

Medicare No Longer Covers Hospital Errors

In a significant policy change that Administration officials say could save lives and millions of dollars, Medicare will no longer pay the extra costs of treating preventable errors, injuries, and infections that occur in hospitals. Private insurers are considering similar changes, which they say could increase the savings and benefits for patients.

Under the new rules, Medicare will not pay hospitals for the costs of treating certain “conditions that could reasonably have been prevented.” Those conditions include: bedsores or pressure ulcers; injuries caused by falls; and infections resulting from the prolonged use of catheters in blood vessels or the bladder. Some of the complications for which Medicare will not pay, under the new policy, are caused by common strains of staphylococcus bacteria. Other life-threatening staphylococcal infections may be added to the list in the future. In addition, Medicare will not pay for the treatment of “serious preventable events” such as: leaving a sponge or other object in a patient during surgery; giving a patient incompatible blood or blood products. The Bush Administration estimates the new policy will save Medicare \$20 million a year, but other experts say the savings could be substantially greater.

When the new rules were first proposed in May, consumer advocates feared that some hospitals might charge patients for costs that Medicare refused to pay. However, the final rules state, “The hospital cannot bill the beneficiary for any charges associated with the hospital-acquired complication.” With that clarification, consumer groups welcomed the change. Lisa A. McGiffert, a health policy analyst at Consumers Union, had nothing but praise for the rules. “Hundreds of thousands of people suffer needlessly from preventable hospital infections and medical errors every year,” McGiffert said. “Medicare is using its clout to improve care and keep patients safe. It’s forcing hospitals to face this problem in a way they never have before.”

On the other hand, while hospital executives endorsed the goal of patient safety, they also said the policy would require them to collect large amounts of data they did not now have. That raises the possibility of changes in medical practice as doctors hew more closely to clinical guidelines and hospitals perform more tests to assess the condition of patients at the time of admission.

Hospital executives also worry that they will have to absorb the costs of these extra tests. And, while Nancy E. Foster, a vice president of the American Hospital Association (AHA), agreed that doctors and hospitals know how to prevent the transfusion of incompatible blood products and should not be paid more if they accidentally leave objects in patients during surgery, she also said that some of the conditions cited by Medicare were not entirely preventable. For example, in their comments on the proposed rules in June, the AHA said, “Certain patients, including those at the end of life, may be exceptionally prone to developing pressure ulcers, despite receiving appropriate care.” Foster added that, since hospital records in most states do not show whether a particular condition developed

before or after a patient entered the hospital, many hospitals will have to perform more laboratory tests to determine, for example, if patients have urinary tract infections at the time of admission.

Dr. Tammy Lundstrom, chief medical officer at Providence Hospital in Southfield, Michigan voiced the same concerns.

(Cont’d page 2)

In this issue . . .	
Medicare No Longer Covers Hospital	1
Specialty Hospitals’ Use of 911 Services	
Questioned	2
Emergency Care Legislation Introduced	3
Progress Report on Flu Pandemic Plan Released . .	3
From the States	4

Specialty Hospitals' Use of 911 Services Questioned

In response to a local Phoenix news report that found physician-owned specialty hospitals had called 911 emergency responders to transport a total of 150 patients to full-service community hospitals when they experienced complications following surgeries, Senate Finance Committee leaders are questioning six Arizona surgical and orthopedic hospitals about their frequent use of 911 to handle emergency cases at their facilities. On August 23, Chairman Max Baucus (D-MT) and ranking minority member Chuck Grassley (R-IA) sent letters to the following hospitals: Surgery Center of Scottsdale in Scottsdale; Biltmore Surgical Center in Phoenix; Arizona Surgical Specialists Center in Tempe; Arizona Spine and Joint Hospital in Mesa; The Orthopedic Surgery Center of Arizona in Phoenix; and Arizona Orthopedic Surgical Hospital in Chandler Heights.

Requesting a response from the hospitals by August 31, the senators wrote that they were "deeply disturbed" to hear that specialty hospital staffs seemingly had relied on 911 to handle emergency cases in their facilities. They asked hospital executives to provide information about staff capabilities in emergency care and other areas, and specifics about the hospitals' financial situation. They also requested details about the status and medical history of patients for whom specialty hospitals

called 911 and the outcomes for patients transferred from the facilities to community hospitals. Finally, Baucus and Grassley asked whether Medicare or Medicaid covered any portion of patient care at the specialty hospitals and whether they were accredited by The Joint Commission.

