

Legislation Introduced to Counteract Medicare Pay Cuts for Physicians

On March 13, 2008, Senator Debbie Stabenow (D-MI) introduced a measure – S. 2785, *Save Medicare Act of 2008* – which would cancel a scheduled 10.6% Medicare pay cut for physicians set for July 1 and replace it with an 18-month pay hike. This equates to a 0.5% pay hike for the remainder of 2008 and as much as a 1.8% pay raise in 2009. Among other provisions, the Stabenow bill also would extend the physician quality reporting system and the Medicare Incentive Payment Program for areas with a physician shortage. The AMA has endorsed S. 2785.

Late in 2007, Congress approved a six-month payment increase for physicians, after failing to approve a longer-term pay hike because of disagreements among lawmakers and the White House over how to pay for it. The law provides physicians a 0.5% payment increase through June 30, postponing a 10.1% cut that had been scheduled to take effect January 1, 2008. The Stabenow bill has not been scored by the Congressional Budget Office, but health care analysts say an 18-month physician payment increase could cost the federal government as much as \$15 billion over five years.

As in 2007, the Senate Finance Committee is crafting Medicare legislation to increase doctors' pay, as well as address numerous other Medicare issues. The Finance Committee is targeting Medicare Advantage managed care plans and other providers to help fund a physician fix package. However, the White House and most congressional Republicans oppose reducing Medicare managed care payments. Managed care plans argue against reducing the payments, and say that cutting plan payments to pay for a doctor pay increase would financially penalize the doctors working for plans.

In a related action, the House and Senate have approved FY 2009 budget resolutions that would provide reserve funds for a Medicare physician payment fix. The House approved its resolution March 13 by a 212 to 207 vote; the Senate passed its measure March 14 by a 51 to 44 vote. Budget resolutions are designed to be guidelines for lawmakers as they craft legislation and are not binding. The two chambers must now reconcile their budget blueprints.

Report Cites Deficiencies in Specialty Hospitals' Emergency Care

A study of physician-owned specialty hospitals, commissioned by the Senate Finance Committee and conducted by the Department of Health and Human

Services' Office of Inspector General (OIG), has found a number of faults with these hospitals' emergency medical care protocols. According to the January OIG report on the study – *Physician-Owned Specialty Hospitals' Ability to Manage Medical Emergencies* – many specialty hospitals are poorly equipped to handle emergency care and, while most adhere to Medicare conditions of participation, some practices could violate participation requirements. The report concludes that better policies for managing medical emergencies are needed, and makes specific recommendations to ensure that specialty (Cont'd page 2)

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(and all) hospitals can handle emergency situations and meet requirements.

Among the findings in the report:

- ▶ Of the 109 physician-owned specialty hospitals reviewed, 45% did not have an ED; and, of the 55% that had an ED, the majority of those facilities had only one ED bed.
- ▶ Fewer than one-third of the hospitals had a physician on-site at all times, and 7% did not always have a nurse on duty.
- ▶ As part of their medical emergency response procedures, 66% of the hospitals instructed staff to call 911. In addition, 34% of the hospitals used 911 to obtain medical assistance to stabilize a patient, and half used 911 to transfer patients to another hospital.
- ▶ One-quarter of the hospitals did not have written policies and procedures for emergency care as required by Medicare.

Although Medicare rules do not prohibit hospitals from calling 911 to respond to medical emergencies or to transfer patients to other facilities, that practice has been harshly criticized by Senate Finance Committee Chair Max Baucus (D-MT) and ranking minority member Chuck Grassley (R-IA). In fact, it was the deaths of two specialty hospital patients after being transferred to larger community hospitals when they suffered medical emergencies following elective surgeries that prompted Baucus and Grassley to request the OIG study.

Both legislators' reactions to the report reflected their long-held opposition to specialty hospitals. Baucus stated, "This report found specialty hospital shortcomings across the board. It's unbelievable that a facility that calls itself a hospital would, at times, not even have a doctor on call or a nurse on duty. It is unacceptable that these facilities are not designed or equipped to handle emergencies." Grassley said, "Most people assume that if it's called a hospital, it can handle emergencies, but this data shows that's not the case." In his written response to the OIG report, Grassley added,

"It's fair to ask whether taxpayers should continue to support erosion of community hospitals. Community hospitals are a pillar of our nation's health care system, and people rely on their full range of services, especially emergency care, to be there when a health care crisis strikes."

— Senator Chuck Grassley (R-IA)

"This new report documents the significant and potentially life-threatening shortcomings of physician-owned specialty hospitals when it comes to emergency services. Congress needs to take action to stem the trend before the situation is irreversible."

In the year-end fight over the bill that averted a 10% cut in the fees Medicare pays doctors, Congress considered – but did not pass – proposed restrictions on and more regulation of physician-owned specialty hospitals.

The issue is far from dead, however. A Senate Finance Committee spokesperson said the panel intends to pursue new patient safeguards and stronger laws governing physician-owned hospitals when lawmakers take up Medicare legislation this year. And Grassley has said that he will continue to push for legislation that would seek to limit the growth of doctor-owned hospitals.

