



915 Lee Street
DesPlaines, IL 60016
www.ena.org



ENA Washington Update

December 24, 2008

Kathleen A. Ream, Washington Representative 703/241-3947 E-mail: enagov@aol.com

Big Challenges for Next CMS Administrator

In light of the incoming Obama Administration's plans for significant changes in the way Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) are run, the President-elect's choice for administrator of the Centers for Medicare and Medicaid Services (CMS) will be facing major issues from day one. In addition to the task of implementing such changes, the new CMS administrator – working under Obama and his new Department of Health and Human Services Secretary, former Senator Tom Daschle (D-SD) – will play a role in the new Administration's push to overhaul the entire health care system. All the while, he or she will be responsible for the day-to-day operations of a massive agency with 4,400 employees, a \$676 billion annual budget, and the duty to provide health care to 44.6 million people enrolled in Medicare, 51 million in Medicaid, and 6.3 million in SCHIP.

In commenting on possible candidates for the position, several of the agency's former chiefs agreed that Obama and Daschle will look for a candidate who has experience managing a large organization, knowledge of the health care system, and good political relationships. Speculation has centered on a handful of Obama insiders, Clinton White House veterans, and longtime Democratic health care experts. Among the names thought to be under consideration are: Obama transition team member and Center for American Progress senior fellow Jeanne Lambrew;

Avalere Health President Dan Mendelson; Urban Institute scholar Robert Berenson; Georgetown University Professor and failed congressional candidate Judy Feder; and Emory University Professor Ken Thorpe. However, Nancy-Ann DeParle, who ran the agency during President Clinton's second term (when it was known as the Health Care Financing Administration), and Tom Scully, who was President Bush's first CMS administrator, cautioned against putting too much stock into such speculation. Their names, they pointed out, were not on any public "short lists" before they were nominated.

The former officials also noted that one of the busiest areas of ongoing business – and difficult management challenges – will be devising the payment rates for physicians, hospitals, nursing homes, and other medical providers that serve beneficiaries. Doctors, they said, present a particular challenge. Without congressional action, doctors' payments face a 20% cut in 2010, and CMS will have the task of helping Congress solve how to fix that problem without breaking the bank. McClellan predicted that the Obama Administration would continue the Bush Administration's efforts to reform the payment system to reward more efficient, higher-quality care.

Under the Democratic health reform plans circulating, CMS could see its responsibilities increased further. For example, if the private health insurance plans that operate under Medicare Advantage and Part D are reined in, insurers could see their Medicare Advantage payments slashed by up to \$50 billion and face more stringent oversight of their activities in both programs. Already states are angling for new federal money to shore up their Medicaid budgets during the recession, but CMS will have to address other thorny Medicaid and SCHIP issues, such as how much flexibility to give states to redesign their benefits. On SCHIP, Congress's reauthorization of the program, which expires on March 31, will include a significant expansion of the program, bringing millions of new children onto the rolls.

IN THIS ISSUE . . .

Big Challenges for Next CMS Administrator	1
Baucus and Kennedy Work Separately on Health Care Reform	2
Study Portrays ED Crowding as a Patient Safety Issue	3
Report on Latest Substance Use Data	3
Shorts	4
From the States	5

Baucus and Kennedy Work Separately on Health Care Reform

Decades of work on health policy issues and his passion for covering the uninsured may make Senator Edward Kennedy (D-MA), chair of the Health, Education, Labor and Pensions (HELP) Committee, the natural leader when it comes to a health care overhaul. Kennedy and his staff have been emphasizing that they plan to use the health plan of President-elect Barack Obama as a blueprint for a comprehensive health care reform plan, and they are working closely with the President-elect's team. However, in a press briefing on November 12, Senate Finance Committee chair Max Baucus (D-MT) made it abundantly clear that he intends to be at the center of the action too.

The previous week, just three days after the election, Baucus announced plans to unveil his own "specific goals and policy options for comprehensive health care reform in 2009" – without waiting for Obama's detailed proposals. In a letter to Obama dated November 6, Baucus said, "Next week I will present to you and to the country my plan to move forward on health care reform in the early days of the 111th Congress and of your administration." He also said, "I made sure the Finance Committee spent this year learning and preparing for action on a comprehensive overhaul of the health care system, and I intend for us to move swiftly and decisively with legislation in early 2009." Baucus added that he would "work together with the new administration and with my colleagues in Congress in refining and advancing this effort." Nevertheless, he left no doubt that he intends to have the first say on the matter.