Widespread concerns about specialty hospitals using 911 services to handle emergency care cases first surfaced in January as a result of the death of a patient transported from a surgical hospital in Abilene, Texas to a community hospital for emergency complications that arose during routine surgery. CMS ultimately ended its Medicare contract with the facility, citing failures to maintain conditions of participation. Those conditions, which were clarified by CMS in April, require most Medicare-participating hospitals, including specialty hospitals, to be able to evaluate and provide initial treatment for any emergency situation.

Grassley and Baucus have spoken out against specialty hospitals several times in the past, and are particularly critical of those in which referring physicians have an ownership interest. They said evidence that specialty hospitals were unable to handle emergency complications following surgeries was especially troublesome.

Medicare No Longer Covers Hospital Errors (Cont'd from page 1)

She said, "The rules could encourage unnecessary testing by hospitals eager to show that infections were already present at the time of admission and did not develop in the hospital." Moreover, she said, "Serious, costly infections can occur even when doctors and nurses take all the recommended precautions."

Yet, Michigan is one state that has had great success in reducing infections related to the use of catheters. The hospitals did not use expensive new technology, but systematically followed well-established infection-control practices. These techniques, hospital executives said, had saved 1,700 lives and \$246 million by reducing infection rates in intensive care units since 2004.

Dr. Kenneth W. Kizer, an expert on patient safety who was the top health official at the Department of Veterans Affairs from 1994 to 1999, said, "I applaud the intent of the new Medicare rules, but I worry that hospitals will figure out ways to get around them. The new policy should be part of a larger initiative to require the reporting of health care events that everyone agrees should never happen. Any such effort must include a mechanism to make sure hospitals comply."

Emergency Care Legislation Introduced

On July 25, Senator Barack Obama (D-IL) and Representative Henry Waxman (D-CA) introduced legislation providing funding for programs designed to improve the nation's EMS systems and to support emergency medical research. [*The Improving Emergency Medical Care and Response Act of 2007*](#) – S.1873 and H.R.3173 – is another reaction to the crisis in emergency care detailed in the Institute of Medicine's landmark 2006 report.

In recognizing that regionalized systems show substantial promise in addressing the complexity of an efficient EMS response, the legislation provides funding for four multi-year grants supporting demonstration programs to design, implement, and evaluate regionalized, accountable EMS systems. The systems will be set up to: coordinate public health, safety, and emergency services; facilitate timely access to the EMS system; establish a mechanism to ensure that patients get to the right medical facility at the right time; track hospital resources, staffing, and capacity (e.g., statistics on bed capacity/ambulance diversion); and coordinate standardized data management to facilitate pre-hospital, hospital, and inter-facility transports during disasters.

Grant applicants must assure that the proposed system meets certain criteria, such as compatibility with applicable state EMS systems, establishment of a designation system for special medical facilities, and inclusion

of a patient tracking system. Following the completion of each demonstration program, a report will identify: the impact of the system; factors contributing to the effectiveness of the system; strategies to ensure long-term financial sustainability; policy and legislative requirements for system maintenance; and barriers and proposed solutions to those barriers.

The legislation also establishes support for emergency medical research throughout the federal government. In the past, funding for emergency care research has proven to be a challenge because of the broad scope of clinical disciplines involved. By coordinating efforts across federal agencies, the legislation will promote such research, thereby furthering the understanding of the basis science of emergency medicine and enhancing patient outcomes through improved medical service delivery.

Both legislators released statements emphasizing the importance of the issue. Obama said, "Our nation's emergency departments are overburdened and ill-equipped to respond to the public health crises we must be prepared to face." Waxman said, "this bill is directly responsive to two key observations from my committee's recent hearing on the crisis in emergency care – the urgent need to promote regionalized, coordinated and accountable emergency care systems and an equally urgent need to advance the science of emergency care."

This bill will ensure our emergency rooms, medical personnel and response teams have streamlined communications systems, real time data, and other coordination tools.

