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Coalition pressures VA to rescind directive

In response to heavy lobbying by the College and other members of a coalition representing surgical specialists, in December 2004, the U.S. Department of Veterans Affairs (VA) rescinded an administrative directive allowing nonsurgeons to perform laser eye surgery at VA facilities. More specifically, the new directive limits the performance of therapeutic laser eye surgery in the VA system to only qualified ophthalmologists.

This issue began to materialize in 1998, when Oklahoma became the first and only state to pass legislation allowing optometrists to perform laser eye surgery. The VA has a longstanding local facility privileging policy that allows health care practitioners to practice up to the limits of their state licenses, regardless of the facility's location. In 2003, it was discovered that an Oklahoma optometrist had performed glaucoma- and cataract-related laser surgery at a VA medical facility in Wichita, KS. After initially refusing to revoke the optometrist's surgical privileges, the VA temporarily suspended them and placed a moratorium on optometrists performing eye surgery in its health care facilities.

To ensure patient safety, Rep. John Sullivan (R-OK) introduced H.R. 3473, the Veterans Eye Treatment Safety (VETS) Act in November 2003. This legislation would have mandated that only licensed physicians and osteopaths perform eye surgery in the VA system. The bill enjoyed strong bipartisan support and ultimately gathered 74 cosponsors. The VETS Coalition, which includes the College, the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgeons, the American Medical Association, the American Osteopathic Association, and the American Academy of Family Physicians, advocated passage of the bill. Congress adjourned before the bill could achieve passage, but the VA's recent action rendered the legislation unnecessary.

MedPAC issues reports on clinical staff

On December 30, 2004, the Medicare Payment Advisory Commission (MedPAC) issued two congressionally mandated reports pertaining to reimbursement for members of the surgical team.

In a report on Medicare fee schedule payments for certified registered nurse first assistants (CRNFAs) at surgery, the commission stopped short of recommending that policies be expanded beyond the currently allowed payments to physicians, physician assistants, and a defined list of advanced practice nurses, such as nurse midwives. However, MedPAC did conclude that any congressional action to add CRNFAs to the list of practitioners eligible for fee schedule payments should include provisions to offset added Medicare program costs so that the policy change will be budget neutral.

A second report focused on cardiothoracic surgeons' practice expenses and whether Medicare fee schedule payments accurately reflect the costs of surgeon-employed clinical staff who provide patient care services in the hospital setting. While the commission acknowledged the thoracic surgeons' concerns, MedPAC concluded that current data limitations and methodological problems hinder Medicare's ability to determine more accurate payment amounts.

ACS comments on final 2005 Medicare fee schedule

A common theme raised in both reports is a concern about duplicate payments for clinical staff who may be employed by either the hospital (and so paid under Medicare Part A) or the physician (and reimbursed under Part B either as a separate payment or as part of the surgeon's payment). A proposed solution would combine facility and physician payments for hospital-based services and allow hospitals and physicians to divide the total amount according to how clinical staff are supplied and used. A stated advantage of this approach is that it would allow the quality of surgical care to be measured as a whole, with the hospital and the surgeon held jointly accountable.

Both reports can be viewed on MedPAC's Web site at www.medpac.gov through links found under the heading of "recent products."

The College submitted comments on January 3 to the Centers for Medicare & Medicaid Services (CMS) in response to the final 2005 Medicare physician fee schedule. The comments focus on the need for CMS to adopt a new methodology and better data collection for calculating professional liability insurance relative value units that would more fairly compensate high-risk surgical specialties. In addition, the College submitted 29 surgical service codes for consideration during the five-year review of relative work values. The five-year review will take place this year, and any resultant changes to the value of these codes will become effective in 2007. In its comments, the College also calls into question the issue of parity with regard to newly established Medicare payment for drug administration codes. To read the text of the College's comments, go to <http://www.facs.org/ahp/views/medicare2005.html>.

Health spending slowed in 2003

According to CMS actuaries, health care spending growth slowed in 2003, for the first time in seven years. Total health care spending under private and public programs grew 7.7 percent in 2003 to \$1.7 trillion, down from a 9.3 percent growth rate in 2002. On a per capita basis, health spending increased by \$353 to \$5,670. Health expenditures accounted for 15.3 percent of the gross domestic product, however, outpacing growth in the overall economy by nearly three percentage points.

Of particular interest:

- Hospital spending, which accounts for nearly one-third of total national health expenditures, grew 6.5 percent in 2003, down from 8.5 percent the year before.
- Spending growth for prescription drugs declined from 14.9 percent in 2002 to 10.7 percent in 2003.
- Spending growth for freestanding home health agencies increased by one percentage point to 8.5 percent in 2003.
- Spending growth for physician services increased slightly to 8.5 percent in 2003, compared to 8.2 percent in 2002.

Detailed national health spending estimates are available at <http://www.cms.hhs.gov/statistics/nhe/default.asp>.