In addressing his packed press briefing on November 12, Baucus distinguished himself by releasing a lengthy white paper, entitled ***Call to Action, Health Reform 2009*** (<http://finance.senate.gov/healthreform2009/home.html>), outlining his overhaul plan. In the paper, Baucus calls for creation of a nationwide insurance pool called the Health Insurance Exchange, and for expanding three government health programs – Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) – as well as opening Medicare to people ages 55 to 64. He also outlines new tax breaks for individuals and small businesses to offset the costs of insurance. As for funding sources, he argues that ideas such as eliminating waste and fraud, focusing on prevention, and using sophisticated data to identify the most cost-effective therapies will save money over the long term. In the short term, he advocates eliminating what Democrats have long criticized as "overpayments" to insurance companies that sell managed care plans to Medicare recipients.

Possibly the most controversial idea in Baucus's plan is his suggestion to revisit the current tax treatment of employer-sponsored health insurance. Referring to GOP proposals eliminating the tax exclusion for employer-based health insurance premiums and converting the benefit to a tax deduction or credit, Baucus said that approach goes too far. Instead, he would encourage Congress to consider a middle road with some limited modification of the relevant tax code.

Meanwhile, Kennedy – although praising the Baucus plan – will likely present appealing arguments for his own set of overhaul plans. Furthermore, his efforts are expected to carry enormous weight, given his lifelong focus on the issue, his early endorsement of Obama, and his own health status battling brain cancer. Over the past several months, he has directed aides to convene negotiating sessions with a diverse group of stakeholders, including physicians, patient advocates, small-business owners, and insurers. Through an aide, Kennedy said, "We're doing all we can to unite Congress around a single, unified bill for early action next year." And, while his aides have refused to indicate what specific direction Kennedy will pursue, they have made it clear he does not intend to cede his longtime leadership role on health policy. He intends to have legislation drafted by Inauguration Day.

At the moment, however, the Baucus plan is getting plenty of attention. A number of lobbies, including America's Health Insurance Plans, the Advanced Medical Technology Association, and the American Medical Association have commended Baucus for offering his proposal without getting into specifics.

While the HELP Committee will share jurisdiction with the Finance Committee over portions of a health care overhaul, Baucus will have jurisdiction over a large part of any health care reform measure Congress tackles next year. Among other areas, the Finance Committee controls policy for Medicare, Medicaid, SCHIP, taxes, and Social Security.

Study Portrays ED Crowding as a Patient Safety Issue

A new study, funded by the Agency for Healthcare Research and Quality, raises concerns about the safety of critically ill patients. Published online in the December *Annals of Emergency Medicine*, the study surveyed 3,562 ED clinicians in 65 hospitals across the nation and concluded that, no matter the size or locale, EDs across the country need major improvements in design, management, staffing, and support to ensure high-quality patient care in a safe environment.

According to the lead author, David Magid, an emergency physician and a senior scientist at the Kaiser Permanente Colorado Institute for Health Research, ED clinicians are reporting widespread problems in four systems that are critical to safety: physician environment, staffing, inpatient coordination, and information coordination and consultation. “We found the same problems everywhere,” Magid said and emphasized that hospitals across the country – large, small, academic-based, community-based – are all experiencing these problems.

While ED crowding has been shown in prior studies, Magid said that this study “. . . was the first to closely examine safety from the perspective of the clinicians who actually work in the emergency department, including physicians and nurses.” In their responses, 25% of the clinicians said their ED is too small, 32% said the number of patients exceeds their ED’s capacity to provide safe care most of the time, and 50% said their patient capacity is exceeded some of the time.

Part of the problem is that, while demand for emergency care has increased by 26% over the past decade, the number of EDs has declined by 9%. EDs “weren’t designed to handle the amount of patients that are coming in now,” Magid said. He added that, when sick patients are put in waiting rooms or hallways, the ED staff may not be able to adequately monitor them. In addition, when patient demand exceeds staff capacity, clinicians may give rushed evaluations or improper treatment in an attempt to provide care to everyone.

Half of the clinicians reported that ED patients requiring ICU admission are rarely transferred from the ED to the ICU within one hour; and fewer than half said that most specialty consultations for critically ill patients occur within 30 minutes of being contacted.

– The Safety of Emergency Care Systems: Results of a Survey of Clinicians in 65 US Emergency Departments

One solution the study’s researchers recommended was to redesign ED space to make care available to more patients and to increase staffing during busy times. Other recommendations included improving information sharing between clinicians, and providing more computer stations for better access to electronic health records. The researchers also said that overall investment in EDs is a key factor. “The requirement for resources to accomplish these

changes suggests that third-party players, including government, will have to be involved in any coordinated strategy to address deficiencies in the safety of ED care.”

