Washington SENTINEL
when minutes count

House Commerce Committee Chair to Focus on Physician Reimbursement

House Energy and Commerce Committee Chair Joe Barton (R-Texas) announced that he plans to focus on physician reimbursement reforms and reauthorization of the National Institutes of Health during this second session of the 109th Congress. In 2005, Congress adopted a one-year fix to address a planned cut in Medicare physician reimbursement. More permanent reforms are needed, however.

The 2005 budget reconciliation bill – S.1932 – found savings to offset the 4.4% scheduled reductions in physician payments, changing the system to allow 2006 physician Medicare reimbursements to remain at their 2005 levels. Burton stated that "Every year that we don't reform the program for determining how to reimburse our physicians," cuts can occur, and "these cuts are cumulative." He added that a system that is "fair to physicians and taxpayers" is needed.

During his testimony before the Energy and Commerce Committee to discuss the president's FY 2007 health care budget, Department of Health and Human Services Secretary Michael O. Leavitt said the best way to reform the Medicare physician reimbursement system is "to assign a value on performance," not just paying doctors based on quantity. The HHS secretary agreed to work with the Energy and Commerce committee to devise a strategy for reforming physician reimbursement system for Medicare before Congress adjourns this year. The president is proposing nearly a $700 billion budget for HHS in FY 2007, and aims to reduce Medicare spending by $36 billion and Medicaid spending by nearly $12 billion.

HHS Programs on Administration's FY 2007 'Hit List'

On February 9, the White House released a list of programs it proposes to cut or reduce in FY 2007. According to the list, the Administration hopes to eliminate six HHS programs to save $866 million, and to reduce funding for another six programs to save – according to Office of Management and Budget (OMB) estimates – another $1 billion. Last year, the Administration tried to eliminate or reduce most of the same programs, but Congress would not go along totally. It is not clear this early in the appropriations process whether the White House will be successful this year or not.

OMB said that the most savings – $630 million – would come from ending the community services block grant, which funds "Community Action Agencies" that provide employment, housing, nutrition, and health care services for the poor. For its rationale, OMB said that: the programs have not delivered; they are not subject to performance measures nor required to meet minimum standards to get funded; the services the (Cont'd page 3)

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HHS Programs on Administration's FY 2007 'Hit List' (Cont'd from page 1)

agencies provide are too diffuse to be effective; and, larger federal programs may better meet the needs involved by focusing money on a specific service.

Other programs proposed for **elimination** include:

The Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services Block Grant

Authorized in 1981, this grant funds chronic disease prevention, immunizations, injury prevention programs, and programs to prevent sex offenses. CDC has budget authority to spend $99 million under the grant in FY2007, but OMB said, "other grants cover many of the same areas."

Maternal and Child Health Small Categorical Grants

By ending certain small categories of funding under this $693 million grant program, the Administration would save $39 million. Funding would stop for programs addressing traumatic brain injury, screening newborns to check their hearing, and **emergency medical services for children** (**EMSC**). According to OMB, the programs involved have not shown improved outcomes or set long-term goals.

Health Resources and Services Administration (HRSA) Title VII – Health Professions Programs

Grants given out by HRSA under these programs aim to direct doctors, nurses, and dentists to medically underserved communities, i.e., areas of the country that have shortages of health professionals. The proposal is to totally eliminate funding for these programs which has gone from a level of $252 million in FY 2005 to $99 million in FY 2006. The health professions programs have been perennial targets of the Bush Administration's budget cutters, but are strongly defended by family physicians. They have already weighed in this year, saying the reductions would eliminate funding for family medicine training programs.

The Administration tried but failed last year to eliminate five of the six programs on the FY 2007 termination list. The new program added to this year's list is the Urban Indian Health Program.

