ASSOCIATION of CANCER EXECUTIVES

ACE update

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The Power of Collaboration: *One Voice Against Cancer*

By Wendy Selig, *Vice President for External Affairs and Strategic Alliances, American Cancer Society Cancer Action Network (ACS CAN).*

Almost a decade ago, the American Cancer Society Cancer Action Network (ACS CAN) organized the cancer community to fight for the continuation of the doubling of the budget of the National Institutes of Health (NIH) to ensure that momentum for the initiative did not wane.

One Voice Against Cancer (OVAC) has continued to develop as a collaboration of national non-profit organizations representing millions of Americans, delivering a unified message to Congress and the White House on the need for increased cancer-related appropriations. As a result of the work of OVAC and other groups, Congress saw the doubling of the NIH budget through to completion.

OVAC has grown into an effective and recognized lobbying coalition on cancer funding, enhancing policymakers' awareness of the need for substantial increases for both cancer research and control programs. Lawmakers and federal agencies are asked also to focus efforts on outreach into ethnic minority and other underserved populations, many of which have a higher risk and mortality from various forms of cancer.

OVAC's united front enhances each member organization's ability to attain the funding levels necessary to win the war on cancer and to equip those facing cancer with the tools they need to fight this deadly disease. OVAC offers an effective platform for its participating members to engage in cooperative efforts that increase understanding of the need for both cancer research and control programs. At the same time, OVAC empowers its volunteers and those touched by cancer to deliver this message creatively and powerfully to policymakers.

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"[OVAC delivers] a unified message to Congress and the White House on the need for increased cancer-related appropriations."

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ACE Calendar

JANUARY 26–29
NEW ORLEANS, LA
THE ROOSEVELT HOTEL

CMS 2010 Proposed Rules – *What the Future May Hold for Radiation Oncology*

By Sally Eggleston
Director of Business Development, Revenue Cycle

On July 1, 2009 the Centers for Medicare & Medicaid Services released the Proposed Rule to Payment Policies under the Medicare Physician Fee Schedule as well as the Proposed Changes to the Hospital Outpatient Prospective Payment System and calendar year (CY) 2010 Payment Rates. These are two entirely different documents with the Medicare Physician Fee Schedule (MPFS) affecting physicians billing for professional only services and for free-standing facilities not billing under a hospital tax ID. The Hospital Outpatient Prospective Payment System (HOPPS) affects hospitals billing for technical only services in the hospital outpatient setting.

HOPPS

CMS projects that the total expenditures under HOPPS for Medicare patients will be $31.5 billion for CY 2010. Proposed changes for radiation oncology procedures performed in a hospital outpatient department under the HOPPS payment system are relatively minor with an overall increase in payment for the majority of procedures performed. Some of the more frequently utilized procedure codes are outlined in Table 1, showing the variance from 2009 national average payments to the proposed 2010 national average payments.

There is a proposed decrease to the specialty procedures of intracavitary and interstitial radioactive implants as well as the G codes utilized for stereotactic procedures. These G codes have seen many changes in the past few years but are still reimbursed relatively well as shown in Table 2.

CMS is proposing a move of 0182T HDR Electronic Brachytherapy from new technology APC 1519 to APC 0313, which happens to be the APC grouping for other brachytherapy procedures. This proposed move would create a reduction in payment from $1,750 per treatment to $1,003.32 per treatment.

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The Power of Collaboration: One Voice Against Cancer

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Much of the core advocacy message focuses on the federally funded cancer research and prevention that occurs at cancer centers and community hospitals across the country. While OVAC advocates for increases in the annual appropriations for the National Institutes of Health and the Centers for Disease Control, the coalition's emphasis is always on the support provided to local communities and its impact on cancer patients and their families.

OVAC is again taking on the challenge of fighting for a doubling. This time it is President Obama's proposal to double cancer research funding at the NIH. OVAC is actively engaging the Administration as well as Congressional leadership to ensure that this proposal remains a budget priority as the Fiscal Year (FY) 2010 budget is developed.

