned to each type of service to capture the relative resources typically involved in furnishing the service. RUVs are established for physician work, PE and MP expense. Before the adoption in1992, of RVU's for payment, physicians were paid on reasonable charges. CMS is required to review the RVUs no less often than every 5 years.
Physician Work RVU	Work RVU	The relative level of time, skill, training and intensity to provide a service compared to other services in healthcare.
Practice Expense RVU	PE RVU	Represents the costs of maintaining a practice including facility, equipment, supplies and nonphysician staff costs.
Malpractice RVU	MP RVU	Represents the payment for professional malpractice liability expense.
Geographic Practice Cost Indices	GPCI	Accounts for the differences in the cost of practice by location across the country.
Budget Neutrality	BN	CMS is prohibited from changing its overall budget by more than $20 million positive or negative. If the RVUs shift in such a way that the CMS budget is impacted by over $20 million, CMS must use a budget neutrality factor to bring its total payments back in line.
SGR	SGR	A formula determines how much Medicare pays for services that physicians provide over particular time periods
Conversion Factor	CF	Used as a multiplier to total RVUs for a particular service
Non-Facility		Services generally provided in a physician's office.
Facility		Covers services to inpatients or in a hospital outpatient clinic setting.

Targeted for Reductions: MPFS and Radiation Oncology

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Not only are radiation oncologists and clinics having to deal with the CF decrease there were large targeted practice expense (PE) RVU reductions to two of the higher reimbursed and utilized radiation oncology codes. How payments are calculated is largely dependent on the RVUs, as described above. There were two codes of extreme concern with regards to the PE proposed reductions. These codes are the Intensity Modulated Radiation Therapy (IMRT) treatment delivery (code 77418) and stereotactic body radiation therapy (SBRT) treatment delivery (CPT® code 77373). While significant attention is drawn to these particular two codes, there was a long list of radiation oncology codes that had proposed PE RVU reductions, such as the treatment device, special treatment procedure, image guidance and simulation codes. It is not a good thing have this many codes under the microscope of CMS. Some of the reason drawn to the IMRT and SBRT treatment delivery codes is the high payment rate and frequency in which they can be billed per patient which can add up to very large potential losses for centers.

CMS proposed to adjust the procedure time assumption for IMRT from 60 minutes to 30 minutes and the procedure time assumption for SBRT from 90 minutes to 60 minutes. CMS has estimates of this procedure time based on patient supplied literature by radiation therapy organizations and centers. The argument for the proposed change to the procedure time calculation is that rigorous statistical methods were not utilized to formulate the proposed times, rather than patient literature. Typically, centers do have time allotments in the 15-30 min range for IMRT patients. However, this is just for the actual time spent in the room, there might be more time allotted for patient questions, time spent in the department utilizing additional RT services. In the final rule, CMS finalized their proposal to adjust the procedure times for IMRT and SBRT. CMS took into consideration the blaze of comments addressed to this proposal and is incorporating items that positively affect the PE RVUs for CY 2013. These are the finalized adjustments affecting the PE RVUs:

- Incorporating a second radiation therapist, 30 minutes of allocated service time, for CPT code 77418
- New equipment item, "IMRT accelerator"
- Radiation treatment vault and water chiller (incorporated in both 77418 and 77373)
- Updating price of the laser, diode, for patient positing
- Reinstating 7 pieces of equipment that were incorrectly removed from 77418 in CY 2012

2012–2013 77418 and 77373 PE RVUs

Code	Description	2012 PE RVUs	Proposed 2013 PE RVUs	Final 2013 PE RVUs
77418	IMRT Treatment Delivery	13.98	8.41	11.91
77373	Stereotactic Body Radiation Therapy, Treatment Delivery, per Fraction to 1 or More Lesions, Including Image Guidance, Maximum of 5 Sessions per Course	46.82	33.66	37.23

The next table displays CY 2012 payment for the codes and the CY 2013 payment with and without the potential conversion factor reduction.

