

## Physician Payment Formula – A Congressional Priority

At presentations delivered on February 14, 2007, at the American Medical Association National Advocacy Conference, Representatives Frank Pallone (D-NJ) – Chairman of the House Energy & Commerce’s Subcommittee on Health – and Dave Camp (R-MI) – Ranking Member of the House Ways and Means Health Subcommittee – agreed that fixing the sustainable growth rate (SGR) used to determine Medicare reimbursements to physicians is a priority for Congress. They also noted, however, that it is not clear what changes should be made. Among complications to fix-

ing the formula is a projected \$252 billion price tag over 10 years for addressing the SGR.

Camp said that one administrative fix would be to remove Part B Medicare drugs from the SGR formula. Pallone said Democrats would be looking at recommendations expected in March from the Medicare Payment Advisory Commission on fixing the SGR, and that hearings would be scheduled after the MedPAC report to examine the various possibilities.

## MedPAC Recommends 2008 Payments, Prepares Report to Congress

Last month, the Medicare Payment Advisory Commission (MedPAC) voted unanimously to approve a recommendation to Congress that it increase payments to doctors in 2008 under the Medicare physician fee schedule by a figure currently estimated to be 1.7%. MedPAC also approved a recommendation to Congress that Medicare payments to long-term care hospitals not be increased in 2008, and that payment rates for inpatient rehabilitation facilities be raised by 1% in FY 2008.

Without congressional intervention this year, Medicare payments to doctors in 2008 would be cut by 10% under the current payment formula. While commissioners expressed considerable confusion over congressional intent regarding the \$1.35 billion “Physician Assistance and Quality Initiative Fund” created by Congress late last year for 2008, they ultimately agreed that the fund should be used to pay for the 1.7% increase, but not to make the increase higher.

As for MedPAC’s recommendations on ways to fix Medicare’s physician payment system, it is expected that the commission’s report to be filed with Congress in March will chart two alternative paths. One will probably entail setting expenditure targets encompassing all providers, not just limiting the expenditure target to physicians, which

is the case under the current system. The other path is expected to entail repealing the current expenditure target known as the sustainable growth rate (SGR) formula. That approach also would involve “developing and adopting new approaches for improving the value” of Medicare spending.

The Commission appears divided on whether the SGR should be repealed altogether. If there is no agreement that the SGR should be repealed, another option will be to widen expenditure targets to include all (Cont’d page 3)

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## Federal Medical Malpractice Debate Resumes

Senator John Ensign, (R-NV) has reintroduced legislation he sponsored in the 109th Congress that places a \$750,000 cap on non-economic damages awarded in medical malpractice cases. The bill, S.243 limits the damages collected from any one provider to \$250,000 with a total cap of \$750,000. The measure does not limit economic damages, but it does place caps on attorneys' fees. Ensign said the bill is modeled after similar legislation in Texas that has helped lower medical malpractice insurance premiums for providers in that state.

Last year, the measure faced heavy opposition from Democrats and trial lawyers, and it is likely that both will oppose it again. Meanwhile, the consumers' watchdog group Public Citizen released a report on January 10 concluding that "there is no medical malpractice lawsuit crisis in America." In its news release announcing the report, Public Citizen cited as more critical problems "a lack of attention to patient safety, the high incidence of preventable medical errors and the lack of accountability for a small set of doctors who account for a majority of medical malpractice payments."

## Health Care Coalition Agrees on New Set of Patient Safety Rules

After a two-year effort to standardize the myriad safety guidelines prompted by the Institute of Medicine's 1999 report on medical errors, a coalition of health care purchasers, quality groups, and federal agencies – working in conjunction with the National Quality Forum (NQF) – has agreed on a single set of 30 "safe practices" for all hospitals to follow to help prevent patient deaths and injuries. NQF will formally issue the new set of safe practice guidelines, which will replace an outdated set first issued in 2003.

Among other practices, the guidelines will recommend that hospitals: promptly disclose medical errors to patients and their family members; adopt evidence-based programs to prevent errors during nurse shift changes; and evaluate all support staff members for patient safety competence. Some of the practices, such as creating a "culture of patient safety," may seem vague. Others are already widely accepted standards of care, but simply are not being universally followed. Examples of the latter include protocols for preventing wrong-site surgery by marking patients' limbs and preventing pneumonia in patients on ventilators with a simple set of care measures such as elevating the head of the bed. NQF President Janet Corrigan said that, by aligning efforts around this single set of standards, "we have a much better chance of being able to focus limited resources on those areas that evidence shows will achieve the

greatest gains and lead to better safety for patients."

According to NQF, adverse health care events continue as a leading cause of injury and death even though well documented methods are available that could prevent them. Furthermore, the health care industry has been slow to fix badly flawed processes that lead to adverse events. Too many conflicting safety programs are a part of the problem; another, safety experts say, is that hospitals are paid no matter what the outcome of their services.

The new safe practices are based on recommendations from a number of organizations including the Leapfrog Group, the Centers for Medicare and Medicaid Services (CMS), the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Institute for Healthcare Improvement, and Kaiser Permanente.

And, while some pioneering hospitals have adopted methods to prevent error and improve safety based on process redesign strategies used in industries like airlines and manufacturing, as few as 10% of hospitals accredited by JCAHO have comprehensive safety programs that use such formal methods. In fact, JCAHO president Dennis O'Leary warned that hospitals might not be able to meet all 30 of the new practices at one time. "We want these changes to happen but our concern is that if you ask hospitals to do too much at once, the risk is they won't do anything well." O'Leary said.