In anticipation of the FY 2011 budget OVAC will be reaching out to cancer centers across the U.S. to solicit information on research projects being supported by the *American Recovery and Reinvestment Act.* This coordinated approach will ensure that the economic benefits, as well as the potential public health benefits, of the cancer research being supported will be highlighted across the biomedical research community. OVAC will also

"While OVAC advocates for increases in the annual appropriations for the NIH and the CDC, the coalition's emphasis is always on the support provided to local communities and its impact on cancer patients and their families."

be incorporating the information that is collected in its advocacy message to Congress on the importance of maintaining support for the promising research that is being started under the *American Recovery and Reinvestment Act.* ■

Wendy Selig is Vice President for External Affairs and Strategic Alliances at the American Cancer Society Cancer Action Network (ACS CAN). ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit **www.acscan.org** *and* **www.ovaconline.org**.

President's Message

Patrick A. Grusenmeyer, ScD
Senior Vice President, Cancer and Imaging Services
Christiana Care Health System

The Continuing Saga of Healthcare Reform

Healthcare reform continues to dominate the news, and what is most disconcerting to me is the disinformation that is being circulated about the different reform proposals. It should come as no surprise that any effort to reform healthcare with be a difficult, arduous process. An attempt to change a system such as healthcare that significantly impacts most Americans, but maybe more importantly, impacts the livelihood (read income) of one-sixth of all Americans (healthcare expenditures represent one sixth of the GDP) will certainly be difficult. The entrenched self-interests can be overwhelming.

A recent Op-Ed piece *The New York Times* on August 12 by Atul Gawande, Donald Berwick, Elliot Fisher and Mark McClellan (www.nytimes.com/2009/08/13/opinion/13gawande.html?pagewanted=all) suggests that part of the problem with the national debate is that it seems to consider only two options, raising taxes or rationing care. Of course, there is uproar about changing healthcare. No one likes to pay more taxes or have their healthcare rationed, especially cancer patients and their families.

The authors argue that the real goal of healthcare reform should be to change how healthcare is delivered so it is both less expensive and more effective. The authors cite several locations across the country where healthcare is less expensive and more effective, and these are not just the Mayo or Cleveland Clinics, they are sites with traditional hospitals and private physician practices like most communities in America. They are doing things differently and we can learn from them.

There are two healthcare initiatives currently being discussed, the big systemic changes represented by the healthcare reform debate, and the changes proposed by Medicare for the new year effective January 1, 2010. The proposals in the Medicare Physician Fee Schedule are stark, including a significant shift in reimbursement from specialist physicians (including many cancer specialists, most notably medical and radiation oncologists, surgeons, and radiologists) to the primary care physicians (including internists, family practice physicians and obstetrics and gynecologists). In my opinion, there is no doubt that primary care physicians have been under-reimbursed in comparison to their specialist colleagues.

Our specialty societies have requested us to contact our congressional representatives when they are home over the August recess to argue for our specialty – to "save cancer care" This is a worthy endeavor. However, the challenge is not to lose sight of the real issue for the long term – our current healthcare system is financially unsustainable, and in many circumstances, inequitable. Change is required. As insiders to the system, our challenge is to make health care less costly and more effective, so that it will be sustainable and equitable. Remember that in your discussions with your representatives.

2010 ACE Annual Meeting

Planning is well under way for the **2010 Annual Meeting,** to be held at the Westin Gaslamp Quarter in **San Diego, California, February 13–16, 2010.** ACE President-Elect Joy Soleiman and the ACE Education Committee lead the planning efforts. If you would like to be part of the planning, please contact Joy at joy.soleiman@mail.jci.tju.edu. ■

CMS 2010 Proposed Rules – What the Future May Hold for Radiation Oncology

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CMS plans a continuation of the packaging of image guidance procedures and specifically rejected issues raised by the APC Panel, including concerns that packaging of radiation oncology guidance services has resulted in a decline in the number of services and that beneficiary access may be affected. CMS continues to encourage hospitals to report all HCPCS codes that describe services provided regardless of packaging as this data is utilized for tracking utilization patterns and resource cost.

MPFS

Proposed changes to the MPFS for calendar year 2010 are much more dramatic and if implemented will result in a major decrease in physician payments. As in the past there is the continued threat of a reduction in the conversion factor. Medicare law requires CMS to adjust the MPFS payment rates annually based on an update formula, which includes application of the Sustainable Growth Rate, or SGR, that was adopted in the Balanced Budget Act of 1997. This formula has yielded negative updates every year beginning in CY 2002, although CMS was able to take administrative steps to avert a reduction in CY 2003 and Congress has taken a series of legislative actions to prevent reductions in CYs 2004-2009. Based on current data, CMS is projecting a rate reduction of -21.5 percent for CY 2010. The proposed conversion factor for CY 2010 is $28.3208. There are already initiatives taking place to curb this decrease in the conversion factor that affects all physicians regardless of specialty.

