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Rule prohibits physician self-referral

On August 27, the Centers for Medicare & Medicaid Services (CMS) issued final regulations prohibiting physicians from referring Medicare patients for certain items, services, and tests provided by businesses in which they or their immediate family members have a financial interest. This regulation represents the third phase of rulemaking to implement the physician self-referral prohibition commonly referred to as the Stark Law. This third phase of rulemaking responds to public comments on the interim final rule published in March 2004, which served as the second stage of regulation development. The final rule does not establish any new exceptions to the self-referral prohibition but makes refinements that could permit or, in some cases, require restructuring of some existing arrangements. Based on public comments on the 2004 rule, this final regulation includes the following actions:

- It provides enhanced flexibility in structuring nonabusive compensation arrangements. For example, rules regarding physician recruitment and retention payments are expanded to permit recruitment of more physicians into extended areas when needed.
- It provides relief for inadvertent violations of the self-referral prohibition under certain circumstances.
- It reduces the regulatory burden for compliance with certain exceptions. For example, the phase III final rule eliminates the requirement that entities providing professional courtesy give written notice to an insurer of a reduction of any coinsurance obligation.
- It clarifies the agency's interpretation of existing regulations.

The final rule was published in the September 5 *Federal Register*. For more information, visit the CMS Web site at <http://www.cms.hhs.gov/PhysicianSelfReferral/>.

CMS proposes new rules for ASCs

CMS recently issued a proposal to revise the requirements that ambulatory surgical centers (ASCs) must meet in order to bill Medicare. This proposed rule would update the existing ASC conditions for coverage to reflect contemporary standards of practice in the ASC community, as well as recommendations from the U.S. Department of Health and Human Services' Inspector General.

The procedures most commonly performed at ASCs currently include cataract removal and lens replacement, other eye procedures, and colonoscopy. However, the specific types of procedures that will be covered when performed in an ASC and the reimbursement rates that will apply have changed dramatically as a result of the final ASC rule that CMS issued July 16. That regulation provides ASC payment for additional surgical procedures and creates a more balanced relationship between reimbursement levels for services furnished in ASCs and the same services performed in either a hospital outpatient department or a physician's office. As a result, CMS anticipates that some of the new ASC procedures currently performed in the hospital outpatient department and the physician's office will move to the ASC setting. Also on July 16, CMS issued a proposed rule setting payment rates and adding procedures to the ASC-covered list, effective for ASC services performed on or after January 1, 2008.

The most recent proposed rule changes include the following:

(1) a quality assessment and performance improvement condition that enables ASCs to take steps to ensure quality care; (2) a new disaster preparedness plan standard; (3) requirements for radiologic services provided in an ASC to ensure they are parallel to those for laboratory services; (4) a new patients' rights condition to address disclosure of physician financial interests in the ASC, advance directives, the grievance process, and confidentiality of clinical records; (5) expansion of the infection control requirement to the condition level; and (6) a comprehensive patient assessment requirement to ensure that accurate and thorough assessments are conducted to ensure appropriate and safe operative care.

The proposed rule is posted at <http://www.cms.hhs.gov/CFCsAndCoPs/Downloads/amburgreg.pdf>.

CBO projects rise in Medicare spending

The Congressional Budget Office (CBO) recently projected that Medicare spending will increase 16.9 percent in fiscal year (FY) 2007, which is much higher than the anticipated 6.9 percent growth in Social Security costs. One explanation for the extraordinary increase in Medicare spending is the fact that FY 2007 is the first full year in which the new prescription drug program will be in effect; accelerated enrollment in the Medicare Advantage program also is cited. Furthermore, despite reductions in Medicare physician payments scheduled to occur in the coming years, spending growth for physician services is projected to rise from 6 percent in 2008 to nearly 9 percent in 2017. To view *The Budget and Economic Outlook: An Update*, go to <http://www.cbo.gov/ftpdocs/85xx/doc8565/08-23-Update07.pdf>.

Bush vetoes SCHIP bill

On October 3, President Bush vetoed the \$35 billion, five-year expansion of the State Children's Health Insurance Program (SCHIP). The President had said he would veto the legislation because he believed it set funding for the program too high and that offering the program to more children would lead to the "federalization" of health care. President Bush's veto means that SCHIP, which provides health insurance to children in low-income families with working parents, will be financed by a continuing resolution that maintains funding at current levels.

Before the veto, the College sent letters relevant to the legislation, which omitted provisions pertaining to Medicare physician payment that were included in the original House bill. One letter was addressed to President Bush and urged him not to veto the SCHIP bill because of its importance in preserving access to care for low-income children. A copy of this letter is posted at <http://www.facs.org/ahp/views/schip.html>. In anticipation of the probability that the Medicare-related provisions would be excluded from compromise legislation, the College and a number of surgical specialty societies wrote to all members of the Senate, urging them to halt physician payment cuts scheduled for 2008 and 2009 and to establish a system of separate spending targets and conversion factors as a step toward enacting true Medicare payment reforms. The College and the surgical societies also wrote to the House Ways and Means Committee about a technical issue raised by the original SCHIP reauthorization bill. Copies of these letters are available at <http://www.facs.org/ahp/views/medicare2008.html>.