CMS has concurred with all four of the OIG's recommendations in the report for actions to improve patient safety and specialty hospitals' ability to manage medical emergencies. In summary, those recommendations are that CMS: develop a system to identify and track physician-owned specialty hospitals; ensure that hospitals meet Medicare requirements for proper RN and physician staffing; ensure that hospitals are capable of treating emergencies and are not relying on 911 as a substitute for their own ability; and require that hospitals have written policies for managing a medical emergency, including the use of emergency response equipment and lifesaving protocols. In a letter to Inspector General Daniel R. Levinson, acting CMS Administrator Kerry Weems indicated agreement with the report and said that most of the recommendations are being pursued by the agency.

Safety is just one element of the contentious debate over physician-owned hospitals, many of which have opened since the mid-1990s. According to the trade group, Physician Hospitals of America, currently about 180 such hospitals are in operation or in the late stages of development – up from about 110 in 2001 – with most specializing in services such as (Cont'd page 3)

Report Cites Deficiencies in Specialty Hospitals' Emergency Care (Cont'd from page 2)

cardiac care or orthopedic surgery. Supporters say that, by focusing on a niche service, physician-owned hospitals are providing a higher level of care than more generalized community hospitals; but critics contend that physicians at specialty centers cherry-pick the healthiest, most profitable patients and leave the more complex and costly cases, as well as the poor and uninsured, to community hospitals.

In other comments arising from the OIG report, each side of the debate weighed in. In its statement, the American Hospital Association said that the report "confirms what we have long known – that many physician-owned limited-service hospitals fail to meet their patients' basic health care expectations."

Molly Sandvig, Executive Director of Physician Hospitals of America, noted that the study provides no comparison data on how well other kinds of hospitals provide emergency services – a fact that OIG acknowledges. But she also said the trade group believes that Medicare officials should take strong action against any hospital that does not meet federal standards. "Staffing requirements are something we always support," Sandvig said, adding that if physician-owned hospitals are using 911 services to stabilize patients, "that's not acceptable . . . Obviously you need staff on site that has the ability to stabilize."

Finally Chip Kahn, president of the Federation of American Hospitals, said that the major problem of specialty hospitals stems from doctors referring profitable patients to their own specialty hospitals. He called for a ban on such practices, saying, "Congress must pass legislation banning self-referral to physician-owned hospitals and addressing this conflict of interest, where physicians' financial incentives interfere with the clinical needs of their patients."

The OIG report is available at www.oig.hhs.gov/oei/reports/oei-02-06-00310.pdf.

From the States . . .

AZ Legislature Revisits ED Lawsuits

In Arizona, State Senator Carolyn Allen (R-Scottsdale) is trying again this year to make it harder for people injured in hospital EDs to sue. Once more she has sponsored a bill – SB 1223 – requiring patients to prove "by clear and convincing evidence" that the care they received did not meet professional standards. Allen pushed an identical measure through the Legislature in 2006, only to have it vetoed by Governor Janet Napolitano (D). At that time, Napolitano said she saw no evidence that making the change would cure the problem of doctors being unwilling to work in EDs. Since then, a task force she appointed has come up with a list of recommendations for ways to ensure there are doctors – and specialists in particular – available when patients are brought to hospital EDs. Altering the standard of proof for malpractice cases is only one of the items on that list.

Allen said she believes doctors who tell her that making it harder to win a malpractice verdict "would give them

the most comfort to be on call 24/7." John Rivers, president of the Arizona Hospital and Health Association, agrees. He considers the higher standard of proof an appropriate trade-off for ensuring the availability of doctors. But, JoJene Mills, a lobbyist and past president of the Arizona Trial Lawyers Association, contends that lawmakers are missing the point. Mills cites the need to improve the quality of medical care as foremost.

The debate could prove academic unless Napolitano changes her mind and agrees to sign the measure, or at least let it become law without her signature.

Consensus on Funding for Arkansas Trauma System Sought

Although Arkansas legislators all agree that a statewide trauma system is needed, they have not been able to agree on a funding source. On December 29, 2007, members of the House and Senate Interim Committees

on Public Health, Welfare and Labor met to try to resolve the matter. They heard from, among others, Dr. James Graham, professor of pediatrics at the University of Arkansas for Medical Sciences and chief of emergency medicine at Arkansas Children's Hospital, who stressed the state's need for a comprehensive system with Level 1, 2, 3, and 4 centers.

Estimates have put the proposed trauma system at anywhere from \$15 million to \$25 million. Graham acknowledged that was a lot of money. He noted, however, the higher cost of not having a trauma system, and pointed out that Wisconsin has about 2,700 trauma deaths a year (compared to Arkansas' 2,000), and that officials there estimate a trauma system would save the state \$64 million.

Graham said he is in his fourth year serving on the Governor's Trauma Advisory Council, which is studying how much the system would cost and how other states are paying for theirs. He reported that some states use moving violation/DWI fees. Others impose a surcharge on insurance premiums or cell phone bills; appropriate money from the general revenue fund; use a tire or vehicle tax; and one state (Oklahoma) uses tobacco tax dollars in addition to other funding sources.