Code	Description	Non-Facility National Average Medicare 2012 Rate	Non-Facility National Average Medicare 2013 Rate With CF Reduction	**Estimated Variance With CF Reduction**	Non-Facility National Average Medicare 2013 Rate Without CF Reduction	**Estimated Variance Without CF Reduction**
77418	IMRT Treatment Delivery	$475.85	$298.01	**-37.37%**	$405.73	**-14.74%**
77373	Stereotactic Body Radiation Therapy, Treatment Delivery, per Fraction to 1 or More Lesions, Including Image Guidance, Maximum of 5 Sessions per Course	$1,596.02	$932.53	**-41.57%**	$1,269.60	**-20.45%**

What is also causing the blow to the radiation oncology practice expense RVUs is the Interest Rate assumption. As stated in the proposed and final rule, the interest rate impacts the per minute rate for medical equipment and is used in the calculation of PE RVUs. This equipment cost per minute is calculated as:

(1/(minutes per year * usage)) * price * ((interest rate/(1-(1/((1+ interest rate)^life of equipment)))) + maintenance)

To expand on this topic, the calculation addresses the following:

- minutes per year = maximum minutes per year if usage were continuous (that is, usage = 1); generally 150,000 minutes
- usage = 0.5 is the standard equipment utilization assumption; 0.75 for certain expensive diagnostic imaging equipment
- price = price of the particular piece of equipment
- interest rate = sliding scale
- life of equipment = useful life of the particular equipment
- maintenance = factor for maintenance; 0.05

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Targeted for Reductions: MPFS and Radiation Oncology

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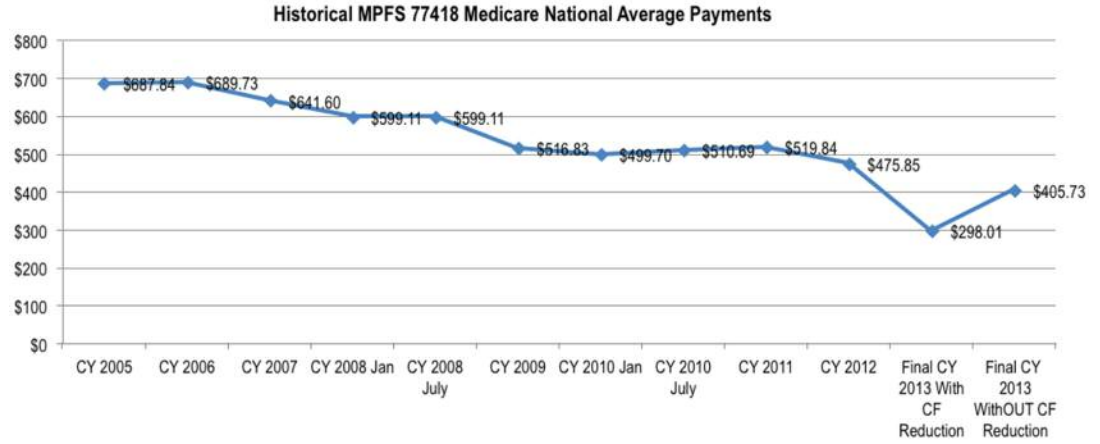
With regard to the interest rate, historically the same interest rate across all equipment was utilized (11%). CMS finalized their sliding scale interest rate approach proposal The sliding scale approach varies the interest rate based on the equipment cost, useful life, and SBA (Small Business Administration) maximum interest rates for different categories of loan size and maturity. Since radiation oncology is very capital intensive, this has a large impact.

This graph displays the historical payment for 77418 since CY 2005.



If we look at a typical course of IMRT therapy for one patient, we can see what is in store for payments in CY 2013. In our example, the payment rate variance from CY 2012-2013, without the conversion factor reduction, is -12%.

