SENTINEL
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when minutes count

House Passes Malpractice Bill Before August Recess

On July 28, 2005, the U.S. House of Representatives voted 230-194 to approve a medical malpractice reform bill – H.R.5, the ***Help Efficient, Accessible, Low-Cost, Timely Healthcare Act of 2005***. The bill is "identical" to legislation that the House approved twice during the 108th Congress, but that died in the Senate, and is endorsed by **AAEM**.

H.R.5, sponsored by Representative Phil Gingrey (R-GA), limits noneconomic damages to $250,000 in malpractice lawsuits; makes each party in malpractice lawsuits liable only for the amount of damages directly proportional to such party's percentage of responsibility; allows courts to restrict the payment of attorney contingency fees; and limits the liability of manufacturers, distributors, suppliers, and providers of medical products that comply with Food and Drug Administration standards.

The rule for House debate did not allow amendments to be added to the measure, frustrating lawmakers who were particularly opposed to a provision regarding pharmaceutical and medical device manufacturers. The provision would protect drug and device makers from punitive damages if the companies can show they complied with all applicable regulations before FDA approval and after their drugs reached the market.

While Democratic House members said that the legislation would reduce legitimate medical malpractice lawsuits and protect pharmaceutical companies from class action lawsuits, sponsors of the bill said it would reduce rising malpractice premiums and help physicians maintain their practices, resulting in improved access to care.

H.R.5 will now move to the Senate where Majority Leader Bill Frist (R-TN) in March promised to get malpractice legislation through the Senate this year. Since then, however, Republican lawmakers such as Senator Rick Santorum (R-PA) and Senate Judiciary Committee Chairman Arlen Specter (R-PA) have said such legislation is essentially stalled in the Senate and faces almost certain demise.

In this issue . . .

Medical Errors Bill Signed by President

Ever since the Institute of Medicine estimated in 1999 that medical errors cause up to 98,000 deaths a year, patient safety bills have seen a flurry of stop-and-go congressional action with lawmakers deadlocked over ways to gather and analyze data about medical mistakes without exposing health care providers to added liability. This year the stalemate is over. On July 27, by a vote of 428 to 3, the House approved a compromise version of H.R.3205 – S.544, the ***Patient Safety and Quality Improvement Act of 2005***. The measure, which encourages the voluntary reporting of medical errors, was negotiated by Representative Nathan Deal (R-GA), Chairman of the **(Cont'd page 5)**

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Controlled Substances Monitoring Program Passed by Congress

In the flurry of activity preceding the August recess, H.R.1132/S.518, the ***National All Schedules Prescription Electronic Reporting Act*** (***NASPER***), passed both chambers by voice votes. It is estimated that more than six million Americans abuse prescription drugs annually. Currently, only twenty-one States have prescription drug monitoring programs. ***NASPER***, which creates a federal grant program to help establish or improve state-run prescription drug monitoring programs, was endorsed by **AAEM**.

> People use EDs for numerous immediate care needs and, typically, the use is for legitimate reasons. However, concern does exist among physicians about quality of care for that cohort of patients who may be frequenting the EDs because they are addicted to a medication and are seeking another prescription. . . . The type of database proposed under H.R.1132/S.518 could be an effective tool to assist the ED professional in readily identifying drug-seeking behavior, prior to prescribing a controlled substance.
>
> **AAEM** President Antoine Kazzi

A 2002 report from the General Accounting Office suggested that individual state programs had been quite successful in combating prescription drug abuse, but the report also clearly described the limitations of that approach. The full extent of the problem is unknown, because not all states have programs in place, and existing programs are not yet equipped to efficiently and effectively share information across state lines.

Introduced earlier this year by Representatives Ed Whitfield (R-KY), Frank Pallone (D-NJ), Charlie Norwood (R-GA), and Ted Strickland (D-OH) in the House and by Senators Jeff Sessions (R-AL), Richard Durbin (D-IL), Edward Kennedy (D-MA), and Christopher Dodd (D-CT) in the Senate, H.R.1132/S.518 received wide bipartisan support. The original bill was introduced by Whitfield in the last Congress but only made it through the House.

The legislation, which will give physicians the resources they need to detect abuse and prevent the practice of "doctor-shopping," now awaits the President's signature.

Senate Committee Approves Health IT Bill

On July 20, the Senate Health, Education, Labor and Pensions (HELP) Committee approved by voice vote S.1418, the ***Wired for Health Care Quality Act***, a measure intended to expand the use of information technology (IT) among health care providers. The bill is compromise legislation that includes provisions of S.1355, cosponsored by HELP Chair Michael Enzi (R-WY) and ranking Committee member Edward Kennedy (D-MA), and S.1262, cosponsored by Senator Hillary Rodham Clinton (D-NY) and Senate Majority Leader Bill Frist (R-TN).

