

Deadline for Medicare Physician Payment Cut Comes & Goes

In the latest attempt to avert the 21% cut in Medicare physician payments rescheduled for June 1, Congress failed to cancel the cut prior to its Memorial Day holiday recess. The cut goes into effect despite House approval May 28 of legislation (H.R. 4213) canceling the cut and replacing it with a 19-month reimbursement increase. The House approved the physician payment section of the bill, which also included tax extenders, by a 245-171 vote. The House action does not forestall the physician payment cut, however, since the Senate also must act on the provision. However, lawmakers have until the middle of June to act on the issue before the cut is felt by physicians as the Centers for Medicare & Medicaid Services has told contractors to hold reimbursement claims for 10 business days.

Originally, House and Senate Democrats had sought a five-year solution to the perennial issue of payment cuts. House Ways and Means Committee Chair Sander M. Levin (D-MI) wanted to include, as part of the tax extenders package, language that would block cuts and freeze the payment rate at 2009 levels for the next five years. The plan lacked offsets to pay for itself and, although offsets were not required under statutory pay-as-you-go rules (P.L. 111-139), Republicans – and some moderate Democrats – opposed the plan, finding the \$88.5 billion cost too high. Also, the American Medical Association (AMA), which has been lobbying for a permanent repeal of the SGR, opposed the plan. In explaining the organization’s position, AMA president J. James Rohack said, “The AMA cannot support

a proposal that would result in steeper future payment cuts and a substantially higher cost for a permanent solution, making it more difficult, if not impossible to repeal the Medicare physician payment formula.”

Members of the House Ways and Means Committee and the Senate Finance Committee spent weeks trying to work out differences between the two chambers’ versions of the extenders package, both of which included plans to address/forestall the payment cuts, for naught. And an earlier bill, passed by the House last November, that would have repealed the SGR and replaced it with a new Medicare payment formula for physician services went nowhere in the Senate because of cost concerns.

The House legislation passed on May 28 cancels the 21% cut due June 1 and replaces it with a 2.2% payment increase for the remainder of 2010 and a 1% pay hike for 2011 at a cost of about \$23 billion. Payment policy would return to current law in 2012, resulting in a 33% pay cut for doctors.

Other health provisions that were under consideration by the House in the original tax extenders package were left out, but presumably they will be considered by the Senate in June and then sent back to the House for its consideration. For example, House Democrats jettisoned a six-month increase in federal Medicaid matching funds, which cost \$24 billion.

Physician groups expressed disappointment that the Senate failed to take action canceling the 21% cut before adjourning. According to the AMA, “The Senate has turned its back on seniors, and America’s physicians are outraged that Congress has deserted patients by failing to address this year’s Medicare cut before the June 1 deadline.”

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CDC Issues Report on ED Use

On May 19, the Centers for Disease Control and Prevention (CDC) released the report “Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?” Prepared by CDC’s National Center for Health Statistics using data from the 2007 National Health Interview Survey and the 2007 National Hospital Ambulatory Medical Care Survey, the report states that the number of ED visits has increased since 1996, while the number of EDs across the country has decreased. The consequences, according to the report, are crowding, longer wait times, and rising health costs.

“As national health care costs continue to rise and policymakers become increasingly interested in ways to make the health care system more efficient, it is important to understand the characteristics of those individuals who use EDs – often in place of other sources of ambulatory care,” the report states. Accordingly, the report’s findings are broken down by the characteristics of those who use the ED, i.e., demographics, insurance status, health status, and access to a usual source of medical care. The key findings are:

- Older adults (aged 75 and over), non-Hispanic black persons, poor persons, and persons with Medicaid coverage were more likely to have had at least one ED visit in a 12-month period than those in other age, race, income, and insurance groups.
- Among the under-65 population, the uninsured were no more likely than the insured to have had at least one ED visit in a 12-month period.
- Persons with Medicaid coverage were more likely to have had multiple visits to the ED in a 12-month period than those with private insurance and the uninsured.
- ED visits by the uninsured were no more likely to be triaged as nonurgent than visits by those with private insurance or Medicaid coverage.
- Persons with and without a usual source of medical care were equally likely to have had one or more ED visits in a 12-month period.