IMRT – Non-Facility								
CPT®	CPT® Description	2012 Global Rate	2013 Global Rate With CF Decrease	2013 Global Rate Without CF Decrease	Quantity Billed	2012 Global Collections	2013 Global Collections With CF Decrease	2013 Global Collections Without CF Decrease
99204	Office/Outpatient Visit, New, Level 4	$160.66	$121.00	$164.74	1	$160.66	$121.00	$164.74
77263	Clinical Tx Plan, Complex	$158.27	$116.75	$158.96	1	$158.27	$116.75	$158.96
				SIMULATION				
77014–TC	CT Guidance	$101.77	$60.75	$82.71	1	$101.77	$60.75	$82.71
77290	Simulation, Complex	$536.09	$390.51	$531.67	1	$536.09	$390.51	$531.67
77334	Treatment Device, Complex	$148.40	$110.25	$150.11	1	$148.40	$110.25	$150.11
				PLANNING				
77301	IMRT Tx Plan	$1,984.73	$1,465.05	$1,994.60	1	$1,984.73	$1,465.05	$1,994.60
77300	Basic Dosimetry Calc	$67.73	$49.00	$66.71	7	$474.14	$343.00	$466.97
77338	IMRT MLC Device	$491.50	$368.01	$501.03	1	$491.50	$368.01	$501.03
				TREATMENT PROCEDURES				
77418	Daily IMRT Tx Delivery	$475.85	$298.01	$405.73	42	$19,985.52	$12,516.42	$17,040.66
77421	Stereoscopic Guidance	$86.45	$54.75	$74.54	0	$0.00	$0.00	$0.00
77014	CT Guidance	$143.64	$91.50	$124.58	42	$6,032.88	$3,843.00	$5,232.36
77427	Weekly Physician Management	$177.00	$131.00	$178.36	8	$1,415.96	$1,048.00	$1,426.88
77336	Continuing Weekly Physics	$46.63	$32.25	$43.91	8	$373.05	$258.00	$351.28
Total for Medicare Only						**$31,862.99**	**$20,640.74**	**$28,101.97**

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Targeted for Reductions: MPFS and Radiation Oncology

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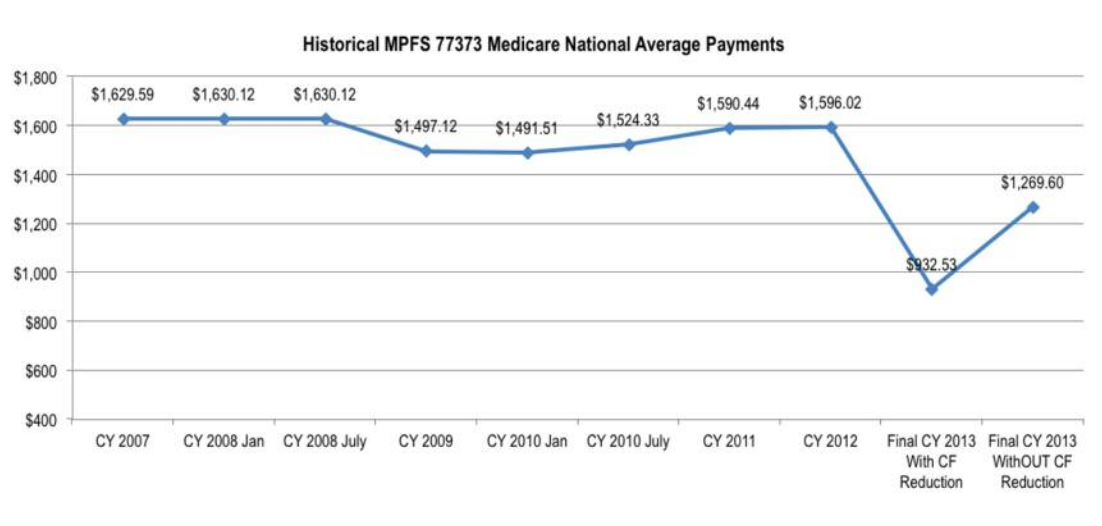
The graph below displays the historical Medicare National Average payment information for stereotactic body radiation therapy treatment delivery. As you can see, even without the conversion factor decrease we face a large reduction for CY 2013.



If we look at a typical course of SBRT therapy, we can see the effects that these cuts would have on one patient's course of therapy for CY2013. In our example, not taking into account the conversion factor reduction, these cuts could result in a decrease of about 16%.

