SENTINEL
Washington
July 23, 2007
AMERICAN ACADEMY OF EMERGENCY MEDICINE
when minutes count

CMS Proposes 9.9% Cut in Physician Payments for 2008

In the July 12, 2007, ***Federal Register***, the Centers for Medicare and Medicaid Services (CMS) announced that Medicare payments to doctors in 2008 would be cut by 9.9%. CMS had the choice of using a $1.35 billion fund created under a 2006 law to whittle down the 2008 cut to about 7.9%, but elected not to do so. Instead, it plans to use the money to boost its system of bonus payments – the Physician Quality Reporting Initiative (PQRI) – started this year for doctors who report data on the quality of their care.

Also, contained in the proposed regulation from CMS is a reduction in emergency medicine practice expenses for two of a four-year phase-in on practice expense methodology. When combined with other adjustments to achieve budget neutrality, the total reduction for emergency medicine will result in cuts close to 12%.

CMS justifies the decision not to use the fund to reduce the size of the cuts on the grounds that payments to physicians should not be based simply on the volume of the services they provide. According to the proposed rule, using the full $1.35 billion for bonus payments will help to promote "quality and efficiency." The bonus payments would boost 2008 payments by about 1.5% for doctors who decide to take part in PQRI. Doctors who participate would have to provide data on a larger number of measures of quality of care than they do in 2007, but the proposal does not say how many more.

In a press release, Acting CMS Administrator Leslie Norwalk stated that the proposal builds on efforts to "transform Medicare into an active purchaser of higher quality services, rather than just paying for procedures." The CMS proposal states that using the Physician Assistance and Quality Initiative Fund created by the ***Tax Reform and Health Care Act of 2006*** to lessen the size of the projected cut in 2008 is not "feasible" because of "fundamental legal and operational problems."

Congress is likely to pass legislation later this year to block the 9.9% cut. The cost of legislation to do that would be $1.35 billion lower were CMS to use the fund to reduce the size of the cut.

Bill Provides Grants for Innovative Medical Malpractice Reform

On May 24, Senate Finance Committee Chair Max Baucus (D-MT) and Senate Health, Education, Labor and Pensions Committee ranking minority member Mike Enzi (R-WY) introduced the ***Fair and Reliable Medical Justice Act of 2007*** – S.1481 – to reform the medical malpractice system via grants for innovative state projects, such as health courts. A companion bill – H.R. 2497 – was introduced in the House by Representatives Jim Cooper (D-TN) and Mac Thornberry (R-TX).

Under this bill, grants would be made available to 10 states to develop "new and better ways to deal with medical malpractice cases." Planning grants totaling (Cont'd page 2)

In this issue . . .

CMS Proposes 9.9% Cut in Physician Payments for 2008 . . . 1
Bill Provides Grants for Innovative Medical Malpractice Reform . . . 1
House Democrats Working on Physician Payments Fix . . . 2
The States: An Update . . . 3

American Academy of Emergency Medicine ◆ 555 E. Wells Street, Suite 1100, Milwaukee, WI 53202 ◆ www.aaem.org
Kathleen A. Ream, Director, Government Affairs ◆ Phone: 703-241-3947 ◆ E-mail: aaemgov@aol.com

House Democrats Working on Physician Payments Fix

House Democrats may include physician payment provisions – a two-year fix that would block scheduled payment cuts and provide an update of at least 0.5% in 2008 and 2009 – in the Medicare package they are assembling. Under the current sustainable growth rate (SGR), Medicare sets a spending target for all physicians that, if exceeded, results in payment cuts in future years to recoup the sum over the target. It is reported that the Democrats on the Ways and Means Committee are considering replacing the SGR of the physician payment system with six separate service expenditure targets: primary care and preventive services; other evaluation and management services; imaging; major procedures; minor procedures and other services; and anesthesia. This is still under development and the targets could change.

While some of the pools would have targets based on the growth in the Gross Domestic Product (GDP), more spending growth might be targeted toward the types of care Democrats seek to foster, such as primary and preventive care. For example, the target for primary and preventive care might be set at GDP plus 3%, rather than just an increase in the GDP.

Beginning in 2010, $54 billion in debt accumulated from the current physician payment formula would be recouped by being "proportionately" spread out among the six targets. The concept is that each service category has the responsibility to pay back its share of the debt.