CMS is making several proposals to refine Medicare payments to physicians, which are expected to increase payment rates for primary care services. The proposals include an update to the practice expense and malpractice expense component of physician fees. These proposals would create very large reductions in the practice expense RVUs for radiation oncology CPT codes. There are two areas specifically targeted for reductions:

(1) Equipment utilization rate is proposed to increase to 90% for equipment valued over $1 million (up from 50% previously)

(2) The physician practice information survey (PPIS) yielded an increase in the PE/HR for radiation oncology; however, other specialties appear to have increased more which offset the radiation oncology increase.

The combination of these two adjustments in RVU's will affect the technical component of radiation oncology procedures that are paid under the MPFS by a negative 17%.

CMS is also proposing to implement a second review and update of malpractice RVUs. The proposed malpractice expense RVUs are based upon three data sources: Actual CY 2006 and CY 2007 malpractice premium data, CY 2008 Medicare payment data on allowed services and charges and CY 2008 Geographic adjustment data for malpractice premiums. Using the three data sources, CMS calculates risk factors to express the relative differences in national average premiums throughout the specialties. The risk factor is an index that is calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average premium. The risk factor for radiation oncology is 2.30 (another example is allergy/immunology=1.0). CMS is assigning malpractice RVUs to the technical component of certain services. Specifically

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Table 1. 2009-2010 Proposed HOPPS National Average Payments

HCPCS Code	Short Descriptor	APC	2010 Payment Rate	2009 Payment Rate	Variance 2009–2010
77280	Set radiation therapy field	0304	$116.96	$114.70	**$2.26**
77285	Set radiation therapy field	0305	$266.15	$255.69	**$10.46**
77290	Set radiation therapy field	0305	$266.15	$255.69	**$10.46**
77295	Set radiation therapy field	0310	$921.22	$892.90	**$28.32**
77300	Radiation therapy dose plan	0304	$116.96	$114.70	**$2.26**
77301	Radiotherapy dose plan, imrt	0310	$921.22	$892.90	**$28.32**
77315	Teletx isodose plan complex	0305	$266.15	$255.69	**$10.46**
77334	Radiation treatment aid(s)	0303	$192.65	$188.16	**$4.49**
77336	Radiation physics consult	0304	$116.96	$114.70	**$2.26**
77413	Radiation treatment delivery	0301	$156.50	$152.05	**$4.45**
77416	Radiation treatment delivery	0301	$156.50	$152.05	**$4.45**
77418	Radiation tx delivery, imrt	0412	$424.21	$410.83	**$13.38**

Table 2. 2009-2010 Proposed HOPPS National Average Payments

HCPCS Code	Short Descriptor	APC	2010 Payment Rate	2009 Payment Rate	Variance 2009-2010
G0173	Linear acc stereo radsur com	0067	$3,506.81	$3,803.23	**($296.42)**
G0251	Linear acc based stero radio	0065	$894.46	$952.38	**($57.92)**
G0339	Robot lin-radsurg com, first	0067	$3,506.81	$3,803.23	**($296.42)**
G0340	Robt lin-radsurg fractx 2–5	0066	$2,504.87	$2,579.82	**($74.95)**

CMS 2010 Proposed Rules – What the Future May Hold for Radiation Oncology

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Table 3.
CY 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes

SPECIALTY	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes*	Impact of MP RVU Changes	Combined Impact
TOTAL	$77,744	0%	1%	0%	**1%**
FAMILY PRACTICE	$5,055	2%	5%	1%	**8%**
INTERNAL MEDICINE	$10,061	1%	4%	1%	**6%**
GASTROENTEROLOGY	$1,779	-1%	1%	0%	**0%**
GENERAL PRACTICE	$719	1%	5%	0%	**6%**
GENERAL SURGERY	$2,213	-1%	4%	1%	**4%**
GERIATRICS	$167	1%	6%	1%	**8%**
HEMATOLOGY/ONCOLOGY	$1,888	0%	-5%	-1%	**-6%**
INTERVENTIAL RADIOLOGY	$227	0%	-10%	0%	**-10%**
NEUROSURGERY	$586	-1%	3%	1%	**2%**
NUCLEAR MEDICINE	$72	0%	-12%	-2%	**-13%**
RADIATION ONCOLOGY	$1,799	0%	-17%	-1%	**-19%**
RADIOLOGY	$5,254	0%	-10%	-1%	**-11%**
UROLOGY	$1,989	0%	-6%	0%	**-7%**
DIAGNOSTIC TESTING FACILITY	$1,044	0%	-19%	-5%	**-24%**
PORTABLE X-RAY SUPPLIER	$85	0%	-8%	-2%	**-11%**

