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when minutes count

MedPAC's Report to Congress

On March 1, the Medicare Payment Advisory Commission (MedPAC) released its report to Congress on Medicare payment updates for 2007. The report recommends that the Centers for Medicare and Medicaid Services (CMS) revise the system used to determine Medicare reimbursements for different forms of medical services. Specifically, MedPAC recommends the establishment of "a standing panel of experts" appointed to help CMS discern overvalued services and review recommendations from the Relative Value Scale Update Committee (RUC) – the private sector advisory committee formed by AMA that advises CMS on the values of physician services, known as relative value units (RVUs).

Under the current system, CMS assigns RVUs to medical services based on the amount of resources required to provide the services, with higher reimbursements provided for services with higher RVUs. CMS reviews the RVUs every five years, based – in large part – on RUC's recommendations. In its report, MedPAC maintains that the five-year review system "does not do a good job of identifying services that may be overvalued" and that CMS has "relied too heavily on physician specialty societies to identify services that are misvalued." In most cases, MedPAC said, RUC recommends higher RVUs for specialty care, which has led to decreased reimbursements for primary care. MedPAC Chair Glenn Hackbarth said that the disparity raises concerns about the future supply of primary care physicians, and added that the number of medical students in primary care residencies has had "a pretty precipitous drop-off." Regarding its recommendation for the establishment of a new committee, MedPAC specified that "The group should include members with expertise in health economics and physician payment as well as members with clinical expertise." Hackbarth said that CMS can establish such a committee independently, but added that Congress likely will have to provide financial support.

The MedPAC report also includes a number of other recommendations finalized in January that would reduce Medicare reimbursements for hospital care, home health care, and skilled nursing care, among other medical services. These recommendations are in line with the Bush Administration's proposal to cut Medicare spending this year. During the hearing on MedPAC's report, Representative Nancy Johnson (R-CT) raised concerns that more than 50% of U.S. hospitals currently operate at a loss on care provided to Medicare beneficiaries. Hackbarth responded that the MedPAC recommendations are intended to compensate for an increase in reimbursements from private health insurers to hospitals. "We shouldn't gear Medicare policy to make sure they make a profit," he added.

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Some Hospitals Deficient in Pediatric-Emergency Preparedness

According to a new report from the Centers for Disease Control and Prevention (CDC), more work is needed to ensure that U.S. hospitals are equipped and staffed to handle pediatric emergency patients. The report, ***Availability of Pediatric Services and Equipment in Emergency Departments: United States, 2002-03***, is based on survey data

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Some Hospitals Deficient in Pediatric-Emergency Preparedness (Cont'd from page 1)

indicating that, although the majority of children who need emergency medical care are brought to hospitals that have appropriate emergency care specialists and equipment, a significant number are treated at facilities that lack the recommended pediatric equipment and a fully-trained staff.

The survey was conducted to learn how well hospitals were implementing the guidelines set by the American Academy of Pediatrics and the American College of Emergency Physicians in 2001. Developed after the Consumer Product Safety Commission's 1998 study of hospital emergency services for children found that emergency and critical care of infants and children varied widely in different regions of the country and by different types of hospitals, the guidelines called for more pediatric services, medical expertise, and supplies and equipment small enough for children. To measure hospitals' compliance with the guidelines and overall preparedness for pediatric emergencies, the Health Resources and Services Administration's Maternal and Child Health Bureau had certain questions added to CDC's 2002-2003 National Hospital Ambulatory Medical Care Survey. The findings included the following:

- While 90% of all U.S. hospitals admitted pediatric patients, less than half (40%) had separate inpatient pediatric wards.
- Half the hospitals surveyed had on hand more than 85% of the recommended medical supplies for pediatric patients, but fewer than 6% had available all the supplies in the full range of sizes.
- Nearly three-quarters (71%) of EDs had board-certified emergency medicine physicians available, and 25% had access to a physician board-certified in pediatric emergency medicine.
- For 62% of EDs, board-certified pediatric physicians were on call or available elsewhere within the hospital, but only 25% of EDs had written protocols outlining when to call in the specialist.
- Between 1998 and 2003, the percentage of hospitals with a pediatric intensive care unit was unchanged at 10%.

In general, the survey found that the vast majority of children who need emergency care are brought to hospitals that see more than 10,000 pediatric patients each year, and that these larger hospitals are more likely to have a pediatric ward, a pediatric intensive care unit, and a board-certified pediatric emergency physician on staff. In commenting on the findings, Kimberly Middleton, a health scientist at CDC's National Center for Health Statistics and the report's lead author, said, "We are pleased to find that the hospitals that see the majority of these young patients are the best prepared, but we also believe other hospitals would benefit from strengthening their capacity."

CDC will gather more information about hospital preparedness for pediatric emergencies in its 2006 survey. The complete report on pediatric-emergency preparedness based on the 2002-2003 survey is available at **www.cdc.gov/nchs**.

