

Dateline Washington

prepared by the Division of Advocacy and Health Policy

Congress debates SCHIP/Medicare bills

At press time, a congressional conference committee was scheduled to begin deliberations on the differences between the House and Senate versions of legislation reauthorizing the State Children's Health Insurance Program (SCHIP). On August 1, the House passed the Children's Health and Medicare Protection (CHAMP) Act of 2007, which, in addition to renewing and expanding SCHIP, includes language pertaining to Medicare physician payment. Specifically, CHAMP would replace the 9.9 and 5 percent Medicare reimbursement reductions slated for 2008 and 2009, respectively, with 0.5 percent increases.

The House bill also takes steps toward long-range Medicare payment reform by replacing the sustainable growth rate with a new system of six separate expenditure targets and fee schedule conversion factors for various categories of physician services. The proposed expenditure targets and conversion factors are consistent with a proposal that the American College of Surgeons and the American Osteopathic Association have advocated. This new methodology holds promise for ending the current problem of across-the-board payment reductions imposed on service categories, such as major procedures, that have experienced relatively low volume and spending growth. These and other provisions would be financed through a tobacco tax increase of 45 cents and a five-year phase-out of overpayments to Medicare Advantage plans.

The Senate passed its SCHIP reauthorization bill on August 2. However, the Children's Health Insurance Program Reauthorization Act of 2007 contains no provisions related to Medicare payment. In light of this and other differences between the two bills, the medical and surgical communities were anticipating that the House-Senate conference committee would have difficulty arriving at a reasonable compromise. Furthermore, President Bush has threatened to veto the legislation because of cost and policy concerns regarding both bills' proposed expansion of SCHIP benefits. For more up-to-date information, contact the ACS Division of Advocacy and Health Policy at ahp@facs.org.

ASC and HOD rules released

This past summer, the Centers for Medicare & Medicaid Services (CMS) released a final rule on the ambulatory surgical center (ASC) payment system and a proposed rule on quality of care and bundled payments in hospital outpatient departments (ODs) that also contains estimated payment rates for ASCs.

The ASC rule calls for basing reimbursement on the ambulatory payment classification system used to pay hospital ODs. Final payment rates are expected to be approximately 67 percent of hospital outpatient amounts. Under the new rule, 3,300 procedures performed in ASCs will qualify for reimbursement, up from 2,500. All provisions are effective January 1, 2008. To access the ASC rule, go to http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp.

The hospital OD proposal calls for outpatient departments to measure and report on quality of care in exchange for a 2 percent update. Two of the 10 measures that CMS is proposing for 2008 relate to perioperative care: timing of antibiotic prophylaxis and selection of prophylactic antibiotic. CMS also proposes to package payment for all ancillary imaging, intraoperative, and observation services into a

Physician assistants report released

bundled payment for the primary diagnostic and treatment procedures with which they are performed. To access the hospital OD proposal, go to [http://www.cms.hhs.gov/ASCPayment/05_CMS-1392P\(ASC\).asp](http://www.cms.hhs.gov/ASCPayment/05_CMS-1392P(ASC).asp).

In cooperation with 22 other surgical specialty societies, the College has issued the fourth edition of *Physicians As Assistants at Surgery*. This report reflects the consensus opinion of the surgical specialties about whether a physician assistant is required “almost always,” “some of the time,” or “almost never” for each surgical procedure listed in the American Medical Association’s *Current Procedural Terminology 2007*. In the foreword, the College warns health insurers, which use the report to make reimbursement decisions, that indications that a physician assistant would “almost never” be needed for some procedures does not imply that one is never needed. In addition, the report acknowledges that nonphysicians frequently may assist in operations, depending on local resources and individual patient needs. The report is available on the College’s Web site at <http://www.facs.org/ahp/pubs/2007physasstsurg.pdf>.

CMS publishes IPPS rule

On August 22, CMS published a final rule aimed at improving the accuracy of Medicare hospital payments under the acute care inpatient prospective payment system (IPPS) and providing incentives for hospitals to engage in quality-improvement efforts. More specifically, the IPPS payment reforms would restructure the inpatient diagnosis-related groups to account more fully for the severity of each patient’s condition. In addition, the rule includes provisions to ensure that Medicare no longer pays the additional costs of certain hospital-acquired, preventable conditions. It also expands the list of publicly reported quality measures.

Payments to all hospitals will increase by an estimated average of 3.5 percent for fiscal year (FY) 2008 when all provisions of the rule are taken into account, primarily as a result of the 3.3 percent market basket increase. Payments to specific hospitals may increase more or less than this amount, depending on the patients they serve. For instance, urban hospitals generally treat more severely ill patients and are estimated to receive a 3.8 percent increase in payments.

With respect to the hospital-acquired complications, the rule implements a provision of the Deficit Reduction Act of 2005 (DRA) that prevents Medicare from giving hospitals higher payment for the additional costs of treating a patient who acquires a condition during a hospital stay. More specifically, the DRA requires hospitals to begin reporting secondary diagnoses that are present upon patient admission, beginning with discharges on or after October 1, 2007. Beginning in FY 2009, cases with these conditions would not be covered unless they were present upon admission. The rule identifies eight conditions, including three serious, preventable events (sometimes called “never events”), that meet the statutory criteria. These include objects left behind in surgery, air embolism, and blood incompatibility. The full text of the regulation is posted on the CMS Web site at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-FC.pdf>.