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August 6, 2008

Carol G. Potter
Medical Facilities Planning Section
701 Barbour Drive
Raleigh, NC 27603

Dear Ms. Potter:

My name is Dr. Robert Schaaf. I am the President of Wake Radiology Oncology Services in Cary North Carolina. I write this letter in opposition to an adjusted need determination in Service Area 20 requesting one additional linear accelerator for dedicated prostate treatments.

Wake Radiology Oncology Services, PLLC has provided full service radiation therapy services in the Cary Community for years, including IMRT for prostate cancer patients since 1998. Wake Radiology approached local hospitals in 1997 to co-develop our cancer center in Cary; there were no takers at that time. IMRT was very new and unfamiliar – so we built the facility ourselves after obtaining a Certificate of Need. To this day we solely own and operate our facility. Advanced radiation therapy services are available at Duke University in Durham, Duke Raleigh Hospital, UNC Chapel Hill, Rex Hospital and US Oncology. There are eight, not seven, operating linacs currently servicing Area 20 with IMRT available at all sites except Franklin Regional Cancer Treatment Center in Louisburg.

Wake Radiology Oncology Services approached Cary Urology in 2001-2003 to create a multi -disciplinary prostate brachytherapy center based at WakeMed Cary Hospital. The project failed to materialize for lack of support by Cary Urology. Cary Urology went on to establish their own office-based program to the exclusion of those of us attempting community hospital based approaches at WakeMed Cary and Rex hospitals. How is it that a multidisciplinary prostate brachytherapy program under the roof of Cary Urology is developed, but considered unacceptable when proposed at WakeMed Cary or Rex hospitals by local radiation oncologists in Raleigh and Cary? There is no evidence that multidisciplinary care is better practiced under one roof. One could make a strong argument that it may in fact be compromised in the hands of self referring physicians. I refer you to the attached op-ed piece that

appeared on the editorial page of the July 30, 2008 News and Observer written by Dr. Peter Bach of Memorial Sloan-Kettering Cancer Center in New York. Medicare is currently studying the ancillary service rules enjoyed by self referring physicians and will likely curtail the practice in the near term.

In summary we believe there is no compelling reason to adjust the need determination at the behest of Cary Urology. Cary Urology is, of course, free to avail themselves of the existing CON process and, in fact, have done so in their most recently denied application. Cary Urology is currently challenging that denied application. There is no rational basis for an organ based linac dedicated to prostate, or lung, or brain, or gastric, or colon, or GYN cancers. Service Area 20 needs are well met by some of the best facilities in the southeast. We respectfully recommend you deny this request.

Sincerely,

Robert E. Schaaf, MD
President

Attachment

# The scan scam? How fee-for-service fails patients

By Peter B. Bach

NEW YORK

The longstanding push-pull between Medicare and Congress has erupted again. Congress, overriding a presidential veto, recently canceled Medicare's scheduled 10.6 percent cut in payment rates for doctors and instead raised the rates 1.1 percent. But this action fails to address the problem with the Medicare payment system, which is not the amounts doctors are paid but the way their payments are calculated.

Medicare pays doctors for specific services. If a patient has a checkup that includes an X-ray, a urine analysis and a physical, Medicare pays the doctor three separate fees.

Each fee is meant to reimburse the doctor for the time and skill he or she devotes to the patient. But it is also supposed to pay for overhead, and this is where the problem begins. To Medicare, a doctor's overhead (or "practice expense") includes such items as rent, staff salaries and the cost of high-tech medical equipment. When the agency pays a fee to a doctor who has performed a CT scan, it is meant to cover some of the cost of buying or leasing the scanner itself. Services using more expensive equipment generate higher fees.

Any first-year business school student can see the profit opportunity here. The cost of a CT scanner is fixed, but a doctor earns fees each time it is used. This means that a scanner becomes highly profitable as soon as it's paid for.

In contrast, the doctor-patient visit, which involves no expensive equipment, offers no significant profit opportunity. So the best way for a doctor to make money in his practice is not to spend time with patients but to use equipment as much as possible. That means moving the maximum number of patients through the practice and spending the minimum amount of time with each one.

From 2000 to 2005, the number of Medicare patients seen by doctors increased by 8.5 percent, while the number of services each one received was up 14 percent, according to the Government Accountability Office.

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**IT'S NOT ONLY MEDICARE THAT PAYS DOCTORS ON A FEE-FOR-SERVICE BASIS;** most private insurers do also. This is part of the reason that spending on physician services nationwide has risen every year since 2000 by about $25 billion. This year the tab will exceed $500 billion.

Doctors who do their own CT scanning and other imaging order roughly two to eight times as many imaging tests as those who do not have their own equipment, a 2002 study by researchers at the University of North Carolina found. Altogether, doctors are ordering roughly $40 billion worth of unnecessary imaging each year — which adds up to nearly 2 percent of the total Americans pay for health care.

No wonder the Government Accountability Office last month urged Medicare to find a way to constrain doctors' use of imaging tests.

Over the years, Congress and Medicare have made various attempts to stamp out some of the most egregious excesses in Medicare payments. Sometimes they have succeeded. In 2004 and 2005, when Congress lowered the fees associated with anti-testosterone drugs used to treat prostate cancer, urologists and other doctors prescribed them less.

Around the same time, though, urologists started buying multimillion-dollar radiation therapy machines for treating prostate cancer. Reimbursement for radiation treatment remains very generous.

Clearly, scattershot strategies aimed at individual fees are unlikely to reduce health care costs. More fundamental changes are needed in the way doctors are paid.

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**FOR THEIR TIME, DOCTORS SHOULD BE GIVEN A STIPEND** for each of their patients. It should be larger for patients with complicated medical conditions and smaller for those who are healthy, and it should not be influenced by the number of services or tests a doctor orders.

For overhead, doctors should be paid an amount that covers the typical cost of tests and treatments needed to address a patient's condition. This strategy — known as "case rate" or "prospective" payment — is standard in hospitals. The hospital receives a payment for dealing with a patient's underlying condition rather than individual payments for each test and treatment. This approach offers no incentive to run unneeded tests, and it has been credited with substantially slowing the growth in Medicare payments to hospitals.

Without changes to the way Medicare pays doctors, the fights in Congress over raising or lowering payment rates will continue. And doctors will still have no financial incentive to do what is most important: spend more time with their patients.

THE NEW YORK TIMES

*Peter B. Bach, a doctor at Memorial Sloan-Kettering Cancer Center, was a senior adviser to the administrator of the Centers for Medicare and Medicaid Services from 2005 to 2006.*

Raleigh N and O
7/30/08