Magid is not sure what impact his study will have, since ED crowding is widely known and yet persistent. He emphasized that people are working on the problem, but increased efforts and new solutions are needed. “Hopefully, results of studies like ours, which go beyond merely showing that the ED is crowded to showing the impact crowding is having on safety issues, might motivate people to do more.”

Report on Latest Substance Use Data

The 2006 Drug Abuse Warning Network (**DAWN**) report – drawn from a sample of hospital EDs across the nation – indicates that more than 1.7 million visits for treatment were associated with some form of substance misuse or abuse. This latest **DAWN** report, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides the most recent data on substance use along with information on how such use affects the nation’s health care system.

While the mission of SAMHSA focuses on “building resilience and facilitating recovery for people with or at risk for mental or substance use disorders,” the data from its annual **DAWN** reports is vital in seeing the scope of the problem, its growth in recent years, and its impact on the health care system in America. The data is collected from a ([Cont'd page 4](#))

Report on Latest Substance Use Data (Cont'd from page 3)

national sample of general, non-federal hospitals that operate 24-hour EDs. For this latest report covering the calendar year 2006, a total of 205 hospitals in selected metropolitan areas submitted the information that was used for estimation purposes.

Some of the report's more notable findings relative to ED visits include: cocaine was involved in 548,608 visits; marijuana in 290,563; heroin in 189,780; alcohol was the only substance involved in 126,704 ED visits by patients under age 21; and stimulants, including amphetamines and methamphetamines, were involved in 107,575 visits. By percentages, the 1,742,887 visits were broken down as follows: 31% - illicit drugs only; 28% - pharmaceuticals only; 13% - illicit drugs with alcohol; 10% - alcohol with pharmaceuticals; 8% - illicit drugs with pharmaceuticals; 7% - alcohol in patients under 21; and 3% - illicit drugs with pharmaceuticals and alcohol.

Another type of ED visit of note in the study was for drug-related suicide attempts. The number of those visits was 182,805. Close to two-thirds of that number involved the combination of multiple drugs, and more than half included psychotherapeutic agents, such as benzodiazepines and antidepressants. The highest percentage – 95% – involved pharmaceuticals, nearly one-third involved alcohol in combination with another drug, and 23% involved an illicit drug.

Also significant was the number of patients seeking detoxification or treatment services of some sort and felt the ED was the best – or most available – resource. The number of those visits was 118,355, with 65% attempting to get help for multiple drug addictions. Nearly half were seeking help or detox from cocaine, 29% from heroin, 19% from marijuana, and 7% from methamphetamine stimulants. Approximately 40% of those in need of such assistance involved alcohol.

The **DAWN** report contains additional detailed information on how problems with a wide range of substances – including the use of other illicit drugs as well as the non-medical use of prescription medications and over-the-counter drugs – contribute to ED visits. The report also provides statistical breakdowns on drug-related ED visits by key demographic groups and other factors. The full report is available at <http://dawninfo.samhsa.gov/pubs/edpubs/default.asp>.

Shorts . . .

HHS Urged to Update Methods of Operation

In a report prepared at the request of Representative Henry Waxman (D-CA), the incoming chair of the House Energy and Commerce Committee, the Institute of Medicine (IOM) said the Department of Health and Human Services (HHS) should streamline its decision-making process and embrace a more modern way of operating. The report, entitled ***HHS in the 21st Century: Charting a New Course for a Healthier America***, states that HHS “has a staggering range of responsibilities” that are greatly “hampered by the diversity of its agencies’ missions and goals, little discretionary funding, workforce shortages” and fragmentation of health care agencies

To help HHS unburden itself from an overly bureaucratic decision-making process, IOM spells out five recommendations. One urges HHS and Congress to develop a “new compact,” wherein HHS would promise to regularly update federal lawmakers on its initiatives in return for a freer hand to implement them. Another recommendation calls on HHS to develop and adhere to a “21st century vision.” The IOM report concluded that a “large-scale reorganization of the entire department was not the best

way to support key decision makers at HHS.” The full report can be viewed at <http://www.iom.edu/CMS/28312/55311/60704.aspx>.

