

Dateline Washington

prepared by the Division of Advocacy and Health Policy

Medicare reforms address physician concerns

In long sessions completed on June 26, both the Senate and House passed Medicare reform legislation before leaving for the traditional July 4 recess. The House passed H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003, by a narrow vote of 216-215. Most notably for surgeons, the House bill provides for Medicare physician payment updates of at least 1.5 percent in 2004 and 2005. Under current law, it is estimated that physician reimbursement will be reduced by an estimated 4.2 percent in 2004, with further negative updates occurring in subsequent years.

In contrast, the Senate overwhelmingly passed its own version of Medicare reform legislation, S. 1, by a margin of 76-21. For surgeons and other physicians, the legislation is not quite as helpful. S. 1 does not include a provision for a positive update for physicians. However, Sens. Jon Kyl (R-AZ) and Arlen Specter (R-PA) both offered resolutions regarding the Medicare payment problem, which were included in the final bill. These resolutions urge Congress to fix the problem to prevent additional cuts in physician payments. While these resolutions do not have the force of law, they will strengthen the negotiating position for physicians when House and Senate conferees meet to resolve differences between the two bills.

Surgeons should urge their elected officials to support provisions in the Medicare package that would avert scheduled cuts and ensure a positive update for 2004 and 2005 by using the College's Legislative Action Center at <http://capwiz.com/facs/home/>. For more information, contact ahp@facs.org.

National Trauma Awareness Month events held

The month of May marked the fifteenth anniversary of National Trauma Awareness Month. To help call public attention to trauma as a persistent public health concern, the College hosted two events in Washington, DC.

On May 21, the ACS Committee on Trauma (COT) sponsored a briefing for the Washington representatives of state governors. The event highlighted draft findings of a soon-to-be released government study showing the states' baseline-level of disaster preparedness and trauma care system capabilities six months after the September 11, 2001, terrorist attacks. The program, hosted by Kurt Newman, MD, FACS, vice-chief of pediatric surgery at Children's National Medical Center, defined the elements of a comprehensive trauma care system and detailed the activities of the Health Resources Services Administration's (HRSA's) National Trauma-EMS Systems Program. HRSA officials believe their study will provide a snapshot of the states' response capabilities immediately following September 11.

One week later, the College sponsored a special briefing at the National Press Club to educate the media and the public about the current state of trauma system development across the country. In addition, COT leadership showcased select findings from the second annual report of the College's National Trauma Data Bank™ (NTDB™), highlighting its promise as a tool for developing better injury prevention programs and for improving care of the injured patient.

During the briefing, COT Chair Wayne Meredith, MD, FACS, and

NQF suggests “safe practices”

John Fildes, MD, FACS, Chair of the COT subcommittee on the NTDB, urged Congress to quickly pass the Trauma Care Systems Planning and Development Act of 2003 and to significantly increase funding for the program in 2004.

At its annual meeting in Los Angeles, CA, last May, the National Quality Forum (NQF) released a report outlining “safe practices” that hospitals should report to the public. One practice identified in the report advises patients that they may benefit from being treated at hospitals that perform a high volume of the specific procedures they need. These include operations such as abdominal aortic aneurysm repair, coronary artery bypass graft, carotid endarterectomy, esophagectomy, and pancreatectomy.

Large health care purchasers, including the Centers for Medicare & Medicaid Services, have asked NQF to develop standard measures of health care quality so that consumers may use the information to compare providers and to purchase services that fit their individual needs.

In addition, demonstration projects are under way to determine whether financial incentives encourage high performers to maintain an acceptable level of care. The “pay for performance” movement has been advanced by the LeapFrog Group, which represents large employers who are concerned about escalating health insurance rates. These purchasers hope to find new ways to control costs while allowing their employees to assume a greater role in selecting their care.

In the course of these discussions, the College has insisted that proper risk adjustment is essential to measuring the quality of surgical care. In addition, the College believes that so-called pay for performance strategies are problematic because the current designs focus on process measures that are best used to manage chronic rather than surgical care. Finally, the College has continued to highlight its promising efforts to validate the Veterans Affairs’ National Surgical Quality Improvement Program’s (NSQIP’s) use in the private sector, as well as other measurement efforts developed by the surgical specialty societies.

Hearings focus on physician quality

As part of the yearlong series of hearings on health care competition law and policy, the Federal Trade Commission (FTC) and the Department of Justice focused their joint May and June sessions on quality and consumer information. LaMar S. McGinnis, Jr., MD, FACS, testified on behalf of the College at a May 29 hearing.

“Quality improvement is an important aspect of practice that has efficiency-enhancing effects greatly outweighing their anticompetitive effects,” Dr. McGinnis said. “The College stresses the importance of practices implementing, tracking, incorporating, and updating data measures or standards of care suggested by their professional societies—formulated in conjunction with patient advocates and consumers at large.

“We continue to encourage surgeons to include the consumer dimension in their clinical discussions,” Dr. McGinnis added. “The give and take of that dialogue will help formulate what is best for the patient’s care in a truly collaborative way.”