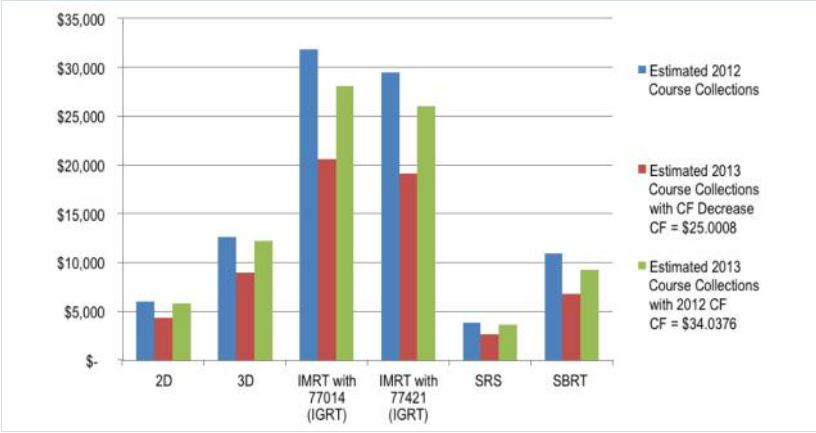
SBRT – Non-Facility								
CPT®	CPT® Description	2012 Global Rate	2013 Global Rate With CF Decrease	2013 Global Rate Without CF Decrease	Quantity Billed	2012 Global Collections	2013 Global Collections With CF Decrease	2013 Global Collections Without CF Decrease
99204	Office/Outpatient Visit, New, Level 4	$160.66	$121.00	$164.74	1	$160.66	$121.00	$164.74
77263	Clinical Tx Plan, Complex	$158.27	$116.75	$158.96	1	$158.27	$116.75	$158.96
77470	Special Tx Procedure	$173.59	$111.25	$151.47	1	$173.59	$111.25	$151.47
SIMULATION								
77014	CT Guidance	$101.77	$60.75	$82.71	1	$101.77	$60.75	$82.71
77290	Simulation, Complex	$536.09	$390.51	$531.67	1	$536.09	$390.51	$531.67
77334	Treatment Device, Complex	$148.40	$110.25	$150.11	1	$148.40	$110.25	$150.11
PLANNING								
77370	Special Physics Consult	$113.35	$86.75	$118.11	1	$113.35	$86.75	$118.11
77295	3D Simulation	$500.01	$327.01	$445.21	1	$500.01	$327.01	$445.21
77300	Basic Dosimetry Calc	$67.73	$49.00	$66.71	2	$135.47	$98.00	$133.42
77334	Treatment Device, Complex	$148.40	$110.25	$150.11	2	$296.81	$220.50	$300.22
TREATMENT PROCEDURES								
77373	SBRT, per Fx, 1 or More Lesions, Including Image Guidance, Max of 5 Fxs	$1,596.02	$932.53	$1,269.60	5	$7,980.12	$4,662.65	$6,348.00
77336	Continuing Weekly Physics	$46.63	$32.25	$43.91	1	$46.63	$32.25	$43.91
77435	SBRT TX Management, Max 5 Fxs	$608.93	$445.51	$605.19	1	$608.93	$445.51	$605.19
Total for Medicare Only						**$10,960.11**	**$6,783.18**	**$9,233.72**

Continued >

Targeted for Reductions: MPFS and Radiation Oncology

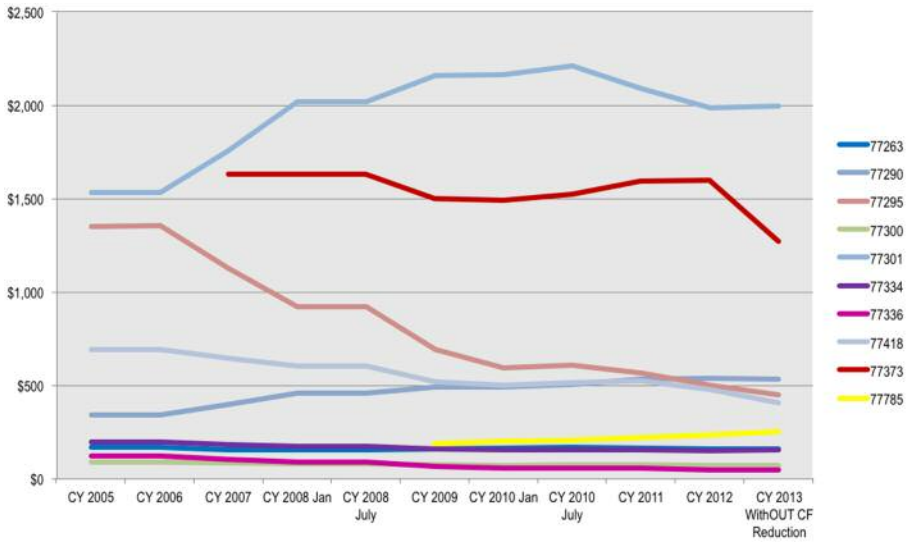
> *Continued from page 11*

At right is a snapshot of the different modalities of treatment we can offer in radiation oncology and their CY 2012-CY 2013 effects.

