Washington Watch

by Kathleen Ream, Director of Government Affairs

MedPAC Approves 2007 Recommendations
At its January 2006 meeting, the Medicare Payment Advisory Commission (MedPAC) approved final recommendations on Medicare payment updates for 2007. These recommendations will be published in its March 2006, ***Report to the Congress***.

Despite a projected negative overall Medicare margin of 2.2 percent in 2006, the Commission recommended an update to the hospital inpatient and outpatient payment rates equal to the increase in the hospital market basket (an inflation measure) minus 0.45 percentage points. For physician services, MedPAC recommended updating payments for physician services by the projected changes in input prices less the productivity expectation growth for 2007. MedPAC estimates a price inflation of 3.7 percent and productivity growth of 0.9 percent, which would make the update 2.8 percent. MedPAC will also comment in its report that it does not support the physician fee cuts scheduled through 2011, and considers the current volume control formula, known as the sustainable growth rate or SGR, to be a "flawed, inequitable mechanism."

HHS Announces Pandemic Flu Planning Efforts
In December 2005, Department of Health and Human Services (HHS) Secretary, Michael Leavitt, announced a series of efforts designed to help state and local communities, as well as decision makers outside the health care field and the general public, prepare for a possible outbreak of avian flu. The new efforts build on the Bush Administration's pandemic flu strategy and plan announced a month earlier in November.

Speaking at a pandemic planning convention for state and local health officials in Washington, D.C., Leavitt said, "This is a grand opportunity, and I believe it's a moment in time we must grasp and move forward. Today really should be viewed as the beginning of a new chapter in public health." In his comments, Department of Homeland Security (DHS) Secretary Michael Chertoff, whose department is working with HHS in emergency preparedness, said the nation's ability to handle an emergency will improve if it comes from a base of serious planning and integrated work at all levels of government. "Emergency planning does not go well when it's undertaken in the middle of a disaster," Chertoff said. "The earlier you begin to plan, the better off you are. This is not a response that the federal government can own or any state or local government can own in and of itself."

During the first four months of 2006, HHS plans to hold a pandemic summit in each state to help public health officials engage political, educational and business leaders in preparing for a possible pandemic. Calling it vital that these summits extend beyond public health and emergency preparedness, Leavitt said, "Public health people get this. If we talk to the public health community, we're talking to ourselves. We need to lift this to the broader community." He said the summits are meant to engage, inform and motivate those people who are key to helping public health officials implement a local plan, and that the summits will not be one time events.

To help local governments prepare their plan, HHS released a six page state and local pandemic influenza planning checklist.The document specifically states that the checklist is not mandatory, but designed to serve as guidance. It includes sections on community preparedness leadership and networking, surveillance, public health and clinical laboratories, health care and public health partners, infection control and clinical guidelines, vaccine distribution and use, antiviral drug distribution and use, community disease control and prevention (including managing travel related risk of disease transmission), public health communications and workforce support. In addition, Leavitt said that, in the coming days, HHS will release checklists for schools and colleges – to be followed by checklists for faith based communities, individuals and families.

Also released was a set of pandemic planning assumptions, which Leavitt said were developed after consultation and extensive study that focused primarily on the flu pandemic of 1918. He added that the assumptions build primarily from models based on the pandemic of 1918, because that year's flu strain is closer genetically to the H5N1 avian flu virus, compared to other years' strains. The assumptions include:

- Susceptibility to the pandemic influenza virus will be universal, and that efficient and sustained person to person transmission signals an imminent pandemic.
- The clinical disease rate will likely be 30 percent or higher in the overall population during the pandemic. Illness rates will be highest among school aged children and decline with age.
- Among working adults, an average of 20 percent will become ill during a community outbreak. Some persons will become infected but not develop clinically significant symptoms. Asymptomatic or minimally symptomatic individuals can transmit infection and develop immunity to subsequent infection.
- Of those who become ill with influenza, 50 percent will seek outpatient medical care.
- The number of hospitalizations and deaths will depend on the virulence of the pandemic virus.
- Rates of absenteeism (from work or school) will depend on the severity of the pandemic, and certain public health measures (e.g., closing schools, quarantining household contacts of infected individuals) are likely to increase such rates.
- The typical incubation period for influenza is approximately two days.
- People who become ill may transmit the infection for up to one day before onset of illness.
- On average, an infected person will transmit the infection to approximately two other people.
- In an affected community, a pandemic outbreak will last about six to eight weeks.
- Multiple waves (periods during which community outbreaks occur across the country) of illness could occur with each wave lasting two to three months.

Leavitt also touched on the national plan to fund state and local efforts, and said he hoped concerns that the plan funds too much or too little will be resolved soon. Some Democrats criticized the Administration's plan, contending that the $100 million allocated to state and local governments, when weighed against $130 million in cuts to CDC's budget, amounts to a $30 million cut for states to absorb. Rajeev Venkayya, Senior Director for Biodefense for the White House Homeland Security Council, rejected that contention, saying that the federal government will continue to fund state and local planning efforts, and that more details will be released soon.