Bill Provides Grants for Innovative Medical Malpractice Reform (Cont'd from page 1)

$500,000 would be issued first, followed by implementation funding. To qualify for a grant, states must show their proposal would provide prompt and fair dispute resolution, encourage early disclosure of medical errors, enhance patient safety, maintain access to liability insurance, and provide patients with notification and the choice to opt out.

Health courts would feature full-time judges specializing in medical malpractice cases. The court would choose impartial medical experts to testify, and winning plaintiffs would be reimbursed for their medical cost and lost income, plus a fixed amount that would be established via an awards schedule. Supporters of the idea say that under such a system, cases would be resolved in months, not years, and legal fees would be reduced.

The legislation calls for the Secretary of the Department of Health and Human Services (HHS) to review grant applications and consult with an advisory committee appointed by the comptroller general. The advisory committee would include health care providers, patient advocates, attorneys with relevant expertise, medical malpractice insurers, state officials, and patient safety experts. The HHS Secretary is also charged with helping to: develop payment schedules for non-economic damages; and identify avoidable injuries.

Because the new bill contains no damage caps for malpractice awards, does not impose a national solution on states, and would allow patients to opt out of an alternative dispute process if they decided instead to file a lawsuit, the sponsors are hopeful that it will gain traction this year, and – as Cooper said – end "gridlock " in Congress on the issue.

Supporters of the legislation include AARP, the American College of Obstetricians and Gynecologists, and the National Committee for Quality Assurance. The AMA did not endorse the bill specifically, but issued a statement saying, "It is important to explore state-based demonstration programs to analyze whether alternative liability reforms hold potential." AMA added that "research on alternative reforms must be rigorous and experience-based to avoid unintended consequences such as lowering the burden of proof" of malpractice.

The States: An Update

✓ Arizona Malpractice Reform Bill Rejected

The Arizona House rejected SB 1032, a bill that would have made malpractice lawsuits against ED physicians and staff more difficult for plaintiffs to win. The legislation, which the Senate had approved in January, would have required plaintiffs in such malpractice lawsuits to provide "clear and convincing evidence" that the care they received did not meet professional standards, rather than a "preponderance of evidence." According to supporters, the bill would have prevented frivolous lawsuits that have led to increased malpractice insurance premiums and prompted physicians to leave the state. Opponents maintain that the legislation would have violated the constitutional right of patients to file malpractice lawsuits. Governor Janet Napolitano (D) vetoed an identical bill last year.

✓ Nebraska "Condolences" Bill Becomes Law

On May 21, 2007, Nebraska Governor Dave Heineman (R) signed into law a bill prohibiting plaintiffs from using statements of sympathy, condolences, apologies, or a "general sense of benevolence" by physicians as evidence in malpractice lawsuits, but allowing them to continue to use statements of fault by physicians as evidence. Similar laws have been enacted in 29 other states.

✓ New Jersey Bill Requires Pediatric Emergency Physicians in EDs

On May 15, New Jersey Senate President Richard J. Codey (D-Essex) introduced SB 2703 – a bill that would require all state children's hospitals to have a pediatric emergency physician on duty at all time in their EDs to ensure that the highest quality emergency care is provided to infants and children in New Jersey. If approved, the new regulation will apply to all hospitals in the state that are designated by the Commissioner of Health and Senior Services as a "children's hospital." Since its introduction, there has been no movement on this bill.

In his introductory comments, Codey credited the R Baby Foundation and its founders, Andrew and Phyllis Rabinowitz, for bringing to light many concerns surrounding the care and treatment of infants in hospital EDs. The couple established the foundation after they lost their infant daughter last year to a viral infection that was treated as a common cold. "Quite frankly, I had been concerned for a while over disclosure procedures in emergency departments, particularly whether parents were being told that their child was being treated by a pediatrician or a regular ER physician," added Codey. " When Andrew Rabinowitz contacted my office looking for support for their new initiatives, we were eager to listen and find out how we could do more."

This summer, Codey intends to convene a panel of experts – physicians, hospital administrators, and academics – to study the issues surrounding infant mortality and the ways in which New Jersey's health care system can better address infant care. The World Health Organization has ranked the United States 36th among nations in infant mortality rates, with one in 141 infants dying within the first 28 days of life.