The programs proposed for large **cuts** include:

Children's Hospital Graduate Medical Education Payment Program

This program began under the Clinton Administration as a $40 million subsidy to children's hospitals, but has grown eightfold since then. According to OMB, such an increase is not justified, in that children's hospitals are more likely to have positive profit margins than other hospitals. The proposal is to cut budget authority from $297 million in FY2006 to $99 million in FY2007, for a savings of $198 million. The remaining funds will be directed to "hospitals having the greatest financial need, treating the largest number of uninsured patients, and training the greatest number of physicians."

HRSA Rural Health Programs

Under these programs, HRSA funds rural facilities known as "Critical Access Hospitals" as well as state offices of rural health and planning to create rural provider networks. According to OMB, budget authority for these programs should be reduced to $27 million, because HHS has 225 other health and social services programs serving rural areas. The reduction would save $133 million. The remaining funding would be used to continue state offices of rural health and to continue research on rural health care.

Poison Control Centers

HHS supports poison control centers while they secure certification and other sources of funding. According to OMB, many centers no longer need assistance to achieve certification. The proposal is to cut budget authority from $23 million in FY2006 to $13 million in FY2007.

Medicaid Cuts Will Impact ED Use

According to a study published in the January/February issue of the journal ***Health Affairs***, a decrease in Medicaid and State Children's Health Insurance Program (SCHIP) enrollment will lead to an increase in ED visits by the uninsured but little change in overall ED volume. The study – ***Medicaid/SCHIP Cuts and Hospital Emergency Department Use: Cuts to Public Programs are Likely to Have Ripple Effects Across the Safety Net for Low-Income American*** – was authored by Peter (Cont'd page 3)

Medicaid Cuts Will Impact ED Use (Cont'd from page 2)

Cunningham, a senior health researcher at the Center for Studying Health System Change. Funding for the study came from the Kaiser Family Foundation's Commission on Medicaid and the Uninsured (KCMU), with additional support from the Robert Wood Johnson Foundation.

To examine how decreases in enrollment in Medicaid/ SCHIP and increases in the number of uninsured people would affect the volume and distribution of ED use among low-income people, the study used data from the 2000-2001 and 2003 Community Tracking Study household surveys. The findings suggest that cost containment efforts that reduce eligibility for and enrollment in public coverage programs will achieve cost savings largely by shifting costs away from Medicaid/ SCHIP and to hospital uncompensated care. The use of community health centers and other free clinics could mitigate the effects of Medicaid cuts, but, the study added, ED "volume will not decrease as much as might be expected because those who lose Medicaid/ SCHIP coverage and become uninsured are likely to have much worse health and higher need than those who are now uninsured."

> " . . . the results show that a decrease in Medicaid acceptance rates by physicians – which could be caused by cuts in reimbursement rates for physicians – is associated with a higher probability of ED use by Medicaid/ SCHIP adults."
>
> Peter Cunningham
> Senior Health Researcher
> Center for Studying Health System Change

As for the specific implications of Medicaid cuts, the study found that a 25% reduction in national Medicaid/SCHIP enrollment would decrease ED visits by less than 600,000 or less than 2%. "However, while providers in general might see little change in ED volume, a higher share of those visits would come from uninsured patients," the study added. ED visits by uninsured patients would increase by about five percentage points, from 24.4% to nearly 29%. "In addition, Medicaid/SCHIP coverage loss could lead to less access to care at physicians' offices, which would result in more reliance on ED care by the uninsured. "

A related KCMU policy brief, ***What Happens When Public Coverage is No Longer Available?***, examines the share of current adult enrollees in public programs who would have other coverage options if public coverage were no longer available. The authors estimate that no more than 9% of currently enrolled low-income adults would have access to an alternative source of insurance in the absence of public coverage. The research suggests that cutbacks in eligibility for public programs, particularly for those with the lowest incomes, would likely leave most of those affected uninsured.