Pandemic Flu Information:
More information on pandemic flu planning is available at **http://www.pandemicflu.gov/plan/convening.html**.
The checklist for state and local planning is available at **http://www.pandemicflu.gov/plan/pdf/Checklist.pdf**.

continued on pg 19

Washington Watch - continued from pg 18

Treating Children Exposed to Bioterrorism Chemicals New AHRQ Video

HHS' Agency for Healthcare Research and Quality (AHRQ) has released a 27 minute video that trains emergency responders and hospital ED staff in decontaminating children who have been exposed to hazardous chemicals during a bioterrorist attack or other disaster. ***The Decontamination of Children: Preparedness and Response for Hospital Emergency Departments*** provides a step by step demonstration of the decontamination process in real time and trains clinicians about the nuances of treating infants and children, who require special attention during decontamination procedures.

Produced for AHRQ's Bioterrorism Preparedness Research Program by Michael Shannon, MD, MPH, Chief of the Division of Emergency Medicine at Children's Hospital in Boston, the video: outlines key differences between decontaminating children and adults; provides an overview for constructing portable and permanent decontamination showers and designating hot and cold zones; and, provides steps to establishing and maintaining pediatric decontamination capacity in an ED.

A short clip of the video can be found at **www.ahrq.gov/research/deconVideo/decon512k.ram**.
A free, single copy of the video, available in DVD or VHS format, may be ordered by calling 1 800 358 9295 or by sending an e-mail to ahrqpubs@ahrq.gov.

State Appeals Court Says No EMTALA Claim If No Transfer or Discharge

On January 12, 2006, the Michigan Court of Appeals decided that a plaintiff could not pursue a claim against a hospital under ***EMTALA*** (***Emergency Medical Treatment and Labor Act***). Rather, the state court ruled that the defendant hospital was entitled to summary disposition of contract and of *EMTALA* claims brought by a plaintiff on behalf of her deceased husband (Lanman v. Kalamazoo Psychiatric Hospital, Mich. Ct. App., No. 263665, unpublished 1/12/06).

The facts in this case involve a man named Lanman who initially was taken by police to one hospital, which found him in need of inpatient psychiatric care. The police then took Lanman to the Kalamazoo Psychiatric Hospital (KPH) "where he was found in need of care but capable of giving informed consent," wrote the court. Lanman signed a voluntary admission form, was admitted for long term psychiatric care, given medicine for back pain and assigned a room. During the night, Lanman "became increasingly agitated, eventually culminating in a struggle with defendant's staff and injection of a calming drug," the court stated. The court continued that during the altercation, Lanman "stopped breathing, allegedly as a result of compression of his breathing capacity by defendant's staff during the struggle." The KPH staff performed CPR and had Lanman "transported to a general hospital emergency room, where he remained until his death a little more than two weeks later."

The decedent's spouse subsequently filed a suit against KPH, claiming a breach of contract based on the voluntary admission form and an *EMTALA* claim for failure to stabilize. The defendant appealed to the state court because the trial court had denied a motion of summary disposition (i.e., a rapid final determination by the court) of plaintiff's contract claims. The Michigan appellate court agreed with KPH's appeal, finding that the trial court had erred in denying the motion for a summary disposition. The state asserted that the plaintiff's contract claims were, in fact, tort claims because no contract for treatment existed. "The particular form in this case," wrote the appeals court in regard to the voluntary admission form, "only constitutes an offer stating the applicant's desire to be admitted to the hospital in exchange for certain promises. The contract based on this form only ***authorizes*** treatment, it does not require it."

The state court also determined that since the requirements of *EMTALA* are inapplicable in this case, summary disposition of the *EMTALA* claim is required. Inapplicability of *EMTALA* was based on the court's reasoning that the "triggering mechanism for stabilization treatment under EMTALA is transfer," and that, therefore, "*EMTALA* mandates stabilization of an individual only in the event of a 'transfer' as defined in *EMTALA*." Because KPH admitted plaintiff's decedent to the hospital for long term treatment of his psychiatric condition, and developed complications only after being treated and medicated, the majority of the state appellate court concluded that *EMTALA* was not implicated under the facts of this case.

The court majority resolved the *EMTALA* claims on the merits, finding resolution of the immunity issue unnecessary. However, a dissent also was filed with this ruling, possibly leaving open some room for other *EMTALA* claim cases. First, the dissenting opinion suggested that a "more harmonious reading of *EMTALA*'s definition of 'stabilization' does not require that a transfer actually be contemplated."

This dissenting judge reasoned that "*EMTALA* provides a benchmark [i.e., a standard to apply for treating all patients, and therefore] . . . the statute is satisfied if the hospital *could* transfer a given patient without risking deterioration of that patient's condition. If a patient could be transferred safely, the patient is 'stable' under *EMTALA*, irrespective of whether anyone in fact *intends* to transfer the patient."

Second, the dissenting judge also was unwilling to conclude that KPH "has not waived its immunity to an *EMTALA* claim." Rather, the dissent wrote, "I would not hold that an *EMTALA* claim is factually unsupportable, and I would neither confirm nor rule out a waiver of defendant's immunity." This conclusion was based on the idea that because KPH entered into an agreement with the federal government to receive federal Medicare funding, the "Social Security Act unambiguously intends to condition receipt of funds on compliance with EMTALA." The dissent recommended remand for further fact finding on a series of issues underlying the EMTALA claims.

Text of the court's majority opinion is available at **http://courtofappeals.mijud.net/documents/OPINIONS/FINAL/COA/20060112_C263665_30_263665.OPN.PDF**.

The dissenting opinion is available at **http://courtofappeals.mijud.net/documents/OPINIONS/FINAL/COA 20060112_C263665_31_263665P.OPN.PDF**.