Washington Watch

MedPAC Recommends 2006 Increase for Physicians

by Kathleen Ream, Director of Government Affairs

In a move estimated to cost $1.5 billion over one year, on January 12, 2005, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress increase physician Medicare reimbursements by 2.7 percent in 2006.

The change would cost $5 to $10 billion over five years, taking into account expected Medicare physician pay reductions forecast for 2006-2012, under the sustainable growth rate formula (SGR). Cristina Boccuti, a MedPAC staff analyst, told the commissioners that any positive update would score as a large spending increase. The 2.7 percent hike, which will be in the commissioners' March report to Congress, would maintain beneficiaries' access to physicians.

Despite the recommendation, the annual physician update is controlled by the SGR, an annual target intended to control the growth in expenditures for physicians' services. Under the formula, when spending for physician services exceeds the SGR, payments must be reduced to compensate for the extra spending. Unless Congress intervenes this year, physicians will receive an approximate five percent reduction in reimbursements in 2006.

During the same session, the commissioners approved six recommendations intended to encourage more appropriate use of physician services and improve quality of care. Two of the recommendations dealt with the "Stark" law that prohibits physicians from referring Medicare/Medicaid patients for certain services to providers with which the physicians have financial relationships. However, facilities that offer nuclear medicine, including PET scans, are not included.

MedPAC staff focused on the rapidly growing volume of imaging services as part of a broader measurement initiative. Studies have shown that more imaging is not associated with improved survival in patients with heart attack, colon cancer, and hip fracture.

Of particular interest to AAEM members, the commissioners recommended that Congress direct the Secretary of Health and Human Services to use Medicare claims data to measure fee-for-service physician resource use and share the results with physicians confidentially to educate them about how they compare with aggregated peer performance. MedPAC believes that physician education through profiling will result in decreased utilization of imaging services over time.

Emergency physicians performing ultrasounds in the ED may be affected by another recommendation. The commissioners also recommended that Congress direct the Secretary to set standards for all providers who bill Medicare for performing diagnostic imaging services. While the committee did not dictate the content of such standards, the discussion focused on equipment, credentials of non-physician staff such as technicians, image quality, supervising physicians, and patient safety.

Recommendations also addressed standards for physicians who bill Medicare for interpreting diagnostic imaging studies. These standards are likely to address physician training, education, and experience. Commissioners did express support for standard setting by specialty certification boards.

Clarification was provided by MedPAC staff on teleradiology – the practice of some facilities (specifically EDs) to transmit radiologic images on off hours to a remote site (frequently overseas) for a "wet reading." They reiterated that reimbursement from Medicare for these services was applicable only to approved Medicare providers for services that are provided within the US. More information on the January meeting including transcripts of the presentations is available at **www.medpac.gov.**

Screening Efforts Can Reduce Hospital Costs

A new study examining emergency department patients with addictions find screening efforts can result in increased savings to hospitals. In the study, Dr. Larry Gentilello, professor of surgery at the University of Texas Southwestern Medical Center, concludes that, "Alcohol is by far the leading risk factor for injuries. Patients are most likely to consider changing a harmful behavior when that behavior has caused a crisis or a severe problem in their life. It appears that an injury makes patients with an alcohol problem much more responsive to counseling. If brief interventions were offered routinely to these patients nationwide, the annual net savings to hospitals and insurers could be up to $1.82 billion."

Cost savings included avoiding the expense of repeat injuries caused by alcohol, the leading cause of injury; Gentilello estimated that hospitals save $3.81 for every dollar spent on brief counseling of ER patients. The study results will appear in the April 2005 issue of *Annals of Surgery.*

Many U.S. hospitals do not screen patients for alcohol use because a 1947 law, the Uniform Accident and Sickness Policy Provision Law (UPPL), allows insurers to deny payment for treatment of alcohol-related injuries. The UPPL was promulgated when treatment for alcohol problems was generally not available, and regional trauma centers did not exist. It is still on the books in 36 states and the District of Columbia. Six states, however, have recently repealed this law.

OSHA Best Practices Released

OSHA Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances is designed to provide hospitals with practical information to assist them in developing and implementing emergency management plans that address the protection of hospital-based emergency department personnel during the receipt of contaminated victims from mass casualty incidents occurring at locations other than the hospital. The document focuses on suggestions for appropriate training and suitable personal protective equipment for healthcare employees who may be exposed to hazardous substances when they treat victims of mass casualties. It also includes several informational appendices with practical examples of decontamination procedures and medical monitoring for first receivers who respond to a mass casualty incident.