U.S. Health Care System Fails Youth

According to a December 9 report from the National Research Council and the IOM, the U.S. health care system often fails adolescents age 10 to 19. The report found that adolescents, more than any other age group, rely on hospital EDs for routine treatment. In addition, many youths lack access to specialty services for mental health, substance abuse, and sexual and reproductive health—this despite the fact that, while most U.S. adolescents are healthy, many engage in risky behavior, from binge drinking to carrying weapons, and have physical and mental conditions that can ultimately be harmful. “Even when services are accessible, many adolescents may not find them acceptable because of concerns that confidentiality is not fully ensured, especially in such sensitive domains as substance use or sexual and reproductive health,” the authors said. To address their findings, the authors recommend that government, private foundations, and insurers

promote a coordinated health care system that seeks to improve care for adolescents, and that lawmakers develop plans to ensure comprehensive health coverage.

These recommendations may be pursued next month when Democrats in Congress plan to renew their efforts to add four million youngsters to the State Children's Health Insurance Program. The legislation was vetoed twice by President Bush last year, but President-elect Obama supports an overhaul of the health care system that would expand subsidies for health insurance and make coverage of all children mandatory.

Bill Links Medicare Reimbursements to Hospital Performance

A draft bill to be proposed by Senators Max Baucus (D-MT) and Charles Grassley (R-IA), would link Medicare Part A payments for such conditions as heart attacks and other illnesses to hospital performance on a variety of quality measures derived largely from guidelines issued by organizations, such as the National Quality Forum. The program would measure overall patient satisfaction of hospital care, although the draft bill gives no specifics about the actual process.

According to Baucus and Grassley, the new Medicare hospital value-based purchasing program builds on the Medicare hospital pay-for-reporting program initiated in

2003. That program, a precursor to the current proposal, provides increased Medicare reimbursements to hospitals for tracking and reporting on how well they followed the identified quality measures. The senators said the new proposal "takes pay-for-reporting one step further by linking Medicare payments not only to reporting and tracking quality activities, but also how well the hospitals actually perform on these quality measures." They said the program would be phased in gradually over four years, beginning in 2012.

Guide on Legal Aspects of Pandemic Planning

The American Health Lawyers Association (AHLA) has published a checklist of legal issues for healthcare providers involved in pandemic flu preparedness planning. The most recent addition to AHLA's Public Information Series, entitled ***Community Pan-Flu Preparedness: A Checklist of Key Legal Issues for Healthcare Providers***, was the result of a May 2, 2008, public interest dialogue session convened by AHLA with the HHS Office of Inspector General and the Centers for Disease Control and Prevention. A select group of 52 participants from diverse areas of expertise shared their thinking on legal impediments and implementation challenges to community pandemic flu preparedness and practical solutions to such challenges. Their recommendations were incorporated into the checklist. Free copies of the 93-page checklist are available from AHLA. To download the PDF, go to www.healthlawyers.org/panfluchecklist. To request a print copy, send an e-mail to djin@healthlawyers.org.

From the States . . .

AR Trauma Data Base in Operation

The first key element for a statewide trauma system in **Arkansas** began its operation on November 3. The "trauma dashboard," a Web site providing up-to-date status information on the state's 108 hospitals, is giving hospital officials a quick way to see where they can transfer patients needing specialized emergency care. James Graham, Chair of the Governor's Trauma Advisory Council, said, "This is a major step forward that's going to help a lot of patients, not just trauma patients."

The trauma dashboard was paid for with \$52,000 of the \$200,000 Governor Mike Beebe (D) designated for computer hardware and software to collect and store information on the state's emergency services. That money, in turn, came from the \$500,000-a-year Governor's Emergency Fund which, Beebe said, is meant to boost efforts to develop an **Arkansas** Trauma system by providing data to legislators as they consider proposals to establish

such a system during the 2009 legislative session.

Arkansas Surgeon General Joe Thompson has estimated the cost of establishing a trauma system at \$28 million to \$35 million. State health officials predict, however, that having a trauma system would prevent 200 to 600 deaths and reduce the state's 1,200 preventable disabilities each year.

According to MEMS director Jon Swanson, the dashboard will be updated every two minutes with status changes called into MEMS by hospital personnel. A color-coded chart will identify a hospital's current capabilities, and MEMS will collect this data to help hospitals identify status trends. Swanson noted though that, while the dashboard will help hospitals speed up inter-hospital transfers, its use by EMS personnel is restricted by state laws that require them to take patients to the hospital of the patient's choice within a specified service area. Those laws, he said, would have to change to have an effective trauma system.

