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prepared by the Division of Advocacy and Health Policy

Trustees project 9.9 percent pay cut

On April 23, the Medicare trustees released their 2007 report regarding the Medicare program's fiscal outlook. The report estimates that the Medicare conversion factor used to calculate physician payments will be cut 9.9 percent in 2008 and 4.8 percent to 5.4 percent each subsequent year through 2016. These cuts stem from Medicare's use of the flawed sustainable growth rate (SGR) to calculate the conversion factor. Last December, Congress stopped a 5 percent reduction in 2007 by freezing the conversion factor at the 2006 level. This marked the fourth piece of legislation that Congress has passed to preempt five years of cuts prompted by the SGR's application in determining the conversion factor. (One bill prevented cuts over two years.) Congress must act again to prevent further reductions from going into effect in 2008 and in future years.

In addition, the trustees' report indicates that in 2013, general revenues are expected to exceed 45 percent of the dollars used to pay Medicare benefits. This finding demonstrates that funds generated through Medicare taxes and premiums are insufficient to keep pace with the program's rising costs. The 2013 date is significant because the Medicare Modernization Act of 2003 requires the President to submit a proposal to Congress to preserve Medicare solvency when, in two consecutive reports, the trustees project that general revenues will exceed 45 percent of Medicare spending within the next seven years. Because this report marked the second year in a row that this projection has occurred, the President will be required to submit a proposal to Congress for containing Medicare spending.

As many Fellows know, in spite of congressional action in December, payments for some services were reduced in January because of other regulatory changes that the Centers for Medicare & Medicaid Services (CMS) issued last year. The College is deeply concerned that these cuts and the pending reductions will significantly challenge the ability of surgeons to maintain financially viable practices and of patients to access the surgical care they need. The College continues to be actively engaged with members of Congress and their staff in calling for measures that would base Medicare physician payments on the rising costs of practicing medicine. For a copy of the trustees' report, go to <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf>.

College supports ASC legislation

Reps. Kendrick Meek (D-FL) and Wally Herger (R-CA), recently introduced H.R. 1823, the Ambulatory Surgical Center Payment Modernization Act of 2007. The College has lent its support to the bill, which would provide a more equitable payment system for ambulatory surgery centers (ASCs) and responds to a Medicare Payment Advisory Commission recommendation that CMS modify the ASC procedures list.

More specifically, the legislation would counteract a proposed rule from CMS that calls for capping ASC payments at 62 percent of the 2008 Hospital Outpatient Prospective Payment System (HOPPS) proposed rate. H.R. 1823 would provide a more reasonable payment level of 75 percent of the HOPPS. In addition, the bill would

allow ASCs to receive reimbursement for any surgical services they provide, unless (1) the Secretary of the U.S. Department of Health and Human Services (HHS) identifies a specific risk associated with performing a procedure in the ambulatory setting, or (2) an overnight stay is required. Under the current rules, CMS arbitrarily adds to and deletes procedures from the ASC list, and Medicare beneficiaries are routinely denied the option of selecting an ASC as the site of service for hundreds of procedures commonly provided safely and effectively in ASCs to private-pay patients. For a copy of the College's letter of support for H.R. 1823, go to <http://www.facs.org/ahp/views/meekletterhr1823.pdf>.

HHS reports movement to value-driven care

On May 9, HHS Secretary Mike Leavitt announced that health plans committed to providing patients with quality and cost information now provide coverage to more than 100 million Americans. The announcement came less than a year after Secretary Leavitt announced his Value-Driven Health Care Initiative, calling upon the nation's insurers to make information about the quality and cost of care more transparent to patients. Soon thereafter, in August 2006, President Bush issued an Executive Order, mandating that the federal government take steps to put in place the "four cornerstones" of value-driven care: health information technology, public reporting of provider quality information, public reporting of cost information, and incentives for value comparison.

According to Secretary Leavitt, the steady progress toward value-driven health care is attributable to actions taken across the spectrum of stakeholders: the federal government; half of the states; approximately 775 employers, including nearly half of the top 200 U.S. corporations; and numerous unions, communities, and physician and hospital coalitions. For more information on efforts to establish a value-driven health care system, go to www.hhs.gov/valuedriven.

Informed consent rules revised

On April 13, CMS announced that it had revised the interpretive guidelines for conditions of participation related to hospital informed consent. The requirement that informed consent forms give the name of a resident participating in an operation and the tasks he or she will perform has been eliminated. Instead, the new guidelines require that the informed consent document state that the participating resident will be chosen at the time of the surgery and that the specific tasks assigned to the resident will be compatible with his or her skills. The revisions became effective immediately. For more information, including the revised guideline language, go to <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-17.pdf>.