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when minutes count

ED Visits Reach Record High

According to a new report from the Centers for Disease Control and Prevention (CDC), visits to U.S. EDs jumped 26% in the past decade, from 90.3 million in 1993 to a record high of nearly 114 million in 2003. Older Americans – many uninsured – accounted for much of the increase. Meanwhile, in that same period, the number of EDs decreased by 14%, the U.S. population rose 12%, and the age 65-and- over population rose 9.6%.

While the increase in visits was most pronounced among adults – especially those age 65 or older, the statistics also show a 19% increase in ED visits by people age 22-49, and a 15% increase by those age 50-64. Among people age 65-74, the ED visit rate was more than five times higher for those residing in a nursing home or other institution, compared with those not living in an institutionalized setting. In addition, at 81 visits per 100 people, Medicaid patients were four times more likely to seek ED treatment than those with private insurance who accounted for 22 visits per 100 people.

Other findings in the report include:

- Despite the increased number of visits, the average waiting time to see a physician – 46.5 minutes – was the same as it was in 2000. Overall, patients spent 3.2 hours in the ED, which includes time with the physician as well as other clinical services.
- Patient complaints of stomach pain, chest pain, fever, and cough accounted for nearly 20% of visits.
- Injury, poisoning, and the adverse effects of medical treatment accounted for more than 35% of ED visits. The leading causes of injuries were falls, being struck by or striking against objects or persons, and motor vehicle traffic incidents which accounted for 41% of injury-related visits. Ironically, some 1.7 million of the visits in 2003 were for adverse effects of medical treatment.
- More than 16 million, or 14%, of patients arrived at the ED by ambulance. Over a third of those patients were age 65 or older.
- More than two million patients were transferred to other facilities, while 317,000 patients either were dead on arrival or died in the ED.
- X-rays, CT scans, or other imaging tests were provided in about 43% of visits. Medications were provided in more than 77% of visits. Painkillers were the most frequent prescription, accounting for just over 14% of medications reported.
- About 58% of EDs are located in metropolitan areas, but they accounted for 82% of visits. Board-certified emergency medicine physicians were available at 64% of EDs, and almost half of all EDs had a nursing triage system. **(Cont'd page 3)**

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AAEM Endorses H.R.2356
Preserving Patient Access to Physicians Act of 2005

In a letter dated June 20, 2005, **AAEM** applauded the leadership of Representatives E. Clay Shaw (R-FL) and Benjamin Cardin (D-MD) in attempting to fix the manner in which Medicare payments to physicians are calculated by introducing H.R.2356, ***Preserving Patient Access to Physicians Act of 2005***. The Senate companion bill, ***S.1081***, was introduced on May 19 by Senators Jon Kyl (R-AZ) and Debbie Stabenow (D-MI).

The 2005 Medicare Trustees Report estimates that the current physician payment system will cut doctors reimbursements by 26% over the next six years – beginning with an across-the-board 4.3 % cut on January 1, 2006. These cuts are due to the flawed Medicare payment update formula.

Payment updates are based on a sustainable growth rate system tied to the gross domestic product (GDP). This means that when GDP declines as the economy softens, payment updates decline as well. From 1991-2003, payment rates for physicians and health professionals fell 14% behind practice cost inflation, as measured by Medicare's own conservative estimates.

> **AAEM** believes it is important to keep the Medicare program strong for America's seniors and disabled so that more of them are not forced to turn to the already crowded EDs for their medical care
>
> **AAEM** President Antoine Kazzi

H.R.2356 repeals the SGR and replaces it with an annual Medicare payment update for physicians that reflects practice cost increases. H.R.2356 provides doctors with a payment update of no less than 2.7%, with the annual update beginning in 2007. The bill establishes a permanent solution, so physicians can continue to give Medicare patients the care they deserve. Recent data from the CDC shows that ED visits have reached an all time high – 114 million in 2003 – and that the greatest increase was among those over age 65.