While some of the report’s findings indicate that poor and uninsured people are more likely to seek ED treatment than others, other findings serve to dispel a common perception that EDs are packed with uninsured people and illegal immigrants, and to reject claims that people are using the ED for routine care. In 2007, for example, just 10% of ED visits by persons under age 65 were for nonurgent causes.

With respect to income, the statistics show a strong correlation between lower levels and a tendency to seek treatment in EDs. The numbers also reveal an apparent tendency of Medicaid beneficiaries to visit EDs more often than others. For Medicaid beneficiaries under age 65, 15% had two or more ED visits, compared with 7% of the uninsured and 5% of people with private insurance; and 5% had four or more visits over a 12-month period, compared with 2% of the uninsured and 1% of people with private insurance. “This finding,” the report’s authors note, “may reflect higher rates of disability and chronic conditions among persons with public insurance.” In conclusion, the authors recommend that “Future work should focus on untangling the complex interactions among the sociodemographic, health status, and health care access factors that appear to be associated with visits to the ED.”

Donald Berwick Nominated to Head CMS

In later April, the White House announced the nomination of Donald Berwick for administrator of the Centers for Medicare and Medicaid Services (CMS). Preoccupation with the year-long battle to enact the health care law had delayed the nomination, but President Obama's selection is already well known throughout the health care policy world. Currently, Berwick is president and CEO of the Institute for Healthcare Improvement, and a professor at Harvard Medical School and the Harvard School of Public Health. He is also a pediatrician, an adjunct staff member in the Department of Medicine at Boston's Children's Hospital, and a consultant in pediatrics at Massachusetts General Hospital.

The Senate Finance Committee, which oversees

Medicare and Medicaid, has jurisdiction of Berwick's hearing. A hearing date has not been announced, but Finance Committee Chair Max Baucus (D-MT) said the hearing will be "expeditious" and he praised the CMS choice. Republicans promised scrutiny, with Senator Charles Grassley (R-IA) saying that the committee "will need to explore the nominee's preparedness for the enormous challenges that face the agency."

Berwick's nomination was met with praise from sectors of the health care industry, and descriptions of him as a proven leader. Those expressing such sentiments included spokespersons for the Federation of American Hospitals, the American Hospital Association, the American Medical Association, Premier Healthcare Alliance, and the American College of Cardiologists.

From the States . . .

CA Reaches Settlement Over 'Balance Billing'

On May 24, **California's** Department of Managed Health Care (DMHC) reached a settlement with Prime Healthcare Services over the hospital system's practice of "balance billing." Under the settlement, Prime Healthcare will audit its billing records from the last six years and provide refunds with interest to patients who paid balance bills. They also will also donate \$1.2 million to six community clinics in **California**. Cindy Ehnes, director of DMHC, said it is unclear how many patients will receive reimbursements or how much Prime Healthcare will need to pay. She said state regulators will pressure the hospital system to deliver the refunds as soon as possible.

FL Sovereign Immunity Bill Dies in Committee

Legislation that would have limited the liability of doctors, nurses, and EMS personnel for ED errors – even in cases of gross negligence – died in the **Florida** Senate Committee on Banking and Insurance on April 30. The bill was backed by the **Florida** Medical Association and the **Florida** Hospital Association.

SB 1474, sponsored by Senator John Thrasher (R), would have extended what is known as "sovereign immunity" to hospital EDs – giving emergency health care providers the same protection from liability lawsuits as public employees and institutions. The bill would have capped damages from lawsuit awards at

\$200,000 per incident, with the state government – not the doctors involved – defending malpractice cases arising from the state's 205 EDs. If juries gave an award in excess of the \$200,000 cap, the state would have assumed the liability. In those cases, however, since the state has sovereign immunity from such lawsuits, plaintiffs would have had to file a so-called "claims bill" in the legislature to get the money.

Florida lawmakers have proposed similar measures extending sovereign immunity to EDs the past three years. Support for and opposition to SB 1474 is not divided along party lines. In agreement with Thrasher's position that the threat of lawsuits is a driving factor behind the shortage of doctors willing to staff EDs, Senator Eleanor Sobel (D) supported the bill. On the other hand, Senator Dennis Jones (R) joined Senate Minority Leader Al Lawson (D) in opposition.

