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Congress at a Stalemate on Many Health Care Issues

MEDICARE PAYMENT CUTS

Congress failed to pass legislation to stop the 10.6% cut in the physician reimbursement rate before leaving for its Independence Day recess on June 27. The House voted on June 24 to pass the bill (H.R. 6331) by a surprisingly large margin of 355 to 59 – a level of support that could overcome a presidential veto. The Senate, however, did not even try to vote on the bill until late in the day on June 26. By a vote of 58 to 40, the Senate refused to invoke cloture to proceed to the legislation, just shy of the 60 votes needed to move on. If cloture had been invoked, the chamber would have then cleared it for the President, who has threatened to veto it.

The Senate is expected to revisit the issue, possibly as early as next week. "We'll be back, and you'll have another opportunity to vote for this," said Majority Leader Harry Reid, D-NV, who changed his vote to "nay" to be on the winning side so that, under procedural rules, the bill could be brought back up.

To avoid disruption in health care services and payments resulting from the Congress' inability to stop the July cuts from occurring, the Centers for Medicare & Medicaid Services today said it has instructed its contractors to hold, for 10 business days, claims for dates of service in July. All claims for services delivered on or before June 30 will be processed and paid under normal procedures. After 10 business days in July, contractors will begin releasing claims into processing under the fee schedule which implements current law – resulting in claims being processed with the negative 10.6% update.

On June 27, Health and Human Services (HHS) Secretary Michael Leavitt issued a statement stating that HHS would take steps to "minimize the impact on providers and beneficiaries" following the inability of Congress to complete action on the Medicare bill. In response, Senators John D. Rockefeller (D-WV) and Charles Schumer (D-NY) sent a letter to Leavitt on June 30, saying the Administration "is misleading the public by claiming to provide a 'temporary hold' on payment which is already authorized by law in order to give the appearance of being helpful to doctors in the Medicare program." The Senators went on to say that current law requires all claims submitted by doctors to Medicare be withheld for 13 days before payment, for electronic claims. They said that Congress instituted this requirement (Section 1842(c)(3)(A) of the ***Social Security Act***) "in order to ensure Medicare contractors take sufficient time to properly review claims."

PRESERVING ACCESS TO MEDICARE ACT

On June 11, Senator Charles Grassley (R-IA), the Finance Committee's Ranking Minority Member, introduced a Republican Medicare reform package. The ***Preserving Access to Medicare Act***, S. 3118, was intended to block a July 1 physician payment cut and increase physician payments 0.5% through 2008 and 1.1% in 2009.

Under this bill, Section 1011 payments to hospitals that provide emergency services to undocumented immigrants would have been extended through 2010. S. 3118 also would have extended the Flexibility grant program for rural hospitals and expanded the outpatient "hold-harmless" provision for small (Cont'd page 2)

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Concerns Over Impending Medicaid Cuts Aired During Hearing

In early May, the House Oversight and Government Reform Committee held a two-day hearing on the new Medicaid regulations reducing federal funding to states (See previous article.). The hearing specifically explored whether the rules issued by the Centers for Medicare and Medicaid Services as part of an effort to curb fraud and waste within the Medicaid system will adversely affect the nation's ability to cope with a major disaster, as Committee Chair Henry A. Waxman (D-CA) maintains.

The Medicaid regulations in question were part of a series of seven regulations that opponents wanted put in moratorium until April 1, 2009. The House passed a bill (H.R. 5613) on April 23 approving the moratorium by a veto-proof margin, but Republicans had blocked the bill in the Senate. Consequently, the hearing also was aimed at stepping up pressure on Republicans to drop their opposition to H.R. 5613.

In an investigation of the regulations, Waxman's committee staff found that the measures were approved in spite of a directive from President Bush requiring federal departments to communicate about overlapping policy that could endanger U.S. security. In addition, his committee staff conducted a survey of ED capacity in seven major U.S. cities and found that, of 34 hospitals surveyed, none reported conditions that would allow them to treat a sudden influx of casualties equal to those seen following the Madrid train bombing in 2004.

According to Waxman, this insufficient hospital surge capacity, combined with the lack of documentation about the impact of the Medicaid regulations on national preparedness, illustrated a failure by the Departments of Health and Human Services and Homeland Security to ensure there are no impediments to care in the case of a medical emergency. Committee Republicans questioned the survey's findings, though, as well as the significance of the Medicaid regulations in an overall debate on emergency preparedness.