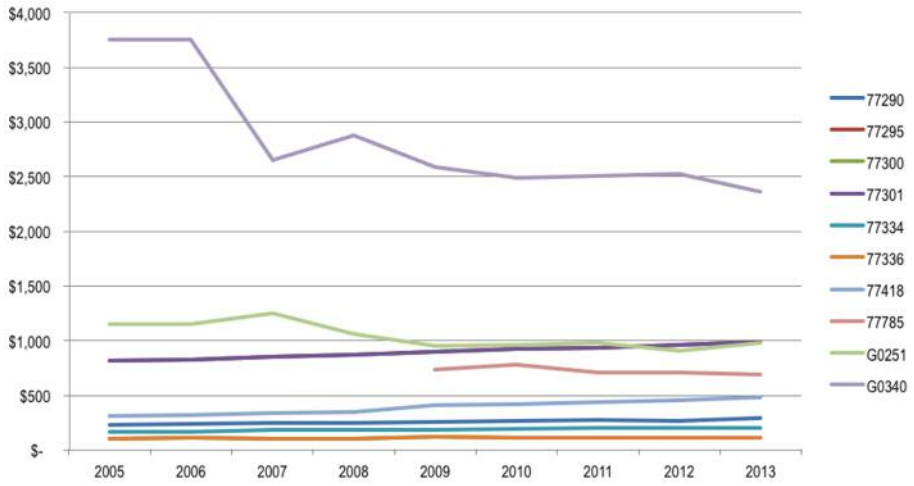


The graph below displays how some of the more frequently utilized codes in radiation oncology have been trending over the past 8 years. From this graph, we can see that trending for MPFS payment rates are declining while hospital rates remain relatively stable and even a slight increase. CMS has stated in regulatory documents that the nonfacility payment rates for IMRT treatment delivery have exceeded payment rates under HOPPS. CMS now realizes that the different settings for IMRT delivery are not likely to be more resource intensive in the freestanding setting, thus the payment rates should be more in alignment between the two settings.

Medicare Physician Fee Schedule National Average Non-Facility Historical Global Payment Rates



Hospital Outpatient Prospective Payment System Medicare National Average Historical Payment Rates



Code & Descriptor Key

77263: Clinical Radiation therapy planning

77290: Set radiation therapy field setting simulation complex

77295: Set radiation therapy field setting simulation 3D

77300: Radiation therapy dose calculation

77301: IMRT planning

77334: Radiation treatment device

77336: Radiation physics consultation

77418: Radiation tx delivery IMRT

77373: SBRT delivery MPFS

77785: Hdr brachytx 1 channel

G0251: SBRT Treatment Delivery Non Robotic

G0339: SBRT Robotic Single Fraction

Continued >

Targeted for Reductions: MPFS and Radiation Oncology

> *Continued from page 12*

The table below compares the CY 2013 HOPPS rates for IMRT and stereotactic treatment delivery to the CY 2013 MPFS rates. For your reference, the CY 2012 national average payment for IMRT treatment delivery is $475.85. The stereotactic treatment delivery codes that are reported are different based on the hospital outpatient setting vs. the freestanding setting. CMS has stated in the proposed rule that they would like to align hospital and freestanding payments, but as you can see from the final rule numbers, we are still seeing discrepancies.