The state's public hospitals already have sovereign-immunity protections in lawsuits. After a debate about medical malpractice in 2003, the legislature passed a law that includes some liability protections for ED doctors (e.g., limits on non-economic damages compensating victims for pain and suffering of \$150,000 or \$300,000, depending on the circumstances). But, in extending the sovereign-immunity limits to EDs at all hospitals that provide emergency care and to all ED workers, SB 1474 goes much further. Debra Henley, a

lobbyist for the **Florida** Justice Association, a trial lawyers group, said, “The scope of this bill is massive.” Citing a similar view, Lawson called the measure “just too broad.”

Georgia Supreme Court Upholds ED Liability Law

In a split 4-3 ruling on March 15, the **Georgia** Supreme Court upheld a controversial provision of the state’s tort reform law that makes it extremely difficult for patients to recover damages in cases involving ED care. The ruling affirmed a state trial court decision that upheld the constitutionality of the statute in the context of a malpractice lawsuit (*Gliemmo v. Cousineau*) brought by Carol and Robert Gliemmo against St. Francis Hospital, ED physician Mark Cousineau, and his employer, Emergency Medical Specialists of Columbus PC.

Carol Gliemmo went to the hospital in 2007 complaining of serious pain behind her eyes and a “snapping in her head.” She said she was diagnosed with high blood pressure and the ED doctor sent her away with a prescription, but failed to diagnose a brain hemorrhage that left her paralyzed. The Gliemmos alleged that the doctor was negligent. The defendants sought to have the suit dismissed under the 2005 tort-reform law that requires “clear and convincing evidence that the physician or health care provider’s action showed gross negligence.”

Plaintiffs argued that the law creates what is tantamount to an insurmountable legal threshold for patients injured by malpractice in hospital EDs. But defense attorneys contended that the statute takes into account what happens in chaotic EDs, where doctors are often faced with life-or-death decisions without knowing their patients’ medical histories.

In rejecting the Gliemmo’s claim, the majority compared the ED law to one already held to be constitutional, the ***Hospital Care for Pregnant Women Act***. That law requires certain hospitals to care for pregnant women in labor, and prohibits lawsuits except when the person providing treatment “has been grossly negligent.” Relying on that precedent, the four justices decided the law the Gliemmos challenged was not an unconstitutional special law. They stated that the **Georgia** Legislature had a legitimate reason to promote affordable malpractice insurance for hospitals and health care providers, and that it is “entirely logical” to assume that

ED care is different from care provided in other hospital settings. In dissent, the minority opinion called the ED provision “unreasonable and arbitrary” and said it leaves ED patients with “a lower standard of care and a higher burden of proof.”

Georgia Cap on Non-economic Damages Ruled Unconstitutional

According to a **Georgia** Supreme Court ruling of March 22 (*Atlanta Oculoplastic Surgery PC v. Nestlehutt, Ga.*), a **Georgia** statute that caps non-economic damages awards in medical malpractice cases violates the plaintiffs’ jury trial rights by nullifying a jury’s findings of fact concerning the amount of damages owed for a specific injury. The **Georgia** Legislature, in enacting Ga. Code Ann. §51-13-1, requires courts to reduce jury awards to set amounts and “thereby undermines the jury’s basic function,” the court said.

IL Supreme Court Strikes Down Malpractice Caps

In April, the **Illinois** Supreme Court struck down a five-year-old state law that capped medical malpractice non-economic damages awards at \$1 million for hospitals and \$500,00 for physicians. The Court ruled that the law violated the separation of powers provision in the state constitution, marking the third time since 1976 that the **Illinois** high court has struck down malpractice damages caps.

The ruling stems from a 2006 lawsuit filed by the family of a girl who suffered severe brain damage during her caesarian birth. The suit, which was a test case for several lawsuits challenging the constitutionality of the 2005 law, partially affirms a 2007 ruling in Cook County Circuit Court. The majority opinion in that case stated, “The crux of our analysis is whether the statute unduly infringes upon the inherent power of the judiciary. The legislature’s attempt to limit . . . damages in medical malpractice actions runs afoul of the separation of powers clause.”

The state’s physician and hospital groups criticized the ruling, characterizing it as rejection of and ignoring the wishes of **Illinois** citizens, while trial lawyers and labor groups saw the ruling as a victory for victims of medical errors. The 2005 law did not cap economic damages or other compensation for victims, such as lost wages, potential future earnings, and medical expenses.