Those who took exception to the tie-in to terrorism preparedness included Representatives Christopher Shays (R-CT), Darrell Issa (R-CA), and Tom Davis (R-VA). Shays noted that he had voted for the moratorium because he agreed changes are needed to the Administration's Medicaid plan, but he cautioned that making them would not create adequate hospital "surge capacity" by itself. Issa said Democrats were exploiting long-known hospital capacity problems to score political points in a debate over Medicaid's future. Davis stated that "During a (Cont'd page 3)

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rural hospitals. Other provisions would have reimbursed critical access hospitals at 101% of cost for lab services provided in the same county.

MEDICAID RULES MORATORIUM

President Bush signed an Iraq war spending bill on June 30 that includes a moratorium delaying six Medicaid rules until April 2009. Last week Congress approved the moratorium, which delays rules covering certified public expenditures, intergovernmental transfers (IGT), and graduate medical education that would have a dramatic impact on hospitals, as well as rules affecting state provider tax laws, case management services, rehabilitation services, and school outreach. Congress excluded from the moratorium a proposed Medicaid rule that would narrowly define hospital outpatient services, jeopardizing community-based services such as screening, diagnostic and dental services for children as well as lab and ambulance services. It also removed provisions that appeared in the previous Senate version which would have imposed a moratorium on specialty hospitals.

In a related move, on May 23, the U.S. District Court for the District of Columbia ruled that CMS violated a congressionally imposed, one-year moratorium by attempting to issue the Medicaid IGT rule in final form on May 25, 2007, the same day President Bush signed the moratorium into law. Judge James Robertson ordered the rule vacated. The regulation, which would cut $5 billion in funding to safety net hospitals, must now be reissued by CMS.

Concerns Over Impending Medicaid Cuts Aired During Hearing (Cont'd from page 2)

catastrophic event hospitals have plans to clear out their emergency departments and free inpatient hospital beds in order to accommodate a surge of casualties." A memo prepared by the Committee's Republican staff said that the issue is more complex than current day-to-day concerns, and that gaps in medical surge capacity are better addressed through targeted investments than national reimbursement policy. Witnesses testified, however, that any loss in funding for hospitals would worsen their ability to deal with a large-scale emergency.

In his testimony, J. Wayne Meredith, chair of the general surgery department at Wake Forest University Baptist Medical Center, addressed the planned changes to the Medicaid program that would eliminate reimbursement for residents and interns at teaching hospitals and payments to public hospitals. Meredith said such changes would cost his hospital $36 million, on top of $4.5 million it spends on its trauma center and $13 million to care for the uninsured. "The hardest hit among them by the Medicaid regulations are those eight safety-net hospitals which serve as Level I and II trauma centers and operate the air ambulance services in their region."

> There is an "almost incomprehensible lack of recognition among some policymakers regarding the cause and effect relationships that exist between the fiscal pressures that have led to decreases in hospital capacity, ED gridlock, and our dwindling surge capacity."
>
> – Roger J. Lewis, Professor of Emergency Medicine
> Harbor-UCLA Medical Center

Three of the CMS regulations which limit the use of IGTs within a state to boost federal matching funds, drop Medicaid funding for graduate medical education, and limit Medicaid reimbursement for outpatient services were addressed by Colleen Conway-Welch, Dean of the nursing school at Vanderbilt University. She noted that the rule would cut $200 million in federal funding to the TennCare program that pays for health care services for low-income residents, and that Tennessee's safety net hospitals, "which play an even bigger role in emergency preparedness, would need to make difficult decisions to cut services and limit access." She added that the outpatient regulation would reduce clinic services, limiting the ability of the facilities to provide triage service and deliver care in an emergency.

Roger J. Lewis, a professor of emergency medicine and an attending physician at the Harbor-UCLA Medical Center, told the Committee that the Medicaid cuts would be devastating for publicly funded teaching hospitals. He stated that "it is difficult to claim that my hospital's Level 1 trauma center has any appreciable 'surge capacity' when our hospital routinely functions at greater than 100 percent capacity" and ED waiting times "are often greater than 24 hours." According to Lewis, the Los Angeles County Department of Health Services would lose $240 million per year as a result of two of the regulations, and Harbor-UCLA, part of the county system, will lose about $50 million. The services lost would be "equivalent to the closure of one of our major teaching hospitals," a potential loss of 90,000 ED visits a year.

