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Author

Brosnan, Douglas

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Arm your Weapons!

Douglas Brosnan MD, JD

You know it is a contentious legislative session when the debate on balance billing clocks in last in this edition's legislative update. The battle for health access is on! An endless array of bills threatening the availability of health care for our patients as well as our very ability to effectively practice emergency medicine is working its way through Congress.

Medicare Cuts Dodged ... this time

In early July, the U.S. Senate passed the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331) by a veto-proof majority of 69-30. Even Senator Kennedy reported for duty in the Senate, his first vote since his neurosurgery in June. The U.S. House of Representatives also approved H.R. 6331 on June 24 by a veto-proof majority of 355-59. The legislation would replace a 10.6 percent cut in Medicare physician payments that took effect July 1 with a 0.5 percent update extension through Dec. 31 and provide a 1.1 percent update for 2009.

In a statement of administrative policy, President Bush expressed strong opposition to H.R. 6331. Bush promises to veto this legislation, citing an unnecessary expansion of the Medicare program that irresponsibly imperils the long-term fiscal soundness of Medicare and Medicaid, through which millions of Americans receive their healthcare services. Bush also opposes reductions in Medicare Advantage (MA) payments, the mechanism for partially funding the bill. Ironically, Bush is also concerned that H.R. 6331 would reduce access, benefits, and choices for many of the approximately 2.25 million beneficiaries who have chosen to enroll in private fee-for-service plans, many of whom live in rural areas.¹ Bush, however, fails to recognize that a draconian cut in Medicare reimbursement *would* result in reduced access for all Medicare beneficiaries and provides no meaningful solution to the Medicare budget problems.

Although this veto-proof vote by Congress is a victory for both physicians and our disabled, elderly, and military patients, the Sustainable Growth Rate (SGR) must be addressed decisively, as the issue will return year after year as it has since 1997.

Now, according to the SGR, reimbursements should actually be cut by more than 40%!² Although a cut of that magnitude is unlikely to ever happen, smaller future cuts will continue to loom over our heads like a guillotine hanging from a frayed rope. Instead of hoping that Congress continues to come to the rescue, we must set for and be *proactive* to help Congress devise a solution that would eliminate the SGR while simultaneously protecting access to care for our elderly and disabled patients.

MediCal Lawsuit: Cautious Optimism

In February the California legislature approved and Gov. Schwarzenegger signed into law a total of \$1.3 billion in cuts to the Medi-Cal program in an effort to stem the state's budget crisis. The cuts, which took effect July 1 represent a 10% "across the board" reduction in Medi-Cal and Denti-Cal payments.

A class action suit, filed jointly by a healthcare coalition led by the California Medical Association (also includes the California Hospital Association, California Dental Association, California Association for Adult Day Services, American College of Emergency Physicians, State Chapter of California (Cal/ACEP), California Pharmacists Association, and the California Association of Public Hospitals and Health Systems) seeks injunction to retroactively block the reduction in Medi-Cal payments, which are causing significant healthcare access barriers for thousands of Californians.

The healthcare coalition has accomplished an early victory in what will undoubtedly be a long legal battle. In late May the California Attorney General's office, acting in its capacity as the state's lawyers, moved the case from state to federal court, asserting that the case was based on questions of federal law. In her decision on June 23, U.S. District Court Judge Christina Snyder ruled that the arguments raised by the healthcare providers were not matters of federal law, and thus the Attorney General's office improperly removed the suit from state court. Lawyers for the coalition of healthcare providers plan to seek an expedited hearing on the matter as soon as possible. Judge Snyder intimated that continued delays by the AG to have this case heard may already have caused "irreparable harm" to the citizens of California – a critical legal threshold

required to gain injunctive relief. The California Hospital Association has also initiated a bold media campaign, “Save my Emergency Room” alerting the public about the increased pressures budget cuts have on everyone’s access to emergency services.

Maddy Fund Extension: Another Win for our Patients

The January 1, 2009, sunset provision to the law allowing county boards of supervisors to levy additional fines for criminal and motor vehicle offenses for the purpose of funding otherwise uncompensated emergency care and pediatric trauma care (Maddy Fund) was successfully extended to January 1, 2014 (SB 1236 – Padilla). Although a massive victory for emergency service providers, the sunset provision smells of the same issue with the Medicare SGR – I posit that when this resurfaces in 2014, we redouble our efforts to eliminate the sunset clause entirely. We already know that this revenue stream works. Why continue spending our limited resources lobbying this issue every few years hoping for the same great result?

AB 2146 (Feuer) Non reimbursement for “Never Events”

California State Assembly Member Mike Feuer’s bill, under the guise of “consumer protection” would prohibit billing patients for medical mistakes. Such mistakes include amputation of the wrong leg, leaving medical equipment in a patient after surgery, or improper administration of drugs. This legislation was approved by the Assembly Health Committee and will be heard mid-July in Assembly Appropriations Committee.³

Although it is unclear whether the billing prohibition applies to hospitals and physicians alike, this bill is probably one of the most dangerous pieces of legislation before the California Congress. While we all would agree that operating on the wrong patient, limb etc. should not be billed; what happens when a “never” complication arises and the patient returns to an Emergency Department seeking care. I can think of hundreds of examples, but let’s just use this one from the “Never Event” list.⁴ A patient with a cholecystectomy reports to the Emergency Department and is found to have a sponge left behind that has eroded the biliary duct. The patient needs transfer to a hospital with a hepatobiliary specialist to repair this “Never Event.” Well, good luck finding an accepting hospital! According to AB 2146, the patient and his/her insurer cannot be billed for the

services required to repair the injury! This bill, on its face, seems like a reasonable proposal. However, it is fraught with a multitude of unintended consequences. Further, the “Never Event” list implies that patients are entitled to risk-free healthcare. Another item on the list is “Death/disability due to patient elopement.” So does Representative Feuer intend that doctors and nurses be quasi jailers, holding patients captive until their treatment is complete? This bill essentially eliminates access to care needed for mitigation of complications from medical treatment.

This is just another way for the insurance companies to hold on to more profits. Further, the “Never Event” list is too vague and overbroad and creates precedent for a slippery slope of potential “Never Events” to be added. What’s next, a patient’s care won’t be reimbursed if they acquire C. diff colitis from antibiotic treatment?

Balance Billing SB 981 (Perata) works its way through the legislature

This bill requires a non-contracting hospital-based physician to seek reimbursement for medically necessary covered services provided to an enrollee of a health plan *solely* from the plan or risk-bearing organization that is financially responsible for the covered services. Physicians would be forbidden from sending balance bills for the amount of the charge that was not reimbursed by the plan or risk-bearing organization. Rather, this bill requires payments to be made at the lesser of the physician's full charge, or some interim payment standard that has yet to be defined. The Department of Managed Health Care must in turn establish a dispute resolution process (proposals for this process so far seem cumbersome to implement) and provides that the bill would sunset its provisions on July 1, 2012. SB 981 is currently in the Senate Health Committee. The interim payment standard as well as the prohibition of bundling and down-coding are still “deal-breaker” issues that continue to be the subject of contention. Stay tuned for further developments on this and the other issues threatening our patients and our profession.

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