CMS Implements Program to Recoup Emergency Health Service Costs for Undocumented Aliens

The Centers for Medicare & Medicaid Services (CMS) has finally announced the provisions of a new program to recoup costs of providing needed emergency medical care for undocumented aliens. Section 1011 of the ***Medicare Modernization Act*** set aside $1 billion through 2008 to help hospitals and certain other emergency care providers recover a portion of their costs associated with providing emergency services under ***EMTALA*** to qualified individuals who are uninsured or cannot afford emergency care.

Each state will receive funding based on the formula established in the law. Payments will be made directly to hospitals, certain physicians, and ambulance providers, including Indian Health Service facilities and Indian tribes and tribal organizations, as long as they did not receive payment from any other source such as the person treated or an insurance company. This program includes payments toward related hospital inpatient, outpatient, and ambulance services furnished to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U.S.

In a letter to House Speaker Dennis Hastert in May 2004, **AAEM** President Antoine Kazzi noted grave concerns regarding H.R.3722, the Undocumented Alien Emergency Medical Assistance Amendments of 2004, and urged the Speaker to oppose this legislation. Kazzi expressed **AAEM**'s opinion that EDs are mandated to evaluate all patients regardless of their ability to pay and opposed several requirements of the proposal that would have turned emergency physicians into de facto INS agents and increased the risk that "undocumented aliens could pose a significant

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CMS Implements Program to Recoup Costs (Cont'd from page 2)

public health threat since the fear of deportation would inevitably prevent undocumented aliens from seeking care until it may be too late."

CMS subsequently backed off its earlier stance, acknowledging many of the same concerns expressed in Dr. Kazzi's message saying,

> "In considering how providers will identify and document patient eligibility for the purposes of receiving payment under this section, CMS believes that documentation standards should: (1) not impose requirements on providers that are inconsistent with EMTALA, (2) minimize the cost and reporting and record-keeping requirements, and (3) not compromise public health by discouraging undocumented aliens from seeking necessary treatment. We believe that asking a patient to state that he or she is an undocumented alien in an emergency room setting may deter some patients from seeking needed care. Moreover, if providers were required to request a Social Security number or other independently verifiable information from a patient, providers would need a mechanism to verify the authenticity of the information submitted."

In this final policy notice, CMS has adopted an indirect approach to determine whether a provider can seek payment for an eligible patient. CMS will not require hospital staff to ask patients directly about their citizenship or immigration status.

Providers must enroll to participate in the program and can claim payment for emergency services furnished to eligible patients beginning May 10. The six states receiving additional funding in FY 2005 based on the highest number of undocumented alien apprehensions are: Arizona, Texas, California, New Mexico, Florida, and New York.

The Federal Register notice providing final guidance regarding the implementation of Section 1011 can be found at **http://www.cms.hhs.gov/providers/section1011**.

New Health Subcommittee Chair Off and Running

Representative Nathan Deal (R-GA), the new Chair of the House Energy and Commerce Committee's Health Subcommittee, is viewed as a quiet, steady, team player. In that respect, Deal is quite like his predecessor Representative Michael Bilirakis (R-FL). The similarity may end there, however, for where Bilirakis seemed more content to listen, Deal seems more inclined to act.

Since he became Chair, Deal has been fully engaged in briefings on a wide variety of health care issues, ranging from preparations for a flu pandemic to revamping Medicaid to medical malpractice to generic drugs to patient safety. A former trial lawyer, Deal describes himself as a health care greenhorn, but his statements have illustrated extensive knowledge. At a hearing on spurring generic drug use, Deal painstakingly explained one of the most arcane generic drug provisions of the Medicare overhaul law. He also showed a sense of urgency about moving legislation that would overturn a court ruling that appears to negate congressional intent in the law. In addition, he has given long and thoughtful answers to the press on a number of health care issues. While some of his approaches may make liberals cringe, he has indicated a readiness to reach out to include ideas espoused by Democrats.