Survey Data Show Meth Abuse Effect on EDs

On January 18, 2006, the National Association of Counties (NACo) released the results of its survey – ***The Effect of Meth Abuse on Hospital Emergency Rooms*** – stating that there are "more meth-related emergency visits than for any other drug and the number of these visits has increased substantially over the last five years." Yet the lack of funding – for addressing the meth abuse problem as a threatening community health issue, even as an "epidemic" – is seen as an obstacle to each county's wellness.

NACo asserts that hospital costs are rising as a result of the increased methamphetamine abuse related to ED visits. The association astutely frames this as a community health care problem affecting the county government budget, and ultimately the taxpayers who feel the effects of this problem – whether directly with family, friends, neighbors involved in abuse, or indirectly when "residents have to pay the rising costs of this uncompensated care."

"There is no question that meth abuse is having a devastating effect on America's communities," said Bill Hansell, President of NACo and Commissioner in Umatilla County, Oregon. "Some states have enacted legislation that has been effective in reducing the number of local labs that produce meth. But officials in two of those states have said that the number of users has not been reduced. . . . We have to find a way to treat those people that have become addicted and prevent others from becoming addicted." (Cont'd page 4)

Survey Data Show Meth Abuse Effect on EDs (Cont'd from page 3)

The hospital ED survey was conducted in late 2005. The results of the survey are based on 200 responses from hospital ED officials in 39 states. Of the 200 responses, 82 respondents (or 41%) were from only five Midwestern states. Although care needs to be taken in interpreting the survey results, owing to the sample profile, the results drive the need for more data, for even more-sophisticated research into a multi-layered, complex community issue, and for assistance in helping counties and communities respond cost-effectively and efficaciously.

Forty-seven percent of the hospital respondents say that in their respective opinions methamphetamine is the top illicit drug seen in presentations at their EDs. The drug next highest on the respondents' opinions of the "top illicit drug seen in presentations at the hospital EDs" is marijuana at 16%, followed by cocaine at 15%, and heroine at 1%. Seventy-three percent of the survey respondents reported that ED presentations involving meth have increased over the last five years, and 68% reported continuing increases during the last three years.

NACo president Hansell said NACo "wants Congress to pass and President Bush to sign comprehensive legislation that will address all aspects of the meth abuse problem. This will include legislation on precursors and increased funding for treatment."

Patient Safety Training Series

Joint Commission Resources (JCR), an affiliate of JCAHO, has received a grant from the Robert Wood Johnson Foundation to develop a training series designed to help medical staff members improve patient safety through better communication. For the project, JCR will develop educational materials for nurses, physicians, and other clinical professionals to encourage effective communication within their respective disciplines and across professions. The materials will include presentation information, trainer guidelines, group- and individual-participant instruction, and video scenarios about patient safety. The series, which will also include a Web site featuring a bulletin-board system and downloadable resources, is expected to be available for use in hospitals by the fall of 2007. For more information, contact Pamela Steinbach, JCR, (630) 792-5405.

AHRQ Webcasts Available

Since 2003, the Agency for Healthcare Research and Quality's Bioterrorism and Emergency Preparedness Research Program has sponsored an ongoing series of distance-learning Webcasts on nearly a dozen emergency preparedness issues, including pediatric preparedness, surge capacity, and mass casualty care. These 90-minute Web conferences are designed to share the latest health services research findings, promising practices, and other important information with healthcare workers, state and local health officials, and health systems decisionmakers. To listen to or view the transcripts from the Webcasts, go to www.ahrq.gov/news/ulp/biotconf.htm.

The States: Medical Malpractice Update

✓ **Malpractice Ballot Measure Unlikely in Arizona**

A group formed by the **Arizona** Medical Association, Arizonans for Access to Health Care (AAHC) has decided not to pursue a constitutional amendment to create new limits on medical malpractice lawsuits. According to polling conducted by AAHC, the state's residents are unlikely to approve such an amendment. Furthermore, a group supported by **Arizona** attorneys has been raising money to defeat a potential ballot measure.