Representative Denny Sumpter (D-West Memphis), sponsor of the trauma system bill filed in the last legislative session, said Governor Mike Beebe (D) had indicated to that, if the Legislature came to a consensus on how to pay for the proposal, he would make it part of an appropriations package.

Colorado Bills Mandate Medical Coverage for Car Insurers

Two bills intended to fill ED funding gaps were introduced in the Colorado Legislature in January. HB 1009, sponsored by Representative Tom Massey (R-Poncha Springs) and Senator John Morse (D-Colorado Springs), requires all automobile insurance policies in Colorado to offer emergency medical care coverage of at least \$15,000 to cover medically necessary and accident-related emergency service, including ambulance or helicopter transport. The companion bill to HB 1009, SB 11, also sponsored by Morse and Massey, creates an emergency responder and trauma care reimbursement program funded through a \$15 motor vehicle registration fee.

According to Steven Summer, president of the Colorado Hospital Association, unreimbursed medical bills from ED visits have resulted in "huge bad debts" for hospitals. And when people come to the ED without health insurance coverage or adequate car insurance it contributes to cost shifting and rising medical costs. Under HB 1009, car accident victims who do not have health insurance would be covered by their auto insurance policies.

But the costs of the proposed legislation to consumers and taxpayers have raised concerns with Carol Walker, executive director of the Rocky Mountain Insurance Information Association. Walker said HB 1009 would result in "duplicate coverage" for Coloradans who already have health insurance or who have opted to add medical coverage to their auto policies. For those who do not already have medical coverage in their auto policies, Walker said, the bill will raise car insurance premiums. She added that the legislation would not solve the problem in trauma care. As for SB 11, Walker said that bill's provisions will result in "triple billing" Coloradans.

Colorado's old "no-fault" system, under which auto insurers were required to pay at least the first \$50,000 for medical coverage before health insurance took over, was overhauled by the General Assembly in 2003 in favor of a "tort system" that removes much of the onus from auto insurers and has resulted in lower auto insurance premiums. Under the tort system, the insurance company of the person who caused the accident pays. But in cases where the fault is disputed, the parties head to court.

Walker said she did not know how HB 1009 and SB 11 would fare in the General Assembly, but she cited a poll showing that 77% of Coloradans oppose the notion of mandates.

Florida Bill Would Limit Liability for ER Doctors

Florida emergency doctors, hospitals and health leaders are pushing a bill – HB 839/SB 1640 – that would protect emergency healthcare workers and hospitals from large legal claims. The bill would make healthcare workers "agents of the state" when they are treating emergencies, and any lawsuits against such workers would be limited to \$200,000 unless legislators pass a special bill to authorize more. But opponents to the bill

say such protection would be unfair to injured patients and open the door to extending protection to doctors in non-emergency cases.

Georgians Support Trauma Care Fee

According to a recent survey conducted by the University of Georgia two out of three Georgians say they would pay \$25 or more a year to support a statewide system of trauma care. That positive response impressed several state officials, who are considering allocating millions of dollars this year for trauma care. "The public is out in front of the politicians on this issue," said Senator Vincent Fort (D-Atlanta). "[It] understands there is a health care crisis . . . and is willing to sacrifice."

The study found 67% of 504 people surveyed were willing to pay for a trauma system. In addition, 89% of

survey respondents said they believe a statewide trauma system is a government responsibility. The survey comes as momentum builds in the Legislature to fund trauma care statewide.

SD Trauma System Bill Becomes a Reality

On March 17, Governor Mike Rounds (R) signed SB 200 into law establishing a statewide trauma system for South Dakota. The legislation authorizes the health department to establish a trauma system and develop rules for patient transfer protocols, designate trauma care hospitals, and develop and maintain a system to track the care of trauma patients. The proposed time line includes hiring a trauma program coordinator in 2008 and adopting administrative rules by early 2009. The review of hospitals to determine that they meet their designated level of trauma care would be completed by January 1, 2012.

Short . . .

Patient Safety Grantees Reduce Patient Risk in Hospital EDs

Agency for Healthcare Research and Quality (AHRQ) patient safety researcher Twila Burdick, Vice President, Banner Health-Arizona State University Partnership for Emergency Department Patient Safety in Phoenix, and a team of investigators recently completed work to reduce waiting time, inefficiencies, and patient risk in eight Banner Health hospital EDs using a patient flow process called "Door-to-Doc." As a result of their work, they developed a toolkit that includes resources to assist others in implementing similar programs. The "Door-to-Doc" process improves patient care by reducing the time patients wait to see an ED physician, which results in lower rates of patients who leave the ED without treatment. The process reorganizes patient flow in the ED and improves the response time between patient arrival and the initiation of care for treat-and-release patients as well as for those who need to be admitted as inpatients.

To learn more about, view, or download the patient safety toolkit, go to <http://www.bannerhealthinnovations.org/DoortoDoc/About%2BD2D.htm>.

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