The compromise bill:

- Approves grants of $125 million in FY 2006 and $155 million in FY 2007 to hospitals and physicians to help increase the use of health IT applications;
- Authorizes the Department of Health and Human Services (HHS) to award grants to health education centers to integrate health IT systems into their programs;
- Authorizes in statute a national coordinator for health care IT;
- Requires federal agencies that gather health information to comply with such standards within three years after the policies are implemented;
- Forbids federal funds from being spent on technology not consistent with the standards;
- Establishes a Health Information Technology Resource Center (HITRC) to help states implement health IT systems; **(Cont'd page 3)**

Senate Committee Approves Health IT Bill (Cont'd from page 2)

Indicates that HITRC privacy rules would apply to any health information stored or transmitted electronically; and
Establishes a quality measurement system that would provide higher payments to physicians with improved quality scores.

Expressing confidence that the bill would be "supportive of our efforts," HHS Secretary Mike Leavitt said in his testimony before the Senate Budget Committee that establishing interoperability standards" is right at the heart of nearly every aspect of my mission" at HHS. He added that health care IT "won't achieve the vision that many of you espouse" until interoperability is achieved. Others, including Enzi, Senator Debbie Stabenow (D-MI), and Senator John Ensign (R-NV), testified similarly, indicating strong support for the bill's objectives.

Changes to Medicare Physician Payment Formula Proposed

On July 29, Representative Nancy Johnson (R-CT), Chair of the House Ways and Means Committee's Subcommittee on Health, introduced a bill – H.R.3617, the ***Medicare Value-Based Purchasing for Physician's Services Act of 2005*** – that would repeal the sustainable growth rate (SGR) formula used to determine physicians' Medicare reimbursements and replace it with a value-based purchasing system. The measure could become part of this fall's budget reconciliation package.

FICEMS: Partial Victory

As we go to press, the final version of H.R.3, the ***Transportation Equity Act***, includes the authorization of a Federal Interagency Committee on Emergency Medical Services (FICEMS), but does not include the advisory council for which **AAEM** also has been advocating. In conjunction with other health care organizations, **AAEM** will work with the Departments of Transportation and Homeland Security to try and create the advisory council administratively. The language contained in H.R.3 also includes an annual report to Congress which should improve accountability of the FICEMS as well.

Thanks to all of you who contacted your congressional delegations to support the creation of FICEMS.

Under the proposed legislation, physicians would receive an increase in 2006, instead of the scheduled 4.3% Medicare pay cut. Further, in 2007 and 2008, physician groups that report performance criteria would receive a full payment update, and those that do not would receive a partial or smaller update. In 2009, full reimbursement updates would be reserved for groups that report on performance and show improvements. With respect to quality measures, specialty medical societies would be able to offer their input in early 2006, and the Department of Health and Human Services would use this input to develop regulations on process and efficiency measures.

At a press briefing to announce the introduction of her bill, Johnson said it is "extremely important" that Congress not continue to "kick the can down the road" by enacting a temporary payment fix to avoid the scheduled cut, as it has done in years past. Johnson said the $30 billion to $40 billion cost of such fixes should go toward a permanent change in the Medicare doctor payment system. Her proposal would eliminate the existing sustainable growth rate formula and replace it with a system under which annual payment increases would be based on the growth of the Medical Economic Index. MEI-based payment increases, which would start in 2007, would be reduced by one percent that year and in 2008 if doctors fail to report data on the quality of care they provide. The legislation does not include "gainsharing" provisions, which allow doctors and hospitals share savings if they develop ways to improve the efficiency of treatments.

On July 12, Johnson and Ways and Means Committee Chair William M. Thomas (R-CA) wrote (Cont'd page 4)

Changes to Medicare Physician Payment Formula (Cont'd from page 3)

to the Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan, asking that he take regulatory action to remove prescription drug expenditures from the SGR formula and account for the cost of new benefits. They said that legislation to permanently fix the SGR "would be prohibitively expensive given current interpretations of the formula."

A Congressional Budget Office (CBO) estimate of frequently mentioned options for changing the SGR showed that, over 10 years, it would cost $154.5 billion to eliminate the SGR and substitute automatic medical inflation updates. While Johnson did not outline specific steps for altering the payment formula, lawmakers in the past have said that a legislative modification would be less costly if CMS removed a calculation of prescription spending from the payment formula. In fact, CBO now estimates that removing the prescription drug calculation from the formula and changing how new and expanded benefits are calculated would reduce the cost of a legislative fix to $111 billion over 10 years.