On Medicaid, Deal said that "personal responsibility" would be the focus of changes. He added that the changes could include having more copayments for services, discouraging ED use for routine ailments, and tightening regulations for asset transfers that allow people to become eligible for Medicaid-funding nursing home **(Cont'd page 3)**

New Health Subcommittee Chair Off and Running (Cont'd from page 3)

care. He characterized the proposal on Medicaid reform from the National Governors Association that was presented to Congress on June 15 as "a tremendous step in the right direction if we want to make some changes," but added that the Subcommittee was preparing its own plan, soon to be finished.

Like the Association's proposal (backed by all 50 governors), the Subcommittee's plan is apt to give states more latitude in reshaping benefits and trimming costs. Where the governors propose changes in the average wholesale, price-based system of Medicaid drug reimbursement, however, Deal said he has not made up his mind about how to cut pharmaceutical costs. As for the $10 billion in savings called for in entitlement spending under the congressional budget resolution that was designated for the Health Subcommittee, Deal revealed that he does not consider the Subcommittee obligated to rely on Medicaid changes exclusively to deliver all of the reconciliation savings. While that suggests the possibility of House-backed cuts in Medicare spending growth, Deal indicated only that he expects Congress to address Medicare's provider reimbursement levels, but probably not as part of the reconciliation process.

With respect to medical malpractice, Deal is busy gathering ideas in hopes of fashioning a measure that can actually get through Congress. He praised the House-passed malpractice revisions rebuffed by the Senate, adding that, in order to move revised legislation that could get through the Senate, "I think the House is probably going to have to take the initiative again." He mentioned, as one approach to reducing liability cases, having doctors issue apologies to patients when they make a medical error that causes harm as reflected in the recent change in Georgia law which incorporated this idea along with a higher cap. Noting a concern of Democrats, he agreed with their point that patient safety legislation should be part of the answer to reducing medical errors that add to liability costs. He added that, while patient safety legislation does not necessarily have to be part of a liability overhaul, it should be complementary, and that he wants to get the stalled patient safety bill moving.

For other issues the revised malpractice legislation should address, Deal cited whistleblower protections, and the adequacy of medical licensing boards in dealing with "bad" doctors. He also said he wants to more closely scrutinize malpractice insurers in regard to their business practices. Finally, Deal indicated that caps on liability payouts will continue to be part of the mix in any medical malpractice reform. "We're going to try to look at all aspects of it," he said – but added, "I'm not going to abandon caps."

Health Subcommittee's Agenda

Deal has laid out an ambitious agenda for his Subcommittee, and designated the following as priorities:

- **Medical Malpractice**
  Deal does not expect the bill passed by the House last Congress capping non-economic damages at $250,000 to be the final language of a malpractice bill. He wants to work with the Senate to come up with a compromise.

- **Patient Safety**
  Last year both chambers passed a patient safety bill, but a conference to reconcile the differences never took place. This year, with the Senate Health, Education, Labor, and Pensions Committee's approval of a patient safety bill (S.544) and negotiations underway with the Senate to move the measure, Deal sees "hopeful signs the legislation can come forward before August."

- **Medicaid**
  Deal anticipates an early September markup on a package of changes that could include "cash and counseling" language that would empower beneficiaries individually "to use their money and make choices with regard to their health care" and health savings accounts that allot to individuals sums of money from which they pay for certain health care expenses and allows them to keep what they do not spend. In addition, he hopes the overhaul will authorize pilot programs to allow a limited number of states to experiment with even more wide-ranging reforms than might be adopted in the current session of Congress.

Hearing on Patient Safety Legislation Held

On June 9, the House Health Subcommittee, chaired by Nathan Deal (R-GA), held a hearing on patient safety and health care. Appearing before the panel, Agency for Healthcare Research and Quality Director Carolyn M. Clancy said the Bush Administration supports passage of patient safety legislation that "protects and encourages error reporting without fear of litigation and looks forward to continuing to work with the committee on this important issue."

AMA, which called the hearing an "encouraging" sign, again urged Congress to move patient safety legislation. It reiterated its support for a measure that establishes a system for the confidential reporting and analyzing of medical errors to improve patient safety. At the hearing, AMA board member Cyril M. Hetsko said, "Health care errors would be prevented by transforming the existing culture of blame, which suppresses information about errors, into a culture of safety, which focuses on sharing information in order to prevent future errors."