On the second day of the hearing, both Leavitt and Chertoff testified. Leavitt told the panel that the new Medicaid regulations will not hurt hospitals' ability to prepare for terrorist attacks and other national emergencies. He stated, "Medicaid's mission is not emergency preparedness. It is to provide health care to people, not institutions." Over time, Leavitt said, states have inappropriately claimed Medicaid dollars for services not covered by the program. "This is not intended to be a hospital entitlement." He added that, if Congress believes more funding is needed to improve hospitals' emergency surge capacity then lawmakers should appropriate more money for that purpose. "I believe there are deficiencies in our surge capacity. I just don't believe Medicaid funds should be used to deal with that deficiency," he said.

In his turn before the Committee, Chertoff testified that it was unclear that more Medicaid funding would mean that hospitals would be better prepared to handle surge situations. "I'm going to be the first person to tell you that there are undoubtedly gaps that need to be plugged, some of which are planning gaps and some of which are capability gaps," he said. "What I can't tell you is that this is simply a matter of emergency rooms. I think it's a much more complicated issue than that."

Shorts . . .

Low-Income Children Predominate in ED Visits

According to the latest ***News and Numbers*** summary from the Agency for Healthcare Research and Quality (AHRQ), lower-income children made almost twice as many visits to hospital EDs than higher-income children in 2005. AHRQ's analysis, which was based on more than 12 million ED visits by children under age 18 in 23 states, compared the number of ED visits by children from low-income communities, where the average household income was $36,999, to those of children from high-income communities with an average household income of more than $61,000. The rate for those from low-income communities was 414 visits for every 1,000 children, while the rate for those from high-income communities was 223 visits for every 1,000 children.

AHRQ also found that:

- Children were treated and released in 96% of all visits. The reasons for those visits included: respiratory conditions; superficial injuries such as bruises; middle ear infections; open wounds such as cuts and scrapes on arms and legs; and muscle sprains and strains.

- For the 5% of children admitted to hospitals, the top reasons were: pneumonia; asthma; acute bronchitis; appendicitis; dehydration and other fluid and electrolyte disorders; depression and other mood disorders; and epileptic convulsions.

- Roughly 45% of the visits were covered by Medicaid, 43% were covered by private insurance, 9% were uninsured, and 3% had other types of coverage.

HHS Announces Grants to Boost Emergency Preparedness

On June 3, the Department of Health and Human Services (HHS) announced that grants totaling more than $1.1 billion are being awarded to health departments and hospitals in states, territories and the metropolitan areas of Chicago, Los Angeles, New York City, and the District of Columbia. The purpose of the funding is to upgrade preparedness for public health emergencies, including terrorism, pandemic influenza, and naturally occurring emergencies.

The money is being provided in two different ways. Through the Public Health Emergency Preparedness cooperative agreement, the Centers for Disease Control and Prevention (CDC) is distributing $704.8 million; and, through the Hospital Preparedness Program, HHS is distributing an additional $398 million.

HHS specified that the CDC-provided funds will be used to: integrate private and public health providers with emergency services providers; assess the medical needs of children and chronic disease sufferers in a public health emergency; and coordinate state and local preparedness and response. The hospital funds will be used to: improve communication and hospital bed tracking systems; advance registration of volunteer health professionals; develop processes for hospital evacuations and sheltering-in-place; and identify means of dealing with fatalities.

For more information regarding the Public Health Emergency Preparedness grants, go to **http://emergency.cdc.gov/planning/coopagreement/08/pdf/fy08announcement.pdf**. For information on the Hospital Preparedness Program grants, go to **http://www.hhs.gov/aspr/opeo/hpp/**.

New AHRQ Web Site Features Innovations in Health Care

AHRQ has launched a new Web site designed as a resource for physicians, nurses, and other health care professionals to help share information on approaches to reduce health care disparities and improve health care overall. The site – the Health Care Innovations Exchange at **http://www.innovations.ahrq.gov** – was launched with 100 examples of innovations in the delivery of health care services. That number, which includes useful descriptions of attempts at innovation that failed, will increase as the site is updated every two weeks.

Through learning and networking opportunities offered by the Exchange, users can: read articles and perspectives on the creation and adoption of innovation, and expert-generated commentaries on specific innovations; comment on specific innovations; participate in

topic-specific presentations and discussions; and join online forums that connect innovators with organizations that adopt them.

Since 2007, AHRQ has reached out to the health care community and called for the submission of potential health care innovations, but only the truly innovative initiatives are included in the exchange. The innovations must be new or perceived as new to a particular context or setting relative to the usual care processes. They must have potential for high impact on the delivery of patient care, whether preventive, emergent, chronic, acute, rehabilitative, long-term, or end-of-life. In addition, they should be designed to address the need for the reduction of health disparities in populations of interest to AHRQ, which include low-income groups, minority groups, women, children, the elderly, and individuals with special health care needs.