Hospital & Freestanding IMRT & Stereotactic 2013 Payment Comparison Table

Code	Descriptions	2013 HOPPS Rate	2013 MPFS Rate Non-Fac With CF Reduction	2013 MPFS Non-Fac Payment Without CF Reduction
77418	IMRT Treatment Delivery	$483.70	$298.01	$405.73
77372	Radiation Treatment Delivery, Stereotactic Radiosurgery (SRS), Complete Course of Treatment of Cerebral Lesion(s) Consisting of 1 Session; Linear Accelerator Based	N/A	$577.02	$785.59
77373	Stereotactic Body Radiation Therapy, Treatment Delivery, per Fraction to 1 or More Lesions, Including Image Guidance, Maximum of 5 Sessions per Course	N/A	$932.53	$1,269.60
G0173	Linac SRS, 1 Session Course	$3,300.64	N/A	N/A
G0251	Linac SRS, Per Session, Max of 5 Fxs	$978.25	N/A	N/A
G0339	Robotic SRS, 1 Session or 1st Fx of SBRT Course	$3,300.64	N/A	N/A
G0340	Robotic SRS, Per Session, Fxs 2-5	$2,354.79	N/A	N/A

Also issued in the MPFS CY 2013 final rule is a laundry list of radiation oncology that CMS has "under review". CMS stated in the final rule since that had concerns with the inputs for the recently reviewed IMRT and SBRT direct PE inputs, they believe it is necessary to re-review other recently reviewed services with stand-alone PE procedure time. Those codes are the following:

77280 Set radiation therapy field; 77285 Set radiation therapy field; 77290 Set radiation therapy field; 77301 Radiotherapy dose plan imrt; 77338 Design mlc device for imrt; 77372 Srs linear based; 77373 Sbrt delivery; 77402 Radiation treatment delivery; 77403 Radiation treatment delivery; 77404 Radiation treatment delivery; 77406 Radiation treatment delivery; 77407 Radiation treatment delivery; 77408 Radiation treatment delivery; 77409 Radiation treatment delivery; 77412 Radiation treatment delivery; 77413 Radiation treatment delivery; 77414 Radiation treatment delivery; 77416 Radiation treatment delivery; 77418 Radiation tx delivery imrt; 77600 Hyperthermia treatment; 77785 Hdr brachytx 1 channel; 77786 Hdr brachytx 2-12 channel; 77787 Hdr brachytx over 12 chan; 88358 Electron microscopy

What to do about it

There are organizations that formulate and submit letters to congress on how these cuts will have a negative impact for access of care and jobs for physicians and staff. While the letters can assist, CMS is very aware of what these cuts will do. Perhaps another angle at combatting these cuts is understanding how the payments are formulated under MPFS and to be able to gather evidence to support the payment rates and have ammunition to avoid cuts. We need to be aware of the target on radiation oncology's back and have a plan in place if we continue to see these large decreases to the radiation oncology codes. What are we going to do to keep some of these cancer centers open, keep our staff and our technology current?

In summary, we avoided the large blow to the radiation oncology codes under MPFS, but we will still see decreases. It is evident that there will continue to be a degree of cuts to be felt for physicians, clinics and vendors. Industry leaders need to be thinking of effective ways to help these individuals keep their doors open, keep their staff, keep their patients and keep up with technology. There are already several radiation oncology codes that are targeted for future review by the AMA Relative Value Update Committee. Get engaged, get educated on the process and help make a change in the direction you feel most appropriate. No matter what you viewpoint getting engaged and educated helps the process along and gives us all a chance to have input on potential change. ■

Bridget Krueger, MBA, BSRT (T), *is the Associate Director of Corporate Consulting for Revenue Cycle Inc. Bridget advises and leads clients in the areas of billing and reimbursement for technology, monitoring government regulatory information and seeking new business opportunities. Her broad healthcare industry experience ranges from administrative to clinical and managerial roles.*

Kelli Weiss, R.T. (R)(T), *is the Executive Director of Revenue Cycle Inc. and leads the consulting division, offering comprehensive consulting services to oncology providers, facilities, and corporate vendors nationwide. Kelli brings 18 years' experience in the oncology field, including positions such as Chief Therapist, Dosimetrist, and Radiographer.*

Revenue Cycle Inc. *is a medical and radiation consulting resource for the oncology industry, providing comprehensive services to healthcare providers including consulting, auditing, training, billing and coding, electronic medical record conversion, corporate vendor relations, cancer center development and practice management.*

Linda Ferris Elected Chair of Accreditation Committee of the CoC

In early November of this year, **Linda W. Ferris, PhD,** ACE President and Centura Health's leader for oncology services, was elected Chair of the Accreditation Committee of the American College of Surgeons Commission on Cancer (CoC). In addition to the honor of the post, Ferris' selection is notable because she is the first non-MD to lead the committee since the founding of the CoC.

