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prepared by the Division of Advocacy and Health Policy

Medicare physician payment bills introduced

Two bills have been introduced in Congress to forestall Medicare physician payment reductions. Although Congress passed legislation two years ago to prevent payment cuts in 2003, 2004, and 2005, the flawed sustainable growth rate (SGR) methodology used to determine Medicare fee schedule updates was left in place for 2006 and future years. As a result, the Centers for Medicare & Medicaid Services (CMS) estimates that Medicare fee schedule payments will be reduced by approximately 4.3 percent next year and between 4 and 5 percent annually through 2011.

On May 12, Reps. Clay Shaw (R-FL) and Ben Cardin (D-MD) introduced legislation in the House that would broadly reform the method used to determine Medicare payments to physicians. The bill, H.R. 2356, would repeal the SGR methodology entirely and replace it with a mechanism more similar to the one used to determine annual Medicare payment updates for other providers such as hospitals. The bill would base physician updates on the Medicare economic index (MEI), which reflects the annual change in physicians' costs to care for patients. Although the proposal mirrors recommendations from the Medicare Payment Advisory Commission and has been endorsed by medical and surgical organizations, its steep price tag—estimated by the Congressional Budget Office (CBO) at nearly \$155 billion over 10 years—makes passage unlikely.

Sens. Jon Kyl (R-AZ) and Debbie Stanbenow (D-MI) introduced the Preserving Patient Access to Physicians Act, S. 1081, on May 19. This more limited legislation would halt the anticipated reductions and increase Medicare payments to physicians for a two-year period—by 2.7 percent in 2006 and by the MEI, estimated at 2.6 percent, in 2007. Although less costly than H.R. 2356, the CBO estimates that the Senate bill would still increase Medicare spending by nearly \$88 billion over 10 years.

To maintain the visibility of this issue, Fellows are encouraged to contact their members of Congress and ask them to support and co-sponsor either S. 1081 or H.R. 2356. To learn more about the legislation and to obtain a sample letter that can be sent to senators and representatives, visit http://capwiz.com/facs/mail/oneclick_compose/?alertid=7672826.

ACS testifies on patient safety and quality initiatives

The House Energy and Commerce Subcommittee on Health held a hearing June 9 on patient safety and quality initiatives. F. Dean Griffen, MD, FACS, Chair of the ACS Patient Safety and Professional Liability Committee, testified on behalf of the College, highlighting the organization's more than 80 years of championing patient safety and high-quality surgical care. Dr. Griffen also emphasized that the College is actively engaged in more recent quality-related initiatives, such as the ACS National Surgical Quality Improvement Program.

The College is renewing calls for a patient safety bill and is negotiating with senators to achieve passage of a compromise bill, using legislation approved in the House last year as a starting point. A copy of Dr. Griffen's testimony can be found at <http://www.facs.org/ahp/testimony/patientsafety.html>.

EMTALA panel examines on-call requirements

The technical advisory group (TAG) that advises CMS on regulations related to the Emergency Medical Treatment and Active Labor Act (EMTALA) and their application to hospitals and physicians met June 15-17. The meeting focused on the physician on-call requirement in EMTALA, also known as the “patient anti-dumping statute.”

In its comments to the TAG, the College urged the panel to reject any legislative or regulatory efforts that would require surgeons to take emergency call as a condition of Medicare participation or as a stipulation for obtaining hospital privileges. Several hospital associations prompted the TAG to consider linking on-call requirements to Medicare physician participation and hospital privileges. Most of the panel members believed such a proposal would lead to a dramatic reduction in physician participation in the Medicare program and, as a result, an access to care problem for seniors and the disabled. Hence, they voted to recommend that CMS *not* require physicians to serve on-call as a condition of Medicare participation.

During its next meeting, scheduled to take place in the fall, the EMTALA TAG will consider additional proposals to address the shortage of on-call specialists. The panel also will continue to examine other related EMTALA issues, such as the problem of inappropriate transfers and the impact of specialty hospitals on EMTALA-mandated care.

The EMTALA TAG is composed of 19 members, including four ACS Fellows: general surgeon Richard Perry, MD, FACS (Phoenix, AZ); pediatric surgeon David Tuggle, MD, FACS (Oklahoma City, OK); orthopaedic trauma surgeon James Nepola, MD, FACS (Iowa City, IA); and neurosurgeon John Kusske, MD, FACS (Orange, CA).

Medicare drug benefit education campaign launched

At a press event on June 16, President George W. Bush, Health and Human Services Secretary Mike Leavitt, and CMS Administrator Mark McClellan, MD, PhD, kicked off the “Medicare Covers America” campaign to educate beneficiaries about the prescription drug benefit that will take effect January 1, 2006.

Enrollment in the voluntary prescription drug coverage plan begins November 15, and all beneficiaries, regardless of whether they have existing drug coverage, will be eligible to participate. All beneficiaries will have a choice of plans, and those plans will: (1) be available in all parts of the country; (2) cover both brand-name and generic drugs; and (3) allow purchase at community pharmacies or through the mail. Low-income beneficiaries will qualify for subsidized coverage.

Surgeons may direct patients to the following resources for further information: the CMS Web site <http://www.cms.hhs.gov/partnerships/>, a special White House educational Web page at <http://www.whitehouse.gov/infocus/medicare/>, or 1-800-MEDICARE.