Currently, it is "unclear" how much support Johnson has for her bill. Thomas has yet to announce his support, but Johnson says he is "supportive" of her efforts.

The Johnson bill "is miles apart" from the Senate bill, S.1356, the ***Medicare Value Purchasing Act of 2005***, which was introduced in June by Senate Finance Committee Chair Charles Grassley (R-IA) and ranking Committee member Max Baucus (D-MT). S.1356 would establish a two-phase implementation of paying various providers bonuses for delivering high quality care to patients but it does not focus on changes to the SGR. The House bill also allows physicians, not CMS, to create performance measures, as under the Senate bill.

EMTALA TAG Convenes for Second Meeting

Although the discussion of on-call specialists continued into the second meeting of the EMTALA Technical Advisory Group (TAG), it was not one of two new main issues that emerged in its June 15-17, 2005 meeting. In comments submitted to the TAG, the American College of Surgeons strongly urged the advisory committee to reject any legislative or regulatory efforts to require surgeons to take call as a condition of Medicare participation or as a stipulation to obtain hospital privileges. Opposition from the majority of the panel members who believed such a proposal would lead to a dramatic reduction in physicians participating in the Medicare program and result in an access to care problem for seniors and the disabled, led the TAG to vote to recommend that CMS not require physicians to serve on-call as a condition of Medicare participation. Members of the advisory group's on-call subcommittee suggested revising language in the May 2004 EMTALA interpretive guidelines (No. 103 HCDR 5/28/04) to remove a specific time in minutes by which physicians are required to respond to emergency departments either by phone or in person.

Advisory group members said hospitals and medical staffs should be allowed to determine response times on a facility-by-facility basis to determine reasonable physician on-call response times based on geography and patient need. The On-Call Subcommittee did not suggest recommendations on two areas of concern for some hospitals and doctors: continuous call and elective surgery while on call. The interpretive guidelines state that physicians should not be required to participate in continuous call, which is defined as round-the-clock coverage for extended periods or indefinitely. However, the guidance leaves room for hospitals to make such requirements in its bylaws. The group determined that prohibiting hospitals from requiring continuous call were beyond the scope of CMS's authority.

The Action Subcommittee of the TAG considered several items prior to the full committee meeting. Several of these have been referred to CMS for clarification/interpretation and will be revisited by the subcommittee in the future. In addition to traditional EMTALA issues of concern, such as on-call coverage and transfer policies, CMS has asked the advisory group to review EMTALA requirements as they relate to transfers between (Cont'd page 4)

EMTALA TAG Convenes for Second Meeting (Cont'd from page 4)

community hospitals and physician-owned specialty hospitals. For physician-owned specialty hospitals, CMS has indicated it will analyze MedPAC's recommendations to improve the accuracy of payment rates for inpatient hospital services and expects to adopt significant revisions in FY07, reform payment rates for ambulatory surgical centers, scrutinize whether specialty hospitals meet the definition of a hospital, and review criteria for approving and starting to pay new specialty hospitals. CMS wants to be assured that, given their limited focus, specialty hospitals meet core requirements that are necessary for the health and safety of beneficiaries. The request is part of a larger six-month study CMS is conducting on specialty hospitals.

CMS said it will seek public input regarding certification issues related to specialty hospitals during a September Open Door Forum. In addition, CMS will consider how EMTALA applies to specialty hospitals, with particular reference to potential transfer cases arising in the emergency departments of other hospitals. Depending on the results of this input and review, CMS will draft appropriate instructions to implement revised procedures, and will consider whether to proceed with changes to the regulations. Complete revisions to these procedures are anticipated in January 2006.

In addition, the TAG heard testimony from the National Association of Psychiatric Health Systems regarding hospital closures and psychiatric bed reductions that have been occurring in both the public and private sectors over recent years. Based on 2001 MedPAC data, it can be estimated that there were approximately 43,920 psychiatric unit beds in 2000 – or a 19% decline between 1998 and 2000 at a time when the number of individuals with psychiatric disorders visiting emergency rooms doubled. In 2003 (the most recent year for which data is reported), there were 3,718,000 emergency visits by individuals with a primary diagnosis of a mental disorder (ICD-9-CM code range 290-319), representing 3.3% of 2002 hospital data from the Medicare database for ED visits. The Action Subcommittee will seek public input to define "emergency medical conditions" and "stable for transfer" as it pertains to psychiatric patients prior to any further recommendations in this regard.