✓ Cap Bill in North Carolina Has Broad Support

A new era of cooperation with respect to medical malpractice reform appears to be dawning in North Carolina. In a marked change from previous years, both doctors and lawyers are supporting a bill – HB 1671 – that caps monetary damages in some medical malpractice cases. Specifically, the measure caps monetary damages in negligence cases at $1 million, but only for those who agree to go to binding arbitration. Both the North Carolina Medical Society and the North Carolina Academy of Trial Lawyers have endorsed it.

The bill, which is modeled on a Washington state law passed last year, was finalized after weeks of negotiation and approved by a wide margin in the House on May 21 and sent to the Senate. Under the bill, plaintiffs and defendants in a patient negligence lawsuit against a doctor or hospital could agree to settle their case under binding arbitration. The legislation covers how the arbitration would occur, with hearings to begin no later than 10 months after the parties agree to enter the procedure. The arbitrator must issue a decision within two weeks of the hearing's close, with all monetary damages limited to $1 million. Appeals would be very limited.

Historically, the main obstacle to medical malpractice reform has been a cap on awards. Doctors blamed rising malpractice insurance premiums on

multimillion-dollar awards by runaway juries and wanted a $250,000 cap on non-economic damages, but the attorneys held that patients need financial protection for mistakes by the truly worst physicians and firmly said no. Now, that the bill is in the Senate, lawmakers and both sides are cautiously optimistic.

✓ Issue of Caps on Damages before Ohio Court

The state Supreme Court has heard arguments in a case that challenges the constitutionality of state caps on damages in malpractice lawsuits. The state law enacted in 2005 caps noneconomic damages in malpractice lawsuits at $500,000 per injury and punitive damages at twice the amount of economic damages. The law does not cap economic damages.

✓ Ohio Bill Requires EDs in Specialty Hospitals

As a group of local surgeons search for a site to build a surgical hospital, a new bill – seen by some as leveling the playing field between Ohio's non- and for-profit hospitals, and by others as stopping specialty hospitals from forming – has been introduced. Senate Bill 120, written by Senator David Goodman (R-Columbus) and cosponsored by Senators Steve Austria (R-Beavercreek) and Steve Stivers (R-Columbus), requires specialty hospitals to operate a 24-hour ED and maintain Medicare and Medicaid provider agreements. Since its introduction in May 2007, there has been no movement on this bill.

✓ Oklahoma Governor Vetoes "Caps" Bill

Oklahoma Governor Brad Henry (D) has vetoed SB 507, a bill that would have capped noneconomic damages in malpractice lawsuits at $300,000. Henry cited concerns that the legislation would not prevent frivolous lawsuits. Under SB 507, juries in malpractice lawsuits could have awarded punitive damages only when they found clear evidence of intentional or flagrant negligence.

✓ Tennessee Non-Compete Bill Signed into Law

On June 21, 2007, Tennessee Governor Phil Bredesen (D) signed into law a bill – HB 240 – allowing providers to restrict doctors from practicing within a 10-mile radius from the practice where they were previously employed or from any facility where the provider offers services. The bill also includes a provision for restricting a doctor's practice, under reasonable time and geographic circumstances, if the practice is sold.

The bill was amended to exclude emergency medicine specialists and radiologists. The inclusion of ED doctors in the bill was a hotly contested issue. Supporters of excluding them maintained that ED doctors do not take patients with them if they move to another facility, and that including them in the legislation would only fuel the ED doctors shortage.

Proponents of the legislation maintained that non-compete agreements save physician groups from significant losses, should doctors they had recruited, trained, and invested money in to build a patient base quit and take their patients with them. Opponents argue that the agreements stop doctors from choosing where they practice and reduce access to care.

While moving through the legislature, the issue triggered hot debate among several specialty groups, including emergency medicine physicians who wanted to be excluded from the legislation, and doctor recruiters who wanted to keep them in. Speaking for the latter position, TeamHealth said its worry was that physicians they recruit would try to steal contracts from their company and other doctors. The firm contended that it rarely enforces a non-compete agreement if the physician worked well with the practice and had nothing to do with a contract's termination.

In support of their position, the ED doctors point out that they do not have patients to take with them, and that including them in the legislation would contribute to a shortage of doctors. In a detailed statement, Kevin Beier, president of the Nashville chapter of **AAEM**, said, "Under the previous restrictive covenant laws, in most groups you could not move to Skyline or Centennial or any other hospitals around, you had to leave the county. And frankly, we can't afford a loss of any more doctors in this area."