*NOTE: The law caps on the MFS imaging payment amount at the comparable payment amount in the hospital outpatient payment system (OPPS cap). In the absence of the negative current law CY 2010 MFS update, the proposed PE change to the equipment utilization rate for expensive equipment from 50-90% would increase expenditures by approximately 1% due to a loss of savings from the OPPS cap.

noted in the proposed rule was data on medical physicist malpractice premiums. The impact of the malpractice change proposed for 2009, specific to radiation oncology, is a negative 1%. The total impact to radiation oncology with the combination of the PE RVUs and MP RVUs is negative19%.

From a coding standpoint the most notable proposal under the MPFS is a change in the status indicator for Consultations to "N". The status indicator "N" has the following descriptor:

"These codes are noncovered services. Medicare payment may not be made for these codes, If RVUs are shown, they are not used for Medicare payment."

In 2006, a report by the OIG found that approximately 75% of services paid as consultations did not meet all applicable program requirements, resulting in improper payments. The majority of these procedure codes were billed at an inappropriate level or were for services that did not meet the definition of a consultation. It was decided by CMS that educating the physician community might resolve some of these coding and documentation issues but there are many physicians who disagree with the interpretation regarding transfer of care. The existing consultation coding definition does remain ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care. Because of the disparity between AMA coding guidance and Medicare policy and physicians having difficulty in choosing the appropriate code to bill CMS is proposing non-payment for consultations. All physicians will utilize the established patient visits (99211-99215) and new patient visits (99201-99205) when providing evaluation and management services if this change in status indicator is finalized. CMS stated that the savings would be redistributed to increase payments for the existing E/M codes.

"The existing consultation coding definition does remain ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care."

Table 3 is taken directly from the proposed rule and outlines the total impact by specialty if the changes in the RVUs are finalized. These reductions do not include the reduction in payments if the conversion factor is also reduced.

As is indicated above, the proposed changes to the MPFS are numerous and could have a profound impact on delivery of treatment in a physician and/or entity owned radiation oncology center. Radiation oncology facilities, physicians, staff and stakeholders can comment on these proposed changes and have until August 31, 2009 to send their comments to CMS. CMS will respond to the comments in a final rule to be issued by November 1, 2009. In addition voicing concern to local senators and representatives may also assist in the reversal or reduction of the proposed cuts. Electronic comments may be submitted to www.regulations.gov. Follow instructions for "Comment or Submission" and enter file code CMS-1403-P. ■

References: Department of Health and Human Services Centers for Medicare & Medicaid Services 42 CFR parts 410, 411, 414, 415 and 485 [CMS-1413-P] RINs 0938-AP40 Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010 & Department of Health and Human Services Centers for Medicare & Medicaid Services 42 CFR Parts 410, 416 and 419 [CMS-1414-P] RIN 0938-AP41 Medicare Program-Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates.

NCI Update

Expediting Clinical Trial Contract Negotiations May Speed Availability of New Cancer Treatments

Contract negotiations between pharmaceutical companies, biotech companies, and academic medical centers often add months to the process of starting a clinical trial, delaying the availability of new cancer drugs to patients in need. To help overcome this key barrier, representatives from the *Life Sciences Consortium* of the *CEO Roundtable on Cancer* and several NCI-designated Cancer Centers have streamlined the clinical trial contract negotiation process through the development of the **Standard Terms of Agreement for Research Trial** (START) clauses for use in clinical trial agreements.

The START clauses were developed following a confidential, third party review of approximately fifty redacted copies of final negotiated clinical trial agreements provided by fourteen Cancer Centers and eleven *Life Science Consortium* companies. The review revealed that negotiations concerning certain key concepts reach a common endpoint at least 70% of the time.

The START clauses provide model language embodying those common endpoints for six key agreement concepts: intellectual property, study data, indemnification, subject injury, confidentiality, and publication rights. Separate clauses were developed for use in company-sponsored and investigator-initiated clinical trial agreements because different common end-points were present in the two types of agreements.