HHS Secretary Warns: Prepare for Pandemic

On February 24, Department of Health and Human Services (HHS) Secretary Mike Leavitt warned communities not to count on federal agencies to save them if a flu pandemic strikes. "Any community that fails to prepare with the expectation that the federal government will come to the rescue will be tragically wrong," Leavitt told the audience at Maryland's Pandemic Influenza Summit.

Leavitt advised people to stockpile food and medical supplies in case an outbreak affects truck drivers and supermarkets. He did not specifically mention the federal government's much-criticized response to Hurricane Katrina, but he noted that a pandemic would be far more difficult to respond to than the hurricane that destroyed large swaths of New Orleans and Mississippi. Leavitt also stated that it would be logistically impossible for the federal government to respond to a widespread flu outbreak. (Cont'd page 3)

BioSense: Detecting Infectious-Disease Outbreaks

With avian flu spreading to countries in Europe, the Middle East, and Africa at a growing pace, health officials are looking to make bigger strides in the rapid detection of infectious-disease outbreaks. As part of this effort, the CDC is developing a national electronic surveillance system called BioSense that is designed to help health officials spot an illness outbreak soon after infected people show up at EDs. By the end of the year, BioSense is expected to link 250 hospitals in more than 30 cities to servers at CDC's Atlanta headquarters where officials will look at disease patterns in several major metropolitan areas at once. State and local health officials will be able to tap into the system to review the data collected on symptoms and diagnoses of illnesses in their area.

According to Blake Caldwell, the senior advisor to CDC who is leading the development of BioSense, in the event of a bioterrorism attack, or if bird flu breaks out in the U.S., "we would have broad, rich data that would show us how big it is, where it's spreading, how fast." He added that the system could also help evaluate whether the public-health response is working. Last year the federal government spent $50 million on BioSense, and CDC expects to receive another $50 million this year.

Sifting through all the data that pour in from hospitals can be a formidable task, however, even electronically. Furthermore, unless an electronic database is connected to every doctor's office, those infected by diseases with the highest threat to overall public health could still slip through the safety net. Public health officials acknowledge that computers are not necessarily going to outsmart doctors, since symptoms such as fever and cough could indicate a variety of problems ranging from a routine 24-hour bug to avian flu. Despite these limitations, real-time electronic monitoring of symptoms seen within an ED is a huge step forward. For decades, federal officials used the handwritten reports mailed by healthcare workers to track diseases. Such paper surveillance systems were becoming inefficient, but the 9/11 attacks and rapid spread of bird flu and SARS made them obsolete.

Currently, at least 100 local or state disease-surveillance programs in the U.S. already crunch data daily on everything from school absenteeism to pharmacy sales of diarrhea medication to the incidence of flu and other common illness. These programs are generally run by state and local health departments, and they will not be a part of Biosense. While the electronic-surveillance systems have raised questions about potential intrusion on patient privacy, some officials say that existing public health laws already give them access to the same data in a public health investigation.

North Carolina's system is considered one of the most advanced disease-detection programs in the country. Initially, a rudimentary version collected data from only six hospitals, but the anthrax attacks in 2001 made health officials realize they needed a more sophisticated system. That system is now up and running in 72 hospitals and – within a few weeks – 113 hospitals are expected to be linked to the state's electronic database, which officials scour at least twice daily for warning signs of infectious-disease outbreaks. BioSense, the national system being developed by CDC, will be similar to North Carolina's system.

HHS Secretary Warns: Prepare for Pandemic (Cont'd from page 2)

To help Maryland prepare, Leavitt promised the state $1.8 million in federal funds. He also said the state is sure to get more as HHS distributes $350 million in funding that Congress has earmarked for states.

As part of HHS' series of pandemic summits being held in each state, Maryland's seminar brought together health care workers, researchers, and the heads of local, state, and federal agencies to discuss strategies for dealing with an outbreak of a new flu strain. A flu pandemic has not occurred since 1918, but fears of a new one are being stoked by the avian flu strain that has devastated poultry stocks and killed more than 90 people, mostly in Asia. Thus far, the virus, H5N1, has only spread from birds to humans, but concern that it could mutate into a form easily transmitted between humans is rising.

Report Outlines Legal Pros, Cons of Medical Liability Proposals

A new report from the Congressional Research Service (CRS) – ***Medical Malpractice Liability Reform: Legal Issues and Fifty-State Survey of Caps on Punitive Damages and Noneconomic Damages*** – leaves aside the policy question of whether overhaul of the medical tort system is a good idea and instead explains specific tort reform proposals and their pros and cons from a legal perspective. Issues that the CRS report examines include the merits and drawbacks of instituting limits on noneconomic damages, the legal pros and cons for capping punitive damages, limiting joint and several liability, limiting lawyers' contingent fees, and other medical malpractice-related proposals.

CRS says that proponents of caps argue that a lack of caps "guarantees inconsistency and unpredictability in the tort system, and forces insurers to counter this uncertainty by charging higher premiums." Backers of caps on noneconomic damages also say that disagreement over these damages is "a major obstacle" to out-of-court settlement, thus increasing litigation and coercing insurers to overpay on settlements of smaller claims, according to the report. Moreover, they counter that juries tend to inflate noneconomic damage awards to cover some or all of the plaintiff's attorneys' fees.