– Senator Barack Obama

Progress Report on Flu Pandemic Plan Released

On July 17, the White House Homeland Security Council released its one-year progress report on the Administration's national strategic plan – launched in May 2006 – to guard the United States against a pandemic flu outbreak. In the report, Council officials said they have completed 86% of the action items detailed in the plan, and they expect to fulfill the remaining goals in six months.

The remaining goals include redoubling efforts to develop "real-time" clinical surveillance, an area where officials said there has been challenge. Their exact statement was: "To be brutally honest, we have a lot of trouble determining when we have an outbreak of infectious disease in a community here in the United States." Other items to be completed are: help create a "surge capacity" in U.S. hospitals; aid the international community in vaccine development and production; and better equip and prepare local governments and health care entities. (Cont'd page 4)

Progress Report on Flu Pandemic Plan Released (Cont'd from page 3)

As for the goals achieved, Rajeev Venkayya, the President's Assistant for Biological Defense, said that throughout the year the government has worked on influenza issues in more than 100 countries, supported the training of more than 129,000 animal health workers and 17,000 human health workers in bird flu surveillance and outbreak response, and aided efforts to improve laboratory diagnosis and early warning networks in 75 countries. In addition, the United States has taken the lead in the international preparedness campaign, contributing \$440 million of the \$2.3 billion raised. Assistant Health and Human Service's Secretary John Agwunobi* reported on the stockpile of vaccines. Currently, he said, the nation has six million doses of a pre-pandemic vaccine that were approved in April. He added that initial clinical studies suggest that supply can be stretched 10 to 20 times.

The report also addressed border issues. Council officials said they would not close the country's borders in the event of a flu pandemic because of the logistical difficulty. Instead, they said, authorities would try to limit the number of virus carriers who enter the country. The Council added, however, that it plans to unveil an agreement between the United States, Mexico, and Canada to cooperatively address border issues and the risk of a pandemic spreading throughout North America. The progress report is available at <http://pandemicflu.gov/>.

*As of August 4, 2007, Agwunobi took a position at Wal-Mart managing the company's pharmacies, vision centers, and health clinics.

From the States . . .

✓ Consensus on North Carolina's Cap Bill

Unlikely on All-Out Tort Reform

When HB 1671, the *Voluntary Arbitration of Negligent Health Care Claims Act*, passed both of North Carolina's legislative houses by a near-unanimous vote, it marked one of the few times the state's legal and medical professions had reached a consensus on medical malpractice reform. Effective January 1, 2008, Governor Mike Easley's (D) signed the legislation into law on August 31, 2007. The measure limits monetary damages in medical malpractice cases to \$1 million for those who agree to go to binding arbitration.

Both sides of the issue strongly favored the bill. Physicians did so because it addresses their concerns that the cost of resolving medical malpractice claims needs to be controlled to bring down liability insurance premiums, and it addresses their goals of limiting the size of judgments and shortening the time frame for resolution. Attorneys did so because it gives plaintiffs access to a resolution even if they did not have the financial resources to pursue litigation, and it clearly defines the arbitration process.

While both sides also agree that the bill is an important step, they point to other areas where agreement will be difficult. Byron Grimmett, part-time lobbyist

for the Mecklenburg County Medical Society and director of its Physicians Reach Out program, said, "It's nowhere close to the comprehensive tort reform that we need." Steve Keene, general counsel and executive vice president of the North Carolina Medical Society, cited some of the things physicians want. For one, they would like to see limits placed on non-economic damages such as pain and suffering that they believe swell judgments. They also see a need for a mechanism for scheduling payments of large awards in installments instead of a lump sum.

Attorneys disagree with physicians about the scope of the problem, and they maintain that liability insurance premiums in the state have been leveling off in recent years. They also point to a study on medical malpractice lawsuits sponsored by the North Carolina Academy of Trial Lawyers indicating that, not only are such suits relatively rare, the average jury award in those cases where the plaintiff prevailed was \$310,300.

In view of these and other disagreements, it is clear that the consensus between attorneys and physicians does not go very deep. According to Grimmett, "It's going to be an ongoing issue for a long time. There are many things that still need to be addressed."