



Senate Fails to Delay Medicare Physician Payment Cut

On February 25, the House of Representatives passed H.R. 4691, legislation that would extend a number of expiring programs for 30 days, including current Medicare physician payment rates, once again postponing the 21% cut in payments. The Senate attempted unsuccessfully to pass the same bill by unanimous consent, but objections were raised by Senator Jim Bunning (R-KY) on the basis that the \$10 billion cost of the program extensions was not offset. The Senate adjourned for the weekend, so the 21% Medicare physician payment cut will take effect as scheduled Monday, March 1. The Centers for Medicare and Medicaid Services (CMS) notified its contractors to hold Medicare physician claims for 10 business days, effective March 1, in hopes that the Senate will not allow this cut to occur.

For too many years, physicians have been threatened with huge cuts in Medicare payments, only for Congress to act at the last minute with a temporary reprieve that grows the problem and increases the cost of a permanent solution. Congress created the SGR (Sustainable Growth Rate) mess and only it can fix the problem. Continuing this game of "kick the can" harms the stability and security of the entire Medicare system and the millions of seniors it is intended to serve. Your senators need to hear from you on this issue.

[Click here to go AAEM's Legislative Action Center and contact your Senators today!](#)

Report Reveals Gaps in Nation's Emergency Preparedness

According to the annual report sponsored by the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF) – *Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism* – the H1N1 flu outbreak exposed gaps in the nation's ability to respond to public health emergencies including, but not surprising, the fact that the economic crisis is straining an already fragile public health system.

Richard Hamburg, Deputy Director of TFAH, called for renewed attention to and investment in prepared-

ness. "The H1N1 outbreak has vividly revealed existing gaps in public health emergency preparedness. The *Ready or Not?* report shows that a band-aid approach to public health is inadequate. As the second wave of H1N1 starts to dissipate, it doesn't mean we can let down our defenses. In fact, it's time to double down and provide a sustained investment in the underlying infrastructure, so we will be prepared for the next emergency and the one after that."

The report found that 20 states scored six or less out of 10 key indicators of public health emergency preparedness, and nearly two-thirds of the states scored seven or less. Eight states tied for the highest score of nine out of 10: Arkansas, Delaware, New York, North Carolina, North Dakota, Oklahoma, Texas, and Vermont. Montana had the lowest score at three out of 10.

Overall, the report found that the investments made in pandemic and public health preparedness over the past (Cont'd page 2)

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Report Reveals Gaps in Nation's Emergency Preparedness (Cont'd from page 1)

several years dramatically improved U.S. readiness for the H1N1 outbreak. But it also found that decades of chronic underfunding meant that many core systems were not at-the-ready. Key concerns included a lack of real-time coordinated disease surveillance and laboratory testing, outdated vaccine production capabilities, limited hospital surge capacity, and a shrinking public health workforce. In addition, more than half of the states have had cuts to their public health funding, and federal preparedness funds have been cut by 27% since FY 2005. Such cuts put improvements made since the September 11, 2001 tragedies at risk.

The report also offers a series of recommendations for improving preparedness. These include: ensure stable and sufficient funding; conduct an H1N1 after-action report and update preparedness plans with lessons learned; increase accountability and transparency; and improve community preparedness. The full report and a list of all the indicators and states' scores are available on TFAH's web site at www.healthyamericans.org and RWJF's web site at www.rwjf.org.

The Latest on Health Care Reform

President Barack Obama wrapped up last Thursday's health care summit with strong words for Republicans: Find common ground with Democrats in the next six weeks or we're moving on without you and letting voters decide in November who was wrong.

From the States . . .

New Jersey Improves Access to Emergency Mental Health Services

On December 10, 2009, the New Jersey Senate overwhelmingly approved – by a vote of 38 to 0 – a trio of bills sponsored by Senate President Richard J. Codey (D-Essex) providing substantial relief for patients seeking critical emergency mental health services. Having initially approved the bills last June, the General Assembly concurred with the technical amendments approved by the Senate, and the bills were sent to then Governor Jon Corzine (D) and signed into law on January 16, 2010.

The bills – A3582/S2444, A3583/S2445, and A3584/S2446 – include the following:

- A requirement that the New Jersey Department of Human Services (DHS) develop a protocol to help streamline the transfer of mentally ill patients from general hospital EDs to an appropriate behavioral health setting if they have remained in the ED for 24 hours or longer.
- Requirements that DHS also provide/establish: clinical facilitators to help ensure that a patient awaiting placement is transferred to a behavioral setting that best meets the patient's clinical needs; a mechanism to enable the department to conduct ongoing assessments of patient flow and access to care; and objective criteria for identifying resources needed to ensure timely implementation of these procedures.
- A requirement that DHS develop appropriate safeguards to ensure that mental health patients in EDs are being thoroughly screened and recommended for the appropriate care.
- Requirements that the DHS and Department of Children and Families (DCF) commissioners develop standardized admission protocols and medical clearance criteria for transfer or admission of an ED patient to a state or county psychiatric hospital or short-term care facility, and for children seeking emergency mental services.