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Senators block medical liability reform

In July, Senate Majority Leader Bill Frist, MD, FACS (R-TN), attempted to bring the Patients First Act of 2003 (S. 11) to the floor for debate and a vote. This medical liability reform legislation was introduced by Sen. John Ensign (R-NV) and is almost identical to H.R. 5, the HEALTH Act of 2003, which the House passed in March. Unfortunately, the Senate vote of 49-48 failed to reach the 60-vote threshold needed to bring such a controversial measure up for consideration.

The medical liability reform provisions contained in both the House and the Senate bills are based on the California Medical Injury Compensation Reform Act of 1975. The College and its coalition partners are continuing their efforts to persuade the Senate of the critical need to pass such legislation.

Physician supply higher in states with noneconomic damage caps

States that limit noneconomic damage awards in medical liability lawsuits have about 12 percent more physicians per capita than states without such caps, according to a study released in July by the Agency for Healthcare Research and Quality (AHRQ).

The study examined the growth of physician supply since 1970, before any state had enacted a cap on noneconomic damage awards, and found that the number of physicians has increased more in states with caps. "Our broken medical litigation system is affecting patients' ability to find a doctor," said Tommy G. Thompson, Secretary of the Department of Health and Human Services (HHS). "This study confirms and quantifies the association between reasonable limits in medical lawsuits and the supply of physicians available to treat patients who need them," added Thompson, whose department runs AHRQ.

The study analyzed state experiences over the last 30 years, and adjusted for the impact of multiple factors that are believed to affect physician supply (such as per capita income and physician residency training programs.) The authors, Fred Hellinger, PhD, and William Encinosa, PhD, suggested that "...these findings demonstrate that state laws limiting noneconomic damages in medical malpractice cases increase the number of physicians who practice in the states." The authors find that by 2000, states that had enacted caps had a significantly higher number of physicians per 100,000 county residents (135) compared to states without caps (120). In contrast, in 1970 there was no statistically significant difference between states in their per capita supply of physicians.

Trauma bills progress

On June 23, S. 239, the Trauma Care Systems Planning and Development Reauthorization Act of 2003, passed the Senate by unanimous consent. Senator Frist and Sen. Edward Kennedy (D-MA) introduced the legislation, which the College actively endorsed and supported. If passed in the House, the legislation will reauthorize the trauma program through 2008, improve the collection and analysis of trauma patient data, reduce the amount of matching funds that states must provide to participate in the program, authorize an Institute of Medicine study on the state of trauma care and research, and double the fund-

HHS to study Medicare pay for performance

ing available for this program to \$12 million. A House companion bill is expected to be introduced by Rep. Jim Greenwood (R-PA) in the fall.

In other trauma news, the Senate and House Appropriations Committees included \$3.5 million to fund the trauma program in FY 2004. To encourage the House and Senate Appropriations Committees to provide an increase for the funding of the trauma care systems program, legislators in both chambers circulated a sign-on letter to their colleagues expressing support for increased funding. The letter was championed by Sens. Pat Roberts (R-KS) and Jack Reed (D-RI), and by Reps. Greenwood and Luis Gutierrez (D-IL), with 54 senators and 128 representatives cosigning.

HHS Secretary Tommy G. Thompson announced the next step in the Medicare program's effort to improve and reward delivery of high-quality inpatient care. The Centers for Medicare & Medicaid Services (CMS) in conjunction with Premier Inc., a not-for-profit group purchasing collaborative of 1,500 facilities, will voluntarily track hospitals' clinical performance in five areas: acute myocardial infarction, coronary artery bypass grafts (CABG), heart failure, community-acquired pneumonia, and hip and knee replacement.

Measures of greatest interest to surgeons include CABG mortality, appropriate identification and administration of prophylactic antibiotics before surgery, postoperative hemorrhage or hematoma (risk-adjusted, requiring a return to the operating room), and readmission for hip and knee replacement. A complete list of measures will be published on the CMS Web site at <http://www.cms.gov>.

The three-year demonstration project will score 35 individual quality measures, and hospitals that rank in the top 10 percent for a given condition will receive a 2 percent bonus on their Medicare payments. Those that score in the next 10 percent will receive a 1 percent bonus. All hospitals in the upper 50 percent quartile will be publicly recognized by CMS for their quality efforts. Medicare will pay \$21 million in incentives during the three-year term of the project. During the third year, however, hospitals with performance rankings falling in the bottom 20 and 10 percent will receive 1 and 2 percent less in their Medicare revenues, respectively.

Premier's "Perspective Online" database will track the results of participating hospitals and report the progress to the hospitals for quality improvement purposes. CMS will post the results of their progress on their Web site.

CMS cancels adjustment

CMS has canceled the plan to process an automatic mass adjustment of incorrect payments for services delivered to Medicare beneficiaries in January and February 2003. The possibility of incorrect payments to providers was the result of a delay in the implementation of the 2003 Medicare fee schedule. Physicians will not receive any "demand" letters asking for repayment of any incorrect payments; however, carriers have been instructed to respond to any provider requests for adjustment to payments.