Use of the START clauses may simplify and reduce the length of the contract negotiation process by allowing the parties to start at the place where negotiations usually end, thereby significantly accelerating the delivery of new therapies to cancer patients. Although developed with cancer clinical trials in mind, the START clauses are applicable to all types of clinical research. ■

The START clauses toolkit is freely available for download at
http://restructuringtrials.cancer.gov/initiatives/standardization/highlights/start.

ACE Members in the News

New Chief Nursing Officer to Join the James Cancer Hospital

COLUMBUS, Ohio – **Susan Brown, RN, MSN,** *(pictured at right)* has been named chief nursing officer for the Ohio State University Comprehensive Cancer Center – James Cancer Hospital and Solove Research Institute. Susan Brown is Past President of ACE. We wish her continued success in her new postition. ■

ACE Welcome New Members

Since May, 2009

■ **David Boggs**
Dalton Boggs & Associates
4500 Bowling Blvd., Ste 100
Louisville, KY 40207
T: 502-228-4030
E: davidb@daltonboggs.com

■ **Karen Bruchak**
Kennedy Health System
900 Medical Center Drive
Cancer Center
Sewell, NJ 08080
T: 856-218-5321
F: 856-582-3009
E: k.bruchak@kennedyhealth.org

■ **Melissa Childress**
OSU-CCC James Cancer Hospital
300 W 10th Avenue
Suite 522
Columbus, OH 43210
T: 614/293-8429
E: melissa.childress@osumc.edu

■ **Allison Cuff**
The Advisory Board Company
2445 M Street NW
Washington, DC 20037
T: 202-266-5713
E: cuffa@advisory.com

■ **Amy Emmert**
Dana-Farber Cancer Institute
44 Binney Street DIB30
Boston, MA 02115
T: 617-632-3876
E: amy_emmert@dfci.harvard.edu

■ **Lynda Mischel**
University of PA Health System
3400 Spruce
Philadelphia, PA 19104
T: 215-662-3143
E: lynda.mischel@uphs.upenn.edu

■ **Ollieta Nicholas**
MD Anderson Cancer Center
1515 Holcombe Unit 455
Houston, TX 77030
T: 713-792-4397
F: 713-792-4436
E: ynon06@hotmail.com

■ **Kimberly Sevening**
HOPE Group LLC
24327 Douglas Circle
Waterloo, NE 68069
T: 402-216-0300
F: 402-315-9968
E: kim@hopegroupllc.com

■ **Kim Walker**
Lakeland Regional Cancer Center
P.O. Box 91057
Lakeland, FL 33804
T: 863-603-6565
F: 863-904-1803
E: kim.walker@lrmc.com

■ **Karen Zatzariny**
PENN Cancer Center
3400 Spruce Street
1610 Penn Tower
Philadelphia, PA 19104
T: 215-615-0428
F: 215-614-1854
E: karen.zatzariny@uphs.upenn.edu

■ **Kent Zimmerman**
Siteman Cancer Center at Barnes-Jewish Hospital & Washington University
Campus Box 8100
660 S. Euclid Avenue
St. Louis, MO 63110
T: 3147470323
F: 3144548051
E: krz4565@bjc.org

Please consider serving in an ACE professional committee. For information please email info@cancerexecutives.org

ACE Committee Updates

Newsletter & Publication

Colleen Jernigan, PhD, RN, AOCN, Committee Chair
UT MD Anderson Cancer Center

This issue of *ACE Update* highlights the decade long collaborative efforts of the American Cancer Society Cancer Action Network (ACS CAN) through One Voice Against Cancer (OVAC) to deliver a unified message to legislative leaders of the pressing need for increased cancer-related appropriations. The author, Wendy Selig, Vice President for External Affairs and Strategic Alliances at ACS CAN, was a featured speaker at our annual meeting in Sarasota. Additionally, the publication will include a highly informative article from Sally Eggleston, Director of Business Development for Revenue Cycle on the impact of the proposed CMS 2010 rules on the future of Radiation Oncology.

Please feel free to join our group or to contact me directly with ideas at cjerniga@mdanderson.org. ■

YOUR INPUT IS IMPORTANT TO US!

ACE appreciates member feedback and suggestions to better serve you.

Please e-mail your questions or comments to **info@cancerexecutives.org**

Share Your News with ACE

Announce your organization's achievements, program changes, staff transitions and events to the entire ACE membership! Send an email with your news and press releases to: **info@cancerexecutives**

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