In its testimony, the National Partnership for Women & Families said patient safety legislation should "provide a clear definition of patient safety information." In addition, they called for the bill to provide a certain level of confidentiality and protection from legal discovery to encourage the voluntary reporting of medical errors and near misses. "This protection, however, should not shield information from a patient that they otherwise would have access to, nor should it preclude information, where appropriate, from use in criminal proceedings."

The complete testimony from the hearing is available at **http://energycommerce.house.gov/108/Hearings/06092005hearing1543/hearing.htm**.

Clinton/Frist IT Bill Introduced

At a June 16 news conference in the admissions area of George Washington University Hospital in Washington, D.C., Senator Hillary Rodham Clinton (D-NY) and Senate Majority Leader Bill Frist (R-TN) announced their plans for a bill that would help establish a national health information technology (IT) network to improve access to medical information. The senators began their day pitching their plan together on network television, before visiting the Washington-area hospital and then introducing the bill, S.1262, the ***Health Technology to Enhance Quality (TEQ) Act of 2005***, and making their case on the Senate floor. In his comments, Frist said, "It's a partnership that I guess surprises some people because we are on two different sides of the aisle. It should speak loudly to the American people that we are united around this common goal of establishing these interoperable standards that we know will improve health care in this country." Frist said he will work with sponsors of other health care IT bills to possibly combine the measures and hasten the legislative process, and that he hoped to pass the legislation within the next 18 months.

Last month, at the unveiling of the House measure, H.R. 2234, the ***21st Century Health Information Act of 2005***, Clinton joined another unlikely partner – former Speaker of the House Newt Gingrich – to promote the medical records bill. The Clinton/Frist version of the IT legislation would authorize $125 million in grants annually over five years to create local and regional health information systems to develop health care IT standards, which would be mandatory for federal government programs and voluntary for the private sector. As Frist explained, this would enable some 6,000 hospitals and more than 9,000 health care providers to better communicate and share patient histories during medical emergencies. Physicians who participate in the project would be eligible for increased reimbursement rates.

The bill would also create an exemption in current federal law to allow health care providers and insurers to provide health care IT equipment to physicians within the scope of certain goals, such as reducing medical errors, lowering costs, or improving quality. In addition, the bill calls for the Department of Health and Human Services (HHS) to establish a "value-based purchasing pilot program" under Medicare to encourage reporting of health care quality data and create a performance-based payment system for health care providers. After two years, HHS could expand the purchasing program nationwide. The bill also would codify **(Cont'd page 6)**

Clinton/Frist IT Bill Introduced (Cont'd from page 5)

HHS' Office of National Coordination for Information Technology, which currently is developing interoperability standards.

The legislation has been criticized by privacy advocates, who say it would be far too lax in protecting patient records. The Foundation for Taxpayer and Consumer Rights said expanding medical databases the way Clinton and Frist hope would put more people at risk of identity theft. In response to that concern, Clinton said lawmakers would have to ensure that electronic records are secure and that confidential information is protected. She also said that hospitals were separately moving toward creating new records-keeping systems and that, without standards for sharing critical data, such steps will only create more confusion and waste.

Both senators stressed the need for medical records legislation to prevent life-threatening mistakes. Frist said, "With all of this advanced care, we are still one of the most fragmented systems in the world." He added, "We're in the stone age. We're not in the information age." Clinton said that she and Frist are "determined to move this legislation because for every month that we wait, people are spending money on these systems which may or may not make the kind of seamless system that we are looking for in this country." HHS Secretary Mike Leavitt said in a statement that he supports the measure and looks forward to working with the senators to "make electronic medical records secure, accessible and portable for everyone."

Asked about how big a role politics would play in consideration of the bill, Clinton referred to her experience leading President Clinton's unsuccessful push for substantial health care overhaul in the early 1990s. "Obviously, Senator Frist has a lot more experience actually delivering health care," she replied. "I probably have more personal scars from talking about this than anybody else. But, together, we're willing to wade into this."

Announcements . . .

