

H.R. 3162
The Children's Health and Medicare Protection Act of 2007
(CHAMP Act)

Selected Provisions

Key SCHIP Provisions of H.R. 3162

- Expands the State Children's Health Insurance Program (SCHIP) by nearly \$50 billion over the next five years to a total of \$75 billion. This increase in funding is estimated to allow an additional 5 million children to obtain coverage under the program that currently covers 6 million children. The SCHIP program is scheduled to expire on September 30th.
- Creates a new "outreach bonus" to states that excel in covering eligible uninsured children.
- Retains the current program eligibility limit of 200% of federal poverty level, but permits state waivers to cover certain individuals
- Allows states to cover uninsured children in SCHIP up to age 21; pregnant women and allows states to cover legal immigrant children and legal immigrant pregnant women
- Establishes a demonstration program for employers to buy SCHIP coverage for uninsured children of workers.

Key Medicare Provisions of H.R. 3162:

- Replaces the Medicare SGR cuts in 2008 (10%) and 2009 (projected to be 5%) with a 0.5 percent positive update in 2008 and 2009
- Beginning in 2010, replaces the SGR with a system of separate updates (mini-SGRs) for physician services grouped into one of six categories: 1) Primary and Preventive Services; 2) Other Evaluation and Management Services; 3) Major Procedures, 4) Anesthesia Services; 5) Imaging Services; and 6) Minor Procedures and Other Services
- The Primary Care & Preventive Service category annual allowed growth would equal growth in the gross domestic product (GDP) plus 2.5%; growth in the other five categories would be tied to GDP. The AMA estimates that the separate expenditure targets for each of these categories could result in cuts of as much as 12% in 2010 and 2011. The conversion factors for all six categories would be frozen at the 2012 rate from 2013 through 2017
- Beginning in 2010, removes the cost of lab tests and Medicare Part B drugs from the calculation of growth in expenditures for the physician payment formula, and national coverage determinations would now be allowed growth, no longer penalizing physicians (these provisions are issues AACE has worked in conjunction with the AMA to exclude from the SGR calculation for the last several years.)
- Establishes an expert panel to identify procedures paid under the Physician Fee Schedule (PFS) that are potentially over-valued or mis-valued
- Effective in 2009, provides a 5% bonus payment to physicians in counties with the lowest per capita Medicare spending
- Provides a two-year extension of the floor on Medicare work geographic adjustment

- Beginning in 2010, requires accreditation for facilities that provide diagnostic imaging services in order to receive reimbursement for those services from Medicare. For facilities providing ultrasound services, the accreditation requirements are not effective until 2012
- Requires a 50% reduction in the technical component for imaging services involving contiguous body parts
- Requires claims for imaging services (TC and Professional) to be billed separate – in other words, no more global billing
- Increases the assumption of the utilization of imaging equipment from 50 to 75% - this would reduce the practice expense relative value unit and significantly reduce the practice expense/technical component payment
- Sets interest rates for capital purchases at the prevailing rate in the market – but no higher than 11 percent
- Eliminates coinsurance and exempts deductibles from Medicare preventive services
- Reduces the number of meetings of the Practicing Physicians Advisory Council quarterly meetings to once a year, unless otherwise authorized by the Secretary
- Reduces the inpatient and outpatient hospital updates by 0.25% in 2008
- Eliminates whole hospital exception to the prohibition on physician self-referrals, although it “grandfathers” existing specialty hospitals. Existing specialty hospitals would have to meet new standards within 18 months of enactment.
- Calls for the Government Accountability Office (GAO) to analysis codes that are commonly furnished together to increase the use of "bundled payment methodologies
- Establishes a system that provides confidential feedback to physicians in Medicare about how their practice patterns compare to peers in the same locality and nationwide - system to be implemented by the Secretary of HHS
- Repeals the bonus fund for the Physician Quality Reporting Initiative (PQRI) after 2007 but allows it to continue as a voluntary program. The funds set aside for this (\$1.35 billion) are used in the bill to pay for the SGR positive updates in 2008 and 2009. (Note: CMS has different ideas on this. In the proposed 2008 Physician Fee Schedule Rule that was recently released, CMS proposes to use the \$1.35 billion to continue PQRI bonus payments in 2008. Also, the reporting program is supported by the Chairman (Senator Baucus) and Ranking Republican (Senator Grassley) of the Senate Finance Committee so whether repeal of the PQRI bonus would survive in a final House-Senate conference agreement is questionable.)
- Effective January 1, 2009, provides the Secretary of HHS with authority to reduce the work values for a physician service if the annual rate of growth in the spending for that service exceeds the average annual rate of growth in spending for all Medicare physicians’ services by more than 10 percentage points during that year.
- Establishes an expanded medical home demonstration program for up to 500 medical practices
- Establishes a federally funded Center for Comparative Effectiveness Research in the Agency for Healthcare Research and Quality responsible for conducting research on the outcomes, effectiveness, and appropriateness of health care services. Creates an independent Comparative Effectiveness Commission to set priorities for the Center

- Requires the Secretary of HHS to designate a single organization, such as the National Quality Forum, to establish a national strategy for performance measurement, coordinate measure development, and endorse national consensus health care measures

Key Financing Provisions of H.R. 3162

- Raises the federal cigarette tax by an additional 45 cents a pack, to 84 cents.
- Eliminates the differential in payments between Medicare Advantage plans and fee-for-service Medicare (reported to be 12% higher than FFS), saving a reported \$50 billion over the next five years and \$157 billion from 2008 to 2017.