The next meeting of the EMTALA TAG will occur in October 2005.

Medical Errors Bill Signed by President (Cont'd from page 1)

House Committee's Health Subcommittee, with the Senate's Health, Education, Labor and Pensions (HELP) Committee Chair Michael Enzi (R-WY) and Ranking Minority Committee member Edward Kennedy (D-MA).

S.544 establishes a legal framework for physicians to voluntarily report medical errors to patient safety organizations run by states, localities, and private entities. It also initiates a national patient safety database maintained by HHS to catalog the reports and identify regional and national trends in medical mistakes. The CBO estimates that the operation of the data collection system will cost about $58 million over the next five years. In addition, the measure authorizes $25 million in grants for FY 2006 and 2007 to help physicians and hospitals upgrade technology that helps reduce medical errors. While some health care analysts believe the number of deaths due to medical error has been exaggerated, that sentiment does not mean they opposed the establishment of a national reporting system.

With one exception, i.e., that the bill would not shield information currently available to attorneys for use in court cases, negotiators agreed that the legislation should be neutral on litigation issues. In an effort to encourage people to report errors, however, the compromise version does provide new legal protections "for new information in this new patient safety reporting system."

With the successful reconciliation of differences between the House and Senate bills, H.R.3205 was signed into law by the President over the weekend.

The States: Medical Malpractice Update

Florida Supreme Court Asked To Enforce Limits on Lawyers' Fees

Last November, **Florida** voters passed a state constitutional amendment allowing plaintiffs in malpractice lawsuits to retain 70% of the first $250,000 in damages awarded, and 90% of damages awarded in excess of that amount. However, to bypass the limits established by the measure some attorneys have asked plaintiffs to sign waivers that allow them higher attorney fees. As a result, on June 29, supporters of the amendment filed a proposal with the state Supreme Court to "force trial lawyers to abide by strict limits" established by the law.

Kentucky Bill Seeks Constitutional Amendment on Caps

At a meeting of the Northern **Kentucky** Medical Society, **Kentucky** Governor Ernie Fletcher (R) said medical malpractice reform that includes caps on noneconomic damages would lower malpractice insurance premiums and stop doctors from leaving the state. Fletcher called on state doctors to help pass a bill in the next legislative session that would place on the November 2006 ballot a constitutional amendment to limit noneconomic damages in malpractice lawsuits. He said a "reasonable" cap would be between $250,000 and $500,000. The bill also would establish a three-member panel of doctors to review malpractice lawsuits and dismiss claims deemed to lack merit.

Rhode Island Groups Fail to Reach Compromise on Malpractice Reform

As requested by the **Rhode Island** General Assembly, members of the **Rhode Island** Medical Society, the Hospital Association of **Rhode Island**, and the **Rhode Island** Trial Lawyers Association (RITLA) have met several times in attempts to reach a compromise on a malpractice reform bill. The bill, which is supported by physicians and hospitals, would reduce the 12% interest rate that accumulates on malpractice judgments during the litigation process. It also requires an expert to certify that malpractice lawsuits have merit and that plaintiffs file lawsuits within one year of the time they become aware of alleged malpractice. The RITLA, however, supports a bill that would limit malpractice insurance premium rates for physicians in high-risk specialties, and require malpractice insurers to base premium rates on "firm data" and disclose their expenditures. The groups have been unable to reach a compromise, making the prospects for legislation this year unlikely.

Special Courts Advocated in Virginia

Some **Virginia** physicians who have lobbied lawmakers for two years to impose caps on noneconomic damage awards in malpractice cases have decided instead to advocate for the creation of special courts that would address only malpractice and medical negligence cases. According to attorney Scott Johnson, who represents physicians in the Medical Society of **Virginia** (MSV), "The votes just aren't there" to pass legislation that would cap noneconomic damages at $250,000. MSV President David Ellington said that while premium increases are hurting physicians, the "real need is to develop a (judicial) system that is fair and equitable." He added that physicians "must accept that there is negligence occurring and injured persons deserve compensation." However, Ellington added that the current malpractice system is difficult for many patients to access, gives up to half of award amounts to attorneys and experts, and can prolong cases for years.

Wisconsin State Caps on Noneconomic Damages Ruled Unconstitutional

It is currently unclear how many lawsuits will be affected by the **Wisconsin** Supreme Court's July ruling that found the state's cap on noneconomic damages in malpractice lawsuits to be unconstitutional. As a result, medical malpractice is expected to again become an issue in the state, and some groups that support caps have indicated they will lobby state lawmakers to pass a cap that can "withstand legal challenges."