"It is an honor to be associated with the Commission on Cancer and to act in service of cancer the CoC accredited programs, their patients, and physicians throughout the nation," Ferris said. It is evident that patients, providers, payers, and policymakers all benefit from accreditation."

Ferris represents the Association of Cancer Executives as a Member Organization on the CoC, one of the 50 affiliated professional organizations dedicated to the mission of the CoC. The CoC is the accrediting body of cancer programs nationally and is dedicated to:

- Establishing standards to ensure quality, multidisciplinary and comprehensive cancer care delivery in healthcare settings;
- Ensuring that facilities are providing or referring patients to the requisite array of services for cancer patients, including access to clinical research, nurse navigation, education and psychosocial support, genetic counseling, physical therapy, spiritual support, palliative care, hospice, survivorship planning, and other services;
- Conducting accreditation surveys in healthcare settings to assess compliance with those standards;
- Collecting standardized, high quality data from CoC accredited settings to measure cancer care quality;
- Maintaining the National Cancer Database, which has captured over 26 million cancer cases since 1985, and utilizing that data to improve clinical outcomes;
- Facilitating the use of data to monitor treatment patterns and outcomes to enhance cancer control and clinical surveillance activities; and
- Developing effective educational interventions to improve cancer prevention, early detection, care delivery, and outcomes in healthcare settings.

In addition to serving on the CoC Executive Committee, she has previously served as the Vice-Chair on the Accreditation Committee and as Chair of the Member Organizations Steering Committee for four years.

As Chair of the Accreditation Committee of the CoC, Ferris will lead the accreditation activities related to the more than 1,500 currently accredited cancer programs and work to increase the number of accredited programs nationally, demonstrating the value of accreditation in providing quality, patient-centered cancer care.

Ferris holds a BA from Wayne State University in Detroit, MI; an MA from Oakland University in Rochester, MI; and a PhD from University of Michigan in Ann Arbor. Dr. Ferris joined Centura Health a year ago from Renown Medical Center in Reno, NV.

Centura Health is committed to accreditation of all of its cancer programs across the state of Colorado. Currently, five accredited programs exist at St. Anthony Hospital in Lakewood, Porter Adventist Hospital in Denver, Penrose-St. Francis Health Services in Colorado Springs, St. Mary-Corwin in Pueblo and Mercy Regional Medical Center in Durango. Three additional programs are preparing for their accreditation with the CoC.

ACE is proud to extend our congratulations to Ferris on behalf of our entire organization. ■

Correction

As a correction to the September edition of *ACE Update*, a more accurate summary of the **Helen F. Graham Cancer Center's Lung Multidisciplinary Center** has been developed. The Lung Center utilizes an actual, not a virtual, multidisciplinary consult model involving the active participation from medical oncology, surgical oncology, and radiation oncology. Each physician meets with the patient during their visit to the Center and is not required to meet separately with the specialists in multiple office locations. Together, these specialists, in consultation with the patient's primary care physician and with the support of a care management team, work to create the most appropriate and effective plan of treatment. Although I-ELCAP participation assisted with initial development of a robust lung cancer screening program, the Helen F. Graham Cancer Center was a participant, but terminated participation several years ago after enrolling over 1,800 patients.

As previously stated, Helen F. Graham Cancer Center's Lung Multidisciplinary Center is believed to be a "best practice" program that should serve as an example to community cancer centers working to develop their own comprehensive lung programs. The Lung Multidisciplinary Center is one of 14 staffed by the Helen F. Graham Cancer Center where over 200,000 annual visits makes this NCI-Selected Cancer Center a key component of the Christiana Care Health System, headquartered in Wilmington, Delaware, one of the country's largest health care providers in the nation. ■

THREE QUESTIONS with an ACE Member

Nancy J. Harris, MPA/HSA

VP, Oncology Service Line, Saint John's Health Center
Chief Administrative Officer, John Wayne Cancer Institute

Stats: Cancer Executive for over 20 years; member of ACE since its inception in 1994; served on several ACE committees, as member of the Board of Directors and Past President of ACE. Education: BS in Biology and Medical Technology from Illinois State University; MPA/HSA from University of Southern California

What keeps you up at night?