From the States . . .

Trial Courts Rule Cap on Noneconomic Damages Unconstitutional

A **Georgia** trial court has found the state's $350,000 limit on noneconomic damages unconstitutional. Fulton County Superior Court Judge Marvin S. Arrington, Sr. said the cap violated patients' equal protection rights and access to a jury trial. Lawyers involved expect an appeal, which would send the issue to the state Supreme Court.

A similar decision was made in **Illinois**, where a trial court last November struck down the state's $500,000 cap for violating the separation of powers between the Legislature and judiciary. The case was appealed to the state Supreme Court. The Litigation Center of the AMA and State Medical Societies, and the **Illinois** State Medical Society (ISMS) filed a friend-of-the court brief in May. A ruling is expected later this year.

Physicians say the court decisions threaten to undo improvements in the medical liability environment in their respective states. Noting that, in the past three years, **Georgia**'s medical liability insurance rates have stabilized, companies have reported an overall drop in claims filings and defense costs, competition is on the rise, and the state has seen a 10% increase in obstetricians at a time when few were practicing, Donald Palmisano, Jr., General Counsel to the Medical Association of **Georgia**, stated "What this all results in is greater access to care for patients, and that's what we should be looking at."

Despite similar progress in **Illinois**, ISMS president Shastri Swaminathan said excessive jury awards still plague the legal system, and that the state's cap is critical to help retain doctors. According to a February AMA report, states with noneconomic damage limits have an increased supply of high-risk specialists. Doctors in those areas also pay at least 17% less in insurance costs.

Trial lawyers, however, argue that the caps come at patients' expense and praise the courts for restoring their rights. The **Georgia** Trial Lawyers Association called attention to research contradicting AMA's report. A March study conducted by the Harvard School of Public Health and George Mason University showed that most ob-gyns' decisions to relocate or stop practicing are unrelated to insurance premiums or tort reform.

The **Georgia** case poses an additional threat to liability protections for physicians involved in emergency care. Plaintiffs challenged the validity of a provision under the reform statute requiring a higher standard of proof in emergency cases – an issue central to the underlying medical claim. The court said it would take up that question in a separate ruling.

Prior state Supreme Court rulings have invalidated other medical liability reforms. In 2006, the Georgia high court declared unconstitutional the venue portion of the liability reform statute that would have allowed defendants in joint medical liability cases to transfer lawsuits to the county where the alleged negligence occurred. And in 1976 and 1997, Illinois justices struck down award limits in medical liability cases.

Louisiana Bills Protecting Medical Professionals Go to Governor for Signing

A package of bills designed to protect medical personnel from lawsuits arising from health care delivered during declared emergencies is awaiting signature by Governor Bobby Jindal (R). Two of the measures, SB 301 and SB 330, sponsored by Senator Joel Chaisson, II (D-Destrehan), are inspired and backed by Anna

Pou, the New Orleans physician who was arrested but never indicted over patient deaths at Memorial Medical Center after Hurricane Katrina. The bills provide lawsuit protections for paid medical professionals not covered under the existing Good Samaritan Act.

Specifically, SB 301 states that a health care official cannot be held liable "as a result of an evacuation or treatment or failed evacuation or treatment" conducted according to the procedures of emergency medicine "and at the discretion of military or government authorities." An amendment adopted by the committee still allows suits for "wanton misconduct."

SB 330 goes a step further with a provision – added in the committee as a way to spell out when physicians, nurses, and others could expect protection – that grants limited immunity for medical personnel working within a disaster zone and giving medical care affected by the disaster. The bill also protects medical personnel from "simple negligence" but not from "gross negligence." The protection in both bills is intended to apply only to individual employees, not owners of the medical facilities in question.

In response to some confusion about SB 330's limited immunity provision, Pou's attorney, Rick Simmons, gave an example of a situation when immunity would not apply, i.e., a chemical spill in an area that does not directly affect the operations of a hospital where victims are treated.

A separate measure, sponsored by Representative Fred Mills (D-Parks), addresses immunity related to health care provided outside the disaster area. That legislation has been signed by Governor Jindal and goes into effect on August 15, 2008.

As for Louisiana's malpractice reform, another slate of bills altering the $500,000 cap on awards in medical malpractice suits appears dead for the session. Representative Nick Lorusso, (R-New Orleans) said representatives of the legal and medical communities will continue to work on potential compromises for next year's regular session.

Legislative Action Center

AAEM's Legislative Action Center located at **http://capwiz.com/aaem/home** 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.

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