✓ **Cap Bill Introduced in Iowa**

In mid-February **Iowa** House Republicans launched a new attempt to limit the cost of medical malpractice awards proposing a $500,000 cap on non-economic damages. Two years ago, **Iowa** Governor Tom Vilsack (D) vetoed a bill that would have set a $250,000 cap on non-economic damages. In response to reporters' questions regarding this new attempt, Vilsack said lawmakers need to find a better solution than capping damages.

✓ Caps Bill on Life Support in Kentucky

After failing to win passage the last three years, a tort-reform measure that could lead to a cap on jury awards in **Kentucky** medical malpractice lawsuits again failed in the Senate after contentious debate on March 1, 2006. The bill – Senate Bill 1 – fell two votes short of the 60% majority needed to approve measures to amend the state Constitution. The vote was 21-15, with two abstentions.

The vote was a blow to physician and hospital groups that contend that a cap on jury awards is needed to halt the rise in premiums for medical malpractice coverage. However, the bill does remains on life support because of a parliamentary maneuver by its sponsor, Senate President David Williams, R-Burkesville.

Approval of the bill could lead to a $250,000 cap on jury awards for pain and suffering. The bill does not itself impose caps, but it would pave the way for them by placing on the ballot a constitutional amendment allowing legislators to cap awards for punitive damages and pain and suffering. The caps could be no lower than $250,000, and they would not apply to awards for economic damages, such as medical expenses. The amendment also would let legislators require that malpractice claims go before "a system of alternate dispute resolution" before they are taken to a jury.

The bill's chief foe is the Kentucky Academy of Trial Attorneys; its main backers are the Kentucky Medical Association and the Kentucky Hospital Association. The arguments for and against SB 1 have not changed much over the years. Backers say rising premiums have caused doctors to leave the state, retire, or stop practicing in risky specialties such as obstetrics; and opponents say the real cause of large malpractice premium increases in recent years is insurers making up for poor investment returns, not jury awards. They note that capping jury awards in other states did not cause big drops in malpractice premiums unless accompanied by other reforms, such as review panels to screen lawsuits. The medical association agrees that review panels would do more to hold premiums down, but maintains that caps also would help.

✓ WA Malpractice Reform Bill Heads to Governor

On February 28, a compromise on medical malpractice regulations cleared its final hurdle when the **Washington** House agreed to it on an 82-15 vote. It now goes to Governor Chris Gregoire (D), who will sign the bill she personally helped negotiate.

The bill addresses several areas:

- Allows doctors to apologize to injured patients with legal immunity if they do so within a 30-day time frame.
- Places a $1 million cap on non-economic damage awards in malpractice cases that go to arbitration instead of trial.
- Requires lawyers to file certificates of merit when filing suit against health care professionals.
- Gives the insurance commissioner expanded powers to regulate the rates doctors pay for malpractice insurance and collect data on malpractice payouts for analysis.
- Increases the kinds of mistakes hospitals must report to the state.
- Adds members of the public to the doctor disciplinary board.

House Bill 2292, was hailed as a breakthrough truce between lawyers and doctors who had fought each other with $14 million in spending on two failed initiatives last a fall.

✓ Wisconsin Proposal Calls for $750,000 limit

Republican lawmakers have unveiled a proposal for a cap of $750,000 on pain-and-suffering damages in medical malpractice cases. Lawmakers have been working to establish a new set of limits on damages for pain, suffering and loss of companionship after a July state Supreme Court ruling struck down the previous caps. Although Republican leaders said they expect to see more bipartisan support for the higher limits, it is still unclear whether Governor Jim Doyle (D) would sign the measure.

Opponents of caps said they are unfair to the most severely injured patients and argued that they do little to reduce the overall costs of health care. Supporters said caps are necessary to keep malpractice insurance rates down, which they maintained is critical for retaining physicians across **Wisconsin**. Without caps, proponents said, residents could face higher health care costs and fewer options for care.