According to the report, opponents of limiting patients' noneconomic awards say that such caps punish those with the worst injuries as a result of medical malpractice and are useless as a means to lower or restrain medical malpractice insurance premiums. Opponents also note that a $250,000 cap has been in place since 1975 in California and that inflation has greatly reduced the value of a $250,000 award. Opponents of caps on noneconomic damages also say that jury awards for noneconomic damages "are not totally arbitrary, as they often are based on multiples of the award for economic damages."

The nonpartisan CRS also included in the report a state-by-state chart detailing current caps on punitive and noneconomic damages.

The States: Medical Malpractice Update

✓ **DE Bill Subsidizes Malpractice Insurance Costs**
A bill – SB 123 – awaiting action in the **Delaware** House Economic Development, Banking and Insurance Committee would provide subsidies to obstetricians and other physicians in high-risk specialties to help cover the cost of malpractice insurance. The measure was approved by the Senate last June by a vote of 18 to 3. According to State Insurance Commissioner Matt Denn, the subsidies, which would total $1.2 million in 2007, will be financed by the state through a surcharge on excess reserves held by health care companies. The **Delaware** chapter of the American College of Obstetricians and Gynecologists recently endorsed the bill, but the Medical Society of **Delaware** has concerns that the measure would discourage additional medical liability reforms.

✓ **Idaho, Iowa, and Vermont Consider Making Apologies for Medical Errors Inadmissible**
On February 17, **Idaho** lawmakers voted to send a bill to the House that would make health care workers' "expressions of apology, condolence and sympathy," as well as explanations of what went wrong, inadmissible in court under certain circumstances in medical malpractice cases. "We are trying to use the law in a way that will allow physicians and patients to speak to one another more freely," said Ken McClure, a lobbyist for the **Idaho** Medical Association. Barbara Jorden, a lobbyist for the **Idaho** Trial Lawyers' Association, said that, while her group largely supports the bill, she believes explanations should be permissible in court.

The **Iowa** House on March 22 voted 77 to 22 to approve a bill – HB 2716 – under which plaintiffs could not submit apologies from physicians as evidence in malpractice lawsuits. According to State Representative Kraig Paulsen (R), the legislation

would allow physicians and other health care professionals to "have a bedside manner where they are able to express some sympathy when an outcome is adverse, regardless of whether there is negligence involved." According to the Iowa Medical Society, studies have found that apologies from physicians have reduced the number of malpractice lawsuits. However, opponents said that the legislation is inadequate.

On March 23, the **Vermont** State Senate unanimously passed a bill under which plaintiffs could not submit apologies from physicians as evidence in malpractice lawsuits. According to supporters, a "genuine apology" from a physician might alleviate the patient's anger over a mistake and might "open the door to a negotiated settlement rather than an expensive court battle over terms" when appropriate.

✓ New Malpractice Ballot Measure in Kentucky

Kentucky state Representative Bob DeWeese (R-Louisville) has teamed with doctors in support of a proposed constitutional amendment aimed at reducing malpractice insurance rates, but without allowing for caps on victims' damages for pain and suffering. DeWeese's plan is similar to the now-stalled Senate Bill 1 in that it would offer voters a proposal requiring that medical malpractice lawsuits be screened before heading to trial, but it is viewed as a compromise because it removes the caps on monetary damages. DeWeese, a physician, believes the move would help reduce the number of frivolous lawsuits.

✓ Bill to Cap Noneconomic Damages in Tennessee Defeated

The **Tennessee** House Judiciary Subcommittee on Civil Practice and Procedure last week voted 3 to 2 to defeat a bill that would have capped noneconomic damages in malpractice lawsuits at $250,000 and placed new limits on attorney fees in such cases. State Representative Rob Briley (D), who chairs the subcommittee and also chaired a legislative study on medical liability, said claims that the state faces a malpractice insurance crisis because of lawsuits are "totally subjective," adding that the legislation would unfairly penalize patients who experience injuries because of malpractice. Briley also said that the subcommittee would not reconsider the legislation this year. Similar bills have failed for the past four years in the state Legislature.

✓ Wisconsin Governor Signs Cap Bill into Law

On March 22, **Wisconsin** Governor Jim Doyle (D) signed a bill that caps noneconomic damages in malpractice lawsuits at $750,000. This bill is the Legislature's second attempt to find a number both the Governor and the state Supreme Court would accept. Doyle vetoed an earlier and lower version of the cap.

Supporters maintain that the new law will help stabilize the state medical community. State Rep. Curt Gielow (R), who co-sponsored the legislation, said, "It's a fine balance between fairness to the injured plaintiff and fairness to the overall public that needs access to health care." However, Dan Rottier, president of the **Wisconsin** Academy of Trial Lawyers, said that the law "takes away the rights of the most severely injured to be treated equally under the law." Opponents predict that the law will face court challenges.