- Developing and growing a comprehensive cancer program in a highly competitive and dynamic market
- Ability to foster and sustain regional physician relationships with growing financial ventures that compete with the hospital
- Declining federal grant dollars
- Shrinking budgets amidst increased demands for high tech clinical and lab equipment, non-reimbursed support services, growing IT infrastructure needs and complexity and maintaining competitive salaries and benefits

What are some of the clinical or scientific advances that will most impact the oncology industry?

- Identification of proteomic, genomic and biologic pathways and related development of targeted therapies designed specifically for an individual and their specific tumor
- Ability to harness a patient's own immune system to prevent, check or eliminate certain cancers
- Maximizing detection, treatment and therapy evaluation modalities and technology using non-invasive and expanded minimally invasive techniques
- Increased collaboration in the use of biospecimen repository samples and clinical data for focused research efforts at reduced cost and time to significant cancer discoveries.

What advice would you give to a new cancer executive?

As founding member, I can attest that ACE has held true to the genesis of inception – to formulate a professional organization that is relatively small in number, but serves an organization of industry and national leaders in oncology.

This collegial network is amazing in its openness and sharing of insight and experience among the membership. It is my first choice when turning to others to see how they have addressed the numerous challenges we face. The annual conference is invaluable in presenting a focused review of major oncology topics of the day, providing opportunities to interface with key vendors in the oncology arena, and forming new and rekindling existing member relationships and friendships.

My advice to every new cancer executive who seeks leadership development, continuing education and professional networking opportunities designed to promote improvement in patient care delivery is: Look no further than ACE to help you acquire the constructive skills and specialized knowledge to quickly and effectively achieve your goals. ■

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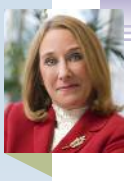

Linda Weller-Ferris, PhD, ACE President
Centura Health System, Centura Health Leader for Oncology Services
State of Colorado

As we prepare to manage the 2013 post-election and grapple with a new legislative year, oncology leaders continue to face unprecedented leadership challenges. The number of cancer patients keeps climbing, given our aging population. And we repeatedly view that television ad that stresses "10,000 people retire every day in the U.S." Yes, we have an aging population that is more likely to develop some form of cancer. In the October 14, 2004 article in *The Economist,* entitled "Up Close and Personal", it was pointed out that ten million people worldwide were diagnosed with cancer that year, and unfortunately six million died from it that year. Despite the launch of the "war on cancer" by then-president Richard Nixon's in 1971, America has funded nearly $70 billion (in actual, not inflation-adjusted, dollars) for cancer research to the National Cancer Institute (NCI). Our cancer programs will continue to be pressed to "do more with less".

As a result, our cancer programs require "change leadership". John Kotter speaks about the differences between "change management" versus "change leadership." Managers have basic tools, structures, and skills to keep the change cycle under control. "Change leadership" involves becoming a driving force, with a vision and the processes to "fuel transformation". Our complex healthcare systems require bold transformation, driven by leaders who can articulate the vision and lead *faster, smarter, and more efficiently.*

The question comes down to us: Do we, as oncology leaders, have the tools, knowledge, and skill sets to take bigger leaps and seize on opportunities and manage the hazards we face? The ACE Education Committee, under the leadership of ACE President-Elect Diane Cassels, has completed the agenda for the **ACE 19th Annual Meeting,** to be held **January 23–26, 2013** at the Grand Hyatt in **San Antonio, Texas.** For those new leaders, there is an **Oncology 101** pre-conference program on Wednesday, January 23.

The Annual Meeting educational program is an opportunity for you to network among peers and learn… Learn about cancer care changes, working with ethicists, patients rights, Rapid Quality Reporting System of the NCDB, the financial benefits of nurse navigation, physician alignment strategies, nutritional issues, management of drug shortages, transitional care models, oncology shared savings to bend the cost curve, cancer survivorship programs, and more. ***This is the oncology leadership educational event of the year that none of us can afford to miss!*** Register online today (more information is at **www.cancerexecutives.org**) and encourage a colleague who could step into an oncology leadership role to attend this phenomenal educational event. It's all about becoming "transformational leaders".

See you in San Antonio!

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