< New Identifier for Use in Standard Electronic Health Care Transactions

CMS is pleased to announce the availability of a new identifier for use in the standard electronic health care transactions. The National Provider Identifier (NPI) will be the single provider identifier, replacing the different provider identifiers providers currently use for each health plan with which they do business. The NPI is one of the steps that CMS is taking to improve electronic transactions for health care. A **May 6th letter** was distributed to aid in understanding the background of this requirement and what steps are necessary to apply for and receive your NPI.

< CDC Releases Revised Injury Research Agenda

In 2002, CDC's National Center for Injury Prevention and Control began to update its ***Injury Research Agenda***, focusing on research that will ultimately make a difference in improving acute injury care systems and the care individuals receive. The process, which involved input from injury care and public health experts, is now complete. The revised ***Acute Injury Care Research Agenda: Guiding Research for the Future*** was released at the National Injury Prevention and Control Conference in Denver on May 11, 2005. The Agenda identifies priorities and aims to help guide research efforts to prevent needless deaths, lessen adverse health effects from injuries, and potentially reduce the cost of medical care to the injured. The document is also intended as a reference for policy makers, educators, service providers, and others interested in learning more about acute injury care. To order a free copy of the ***Agenda***, send an E-mail to **dwa2@cdc.gov** and include the following information: name, title, e-mail address, mailing address, telephone, and fax.

The States: Medical Malpractice Update

CT Governor to Sign Malpractice Bill

Governor M. Jodi Rell (R) recently stated that she is "inclined to sign" medical malpractice legislation approved by the state Legislature "as is" to "see if we get the results that are intended." Under the legislation, the state Insurance Department would have to approve malpractice insurance premium rate increases of 7.5% or more. The bill also would reduce interest rates on malpractice settlements paid over time, limit attorney fees in malpractice cases, and require **Connecticut** hospitals to develop procedures to reduce medical errors. The bill does not include a cap on noneconomic damages in malpractice lawsuits. Rell said she would like the bill to be "a little stronger," but she added that the state could "come back again and strengthen it."

Legislation Proposed to Stabilize Malpractice Insurance Premiums in DE

State Insurance Commissioner Matt Denn has proposed legislation to help stabilize malpractice insurance premiums and attract more physicians and malpractice insurers to **Delaware**. The bill would provide malpractice insurance premium subsidies for physicians in high-risk specialties and establish a system to review claims submitted by malpractice insurers to justify premium rate increases. However, the legislation would not cap damages in malpractice lawsuits.

Illinois Legislature Agrees to Cap on Noneconomic Damages

In a surprise breakthrough embraced by doctors, hospitals and insurers, **Illinois** Governor Rod Blagojevich (D) and key legislative leaders in late May ended two years of stalemate by agreeing to cap how much injured patients can recover through malpractice lawsuits. Under the new proposal, individual doctors could be sued for no more than $500,000 in noneconomic damages, and hospitals would face no more than $1 million awards for pain and suffering. The measure reduces frivolous lawsuits by requiring plaintiffs to obtain a report from a consulting physician attesting to the merit of claims, and provides immunity to retired doctors who volunteer at medical clinics or other health care facilities. The bill also creates a Web site that provides information to the public on physicians' backgrounds, including criminal convictions, malpractice awards, and disciplinary actions.

Both supporters and opponents of the bill say the issue is likely to end up before the state Supreme Court, which could delay its effect on malpractice insurance rates.

NH Governor Signs Malpractice Bills

Governor John Lynch (D) has signed into law two bill that affect medical malpractice suits in **New Hampshire**. SB 214 allows a panel to review malpractice lawsuits before they proceed to trial. Under the bill, if plaintiffs and defendants agree, a panel composed of a retired judge, a physician, and an attorney would review evidence in malpractice lawsuits and make recommendations on whether negligence is involved. The bill also allows attorneys to use unanimous recommendations by the panel as evidence in the event those malpractice lawsuits proceed to trial. HB 584 allows physicians to apologize to patients without concerns that plaintiffs could use the statements as evidence in malpractice lawsuits.