The OSHA document can be found at **www.osha.gov/dts/osta/bestpractices/firstreceivers_hospital.html**.

continued on pg 19

Washington Watch - continued from pg 18

AAEM's Government Relations Resources

Advocacy is more than just understanding the issues. To make a difference, you have to make your voice heard. The involvement of individual emergency medicine physicians is vital to the success of AAEM's grassroots efforts. To assist you in your government relations activities, AAEM provides the following services and information:

- **AAEM E-Mail Alerts**
  AAEM E-Mail Alerts provide strategic information to affect key policy issues of concern to emergency medicine. If you would like to receive future Alerts, send a note to aaemgov@aol.com or sign up directly from the homepage of AAEM's Legislative Action Center accessible at **http://capwiz.com/aaem/home**.

- **Legislative Action Center**
  The Legislative Action Center located on AAEM's Web site **www.aaem.org** is "one-stop" shopping for federal legislative and regulatory information. It contains the important issues that AAEM is tracking for you, recent votes, current bills, and other relevant items. You can search the congressional database by name, state, committee, or leadership, and send messages to your congressional delegation directly from the site.

- Additional features include:
  "Sponsor Track" which attaches information on relevant bill sponsorship on Members' bio pages; A "Vote Scorecard" listing every Member of Congress and how they voted on bills of interest to AAEM; "Megavote" provides you with a weekly e-mail on the voting patterns of your Representative and Senators; A searchable "Guide on National and Local Media" including newspapers, magazines, and TV networks and stations; users can send e-mails, faxes or printed letters to newspaper journalists, radio talk show hosts, and television commentators; and detailed "Campaign Contribution Data".

- *Washington Sentinel*
  The ***Washington Sentinel*** – AAEM's monthly newsletter on legislative and regulatory issues of concern to emergency medicine. You can receive the ***Washington Sentinel*** as a downloadable PDF document by sending an e-mail note to aaemgov@aol.com.

Point - continued from pg 16

As a result of this, health care costs in the US consume close to 15% of our GDP, as compared to 7-10% in countries in most of the rest of the world, the majority of which have national, universal health care. Moreover, we rank among the lowest of the industrialized countries in measures such as infant mortality, infant birth weight, and longevity and patient satisfaction.

I am an advocate for single-payer national health insurance, universal health care that would cover everyone. This is the only way to address the systemic problems of health care in the United States. Health care should be a right not dependent on financial status or the vagaries of employment, particularly in an economy that creates fewer and fewer long-term jobs with decent benefits.

Everyone should have access to a regular source of care so they will only show up in emergency rooms when there is a true emergency. As physicians in the richest, most powerful nation in the world, we are troubled by the fact that vast segments of our population cannot afford the health care they need and are unable to pay for the their prescription drugs. What is our response to seeing so many patients who have put off treatment until they are forced to head to the nearest emergency room? And how do we feel when we find that medical bills are the cause of half of all bankruptcy cases in this country?

In a time when tort reform has become the rallying cry in the battle over onerous malpractice fees, we should adopt a plan that will put physicians and patients back on the same side, where the high costs of settlements would be slashed because the costs of long-term care responsible for so much of those high settlements would be included in the budget for coverage that all of us would have?

The savings from switching to a single payer, Expanded and Improved Medicare for All system would pay for healthcare and prescription drug coverage for everyone. As AAEM has taken the lead in espousing democratic principles within our specialty, so should we take the lead in espousing proper healthcare coverage for all in our society.

BCEM - continued from pg 13

medical, pediatric, and OB/GYN experience. Internal Medicine residents have minimal surgical, trauma, pediatric, orthopedic, and OB/GYN experience, and so on. These residents have limited exposure to the breadth of patients seen in the ED, managing patient flow, and performing many ED procedures such as LPs, vaginal deliveries, procedural sedation, etc.

Many non-residency trained BCEM physicians are likely outstanding doctors, and some may be better than many of their residency trained ABEM/ABOEM-certified colleagues. However, at the end of the day, we should be doing what is in the best interest of our patients. It takes supervised experience to become a good emergency physician. It is not fair to patients when unsupervised physicians "learn on the job." I'd imagine many BCEM physicians performed their first (or second or third) chest tube, vaginal delivery, difficult airway, etc. without supervision. This has the potential for disastrous outcomes. How do you fix mistakes when you don't know what you did wrong?

AAEM and AAEM/RES are taking a strong stand on this issue. As the only EM specialty society requiring ABEM/ABOEM-certification for full membership, this issue related to one of the core parts of our mission statement. In addition, we are reaching out to other organizations such as ACEP, EMRA, CORD, SAEM, AACEM, for their help. We are prepared to represent our membership in each state where this issue arises. As we take this battle to individual states where BCEM physicians bring this issue forward, we will need our local members to assist us in representing our case. Please keep informed through AAEM's communications to you, and we hope you will offer to participate if and when we come to your state.

Mark Reiter MD MBA
EM-2, University of North Carolina
Vice President, AAEM Resident Section