Although voluntary, it is likely that the new practices will be incorporated into the growing number of programs that reward those who take steps to improve safety and penalize those who do not. Members of the Leapfrog Group, for example, use [\(Cont'd page 3\)](#)

## Health Care Coalition Agrees on New Set of Patient Safety Rules (Cont'd from page 2)

hospital-safety surveys to create public report cards and negotiate contracts with hospitals and health care providers, and to refer their employees to high-scoring respondents and steer them away from those that do not measure up. Medicare and private insurers are expected to use the safety practices in “pay-for-performance” programs that provide incentives for compliance. And by failing to comply with safety practices, hospitals risk losing JCAHO accreditation or the certifications by state health agencies and CMS needed to be eligible for Medicare and Medicaid payments.

When it issues the safe practice guidelines, NQF will also include detailed guidance on how to implement them including examples of programs hospitals can use to train staff to convey difficult information to patients, discuss end-of-life care, and disclose bad outcomes. In addition, the committee that developed the safe practices will hold free workshops around the country to help hospitals train staff to adopt the new procedures. The workshops will be open to consumers; and consumers also will be able to view the guidelines on the NQF Web site at [www.qualityforum.org](http://www.qualityforum.org).

## MedPAC Recommends 2008 Payments . . . (Cont'd from page 1)

types of providers. MedPAC Chair Glenn Hackbarth said he sees “broad agreement” on the commission for that option, and for a component setting expenditure targets on a geographic basis. Other components tantamount to a transformation of the U.S. health system involve combining providers into accountable health systems that would be rated on the quality and efficiency of their care and paying them accordingly.

MedPAC is not prepared to advise Congress which of the two paths to take in overhauling Medicare’s physician payment system. But commissioners cautioned that whatever path Congress takes, a substantial investment of new resources in the Centers for Medicare and Medicaid Services will be essential to establishing the new system.

## The States: An Update

### ✓ **Pennsylvania Extends Medical Malpractice Insurance Subsidy**

**Pennsylvania** Governor Edward G. Rendell (D) has extended through 2007 a program that pays up to 100% of **Pennsylvania** health care providers’ yearly assessments to the state-run excess liability malpractice insurance fund. This program also allows physicians who provide emergency services in hospital EDs to have their Medical Care Availability and Reduction of Error (MCARE) Fund assessments fully refunded in 2007.

The MCARE Fund provides \$500,000 in excess liability coverage beyond the \$500,000 in basic medical malpractice insurance coverage that **Pennsylvania** physicians must purchase in the commercial market. The legislation enacted in 2003 abated or provided refunds for all or part of the assessments health care providers had to pay into the Fund in 2003 and 2004. In subsequent years, bills were enacted to extend the abatements to 2005 and 2006 assessments.

The state’s MCARE Fund premium payments on behalf of providers since 2003 total \$830 million.

The abatement program, which is paid for with cigarette tax revenues, is intended to give physicians short-term relief from high malpractice insurance premiums while they wait for premiums to drop in response to legal reforms, patient safety initiatives, and other long-term measures aimed at addressing the underlying causes of rising insurance costs. Surgeons, neurosurgeons, orthopedic surgeons, obstetricians, emergency physicians, rural doctors who routinely deliver babies, certified nurse-midwives, and nursing homes receive a 100% abatement of their assessments. All other physicians and podiatrists receive a 50% abatement. Emergency physicians certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine employed full time at trauma centers began receiving a 100% abatement three years ago. Now, with the enactment of Rendell’s

program, full-time, board-certified emergency physicians working in hospital EDs also will be eligible for a 100% abatement.

MCARE Fund payouts declined in 2006 for the third consecutive year. Rendell interpreted the decline as a signal of continued stabilization and improvement in **Pennsylvania's** medical malpractice market. He said the MCARE Fund will pay about \$210 million in claims this year, a decline of \$23 million from 2005 and \$169 million lower than 2003. "In addition, the two largest private medical malpractice carriers have not increased their base rates in two years and, since I have been in office, four new insurance companies and 29 risk retention groups have started writing medical malpractice insurance in **Pennsylvania**," Rendell stated.

While Hospital & Healthsystem Association of **Pennsylvania** president Carolyn F. Scanlon said that extending the MCARE abatement will help preserve patient access to health care, she added that access to care in **Pennsylvania** remains vulnerable despite the evidence of improvements in the medical liability environment. "We believe there needs to be a long-term solution," Scanlon said. "Therefore, we look forward to reviewing the upcoming report of the MCARE Commission." The commission was established early in 2006 to review the MCARE Fund's unfunded liabilities and make recommendations on issues including the Fund's future and the assessment abatement program.

### ✓ **Washington Panel's Recommendations Address ED Use**

In **Washington**, the Blue Ribbon Commission on Health Care Costs and Access, co-chaired by Governor Chris Gregoire (D) and former state Senator Pat Thibaudeau (D-Seattle), has made 16 recommendations to improve health care in the state. One of the recommendations calls for the reduction of unnecessary ED visits. The commission says that patients should have information about and access to alternatives to ED care, and incentives to use them.

### ✓ **Utah Malpractice Tort Reform Bills Criticized**

Two **Utah** bills seeking to increase the evidence requirements for malpractice suits related to ED visits are receiving some sharp criticism. HB 338 and SB 115 would up the standards of evidence required to wage a malpractice suit against an ED service provider.

The **Utah** Citizens Alliance, an organization that works for accountability and safety in health care, strongly opposes the bills saying that they are designed to protect doctors. On the other hand, the **Utah** Medical Association (UMA) supports both bills because they believe that the standard to prove fault in malpractice should be higher. "The emergency room is such a unique environment," the UMA added. "The doctors that work there don't have a choice to treat or not to treat a patient. They must treat and they do that with a limited knowledge of medical background, sometimes not knowing the patient's name."