CA Repeals UPPL Law

Last month **California** Governor Arnold Schwarzenegger (R) signed into law a measure that removes from the state's insurance code the so-called Uniform Policy Provision Law (UPPL) that allowed insurers to deny coverage to hospital patients if they were under the influence of alcohol at the time of their injury. Addiction treatment advocates strongly backed the repeal, arguing that "alcohol exclusion laws" like UPPL present a major roadblock to implementation of screening, brief intervention, and referral to treatment programs (SBIRT) in hospital settings, because they effectively discourage health care providers from testing patients for alcohol and other drug use.

"Repeal of UPPL is a step toward creating the necessary infrastructure for a comprehensive, effective approach to substance abuse disorders," said Timmen Cermak, President-elect of the **California** Society of Addiction Medicine, a key supporter of the UPPL repeal bill sponsored by Assembly Paul Krekorian (D-Burbank). Now that a significant barrier to SBIRT has been lifted, Cermak said, advocates need to ensure that screening and brief intervention are integrated into the standard continuum of health care. Otherwise, he added, "our victory will remain small."

CA Prohibits Text Messaging by Drivers

On September 24, Governor Schwarzenegger signed into law SB 28, a measure that prohibits all text messaging on mobile phones while driving. The law goes into effect January 1, 2009. Specifically, it ". . . bans the use of an electronic wireless communication device to write, send, or read a text-based communication while driving a motor vehicle." Violation of the law will result in fines of \$20 for first-time offenses and \$50 for each successive offense.

Previous legislation restricting cell phone use while driving, SB 1613, went into effect on July 1, 2008. That law requires drivers to use hands-free devices to communicate with cell phones but limits its text messaging prohibition to drivers under the age of 18. "I suspect that not including [universal restriction for] texting was an oversight," said Phyllis Agran, professor emerita of pediatrics and senior researcher for the Center for Trauma and Injury Prevention Research.

Although a universal text message ban was left out of the original law, Agran insisted that police officers have the authority to ensure safety on the road. "An officer can pull over and issue a citation to a driver of any age if, in the officer's opinion, the driver was distracted and not operating the vehicle safely," Agran said. While acknowledging the danger of other distractions, Agran also said she doubts

the new law will lead to the banning of other driver distractions, because ". . . all distractions are covered under reckless driving laws."

According to University of **California**, Irvine Police Department Chief Paul Henisey, it is too soon to tell if the original law has prevented injury. But, he said, "Our perspective is that [the amount of drivers] using cell phones [without hands-free devices] has dropped considerably." As for the new law's restriction on text messaging, it will not apply if the driver is reading, selecting, or entering a phone number to make or receive phone calls. Differentiating between these similar actions will be more difficult than verifying whether a driver is using a hands-free device during a call, but will ultimately be up to the officer involved. "It's going to be a judgment call," Henisey added. "One of the negatives of the law is that it's not clear-cut, not black and white. We're leaving much up to the officer's discretion, and it's up to the officer to prove that a violation occurred."

GA May Consider Insurance Fees for Trauma Funding

In September, more than 80 **Georgia** legislators met with dozens of trauma care professionals to discuss the state's financially strained trauma care system, which desperately needs a permanent funding source. In his address at the forum, **Georgia** Insurance Commissioner John Oxendine said he is considering the addition of fees on car and other forms of insurance to support trauma care services for car accident victims and others. He suggested that, since trauma cases often arise from incidents such as car crashes and work accidents, it makes sense that the fees would apply to these forms of insurance. Oxendine emphasized that he simply wanted to float the idea, and that he had no specific proposal in hand; but he said his office would research the matter and, should he support it, a proposal could be ready for the state Legislature when it convenes in January.

The fees being considered, Oxendine said, could apply to insurance on vehicles, health insurance, and workers compensation. Unknowns included how much the fee would be, how much it would raise, or whether it would be leveled on the insurance company or individual policies. Some industry advocates said that such fees could raise costs to consumers and constitute new and unfair taxes to an industry already paying its share.

Last year, Governor Sonny Perdue (R), House Speaker Glenn Richardson (R), and Lt. Governor Casey Cagle (R) supported trauma care funding, but their negotiations on a \$10 car tag fee fell apart. Instead, Perdue provided a one-time shot of \$59 million to prop up the system.

Considering the current state budget crisis, trauma care advocates say finding state money will be even harder now, so they are pressing for a dedicated funding source such as annual fees.

MA Recognizes Nurse Practitioners as Primary Care Providers

With the passage and enactment into law of legislation, Chapter 305 of the Acts of 2008, sponsored by Senate President Therese Murray (D-Plymouth), **Massachusetts** has joined 24 other states that recognize nurse practitioners as primary care providers. As the state insures health insurance coverage for all its citizens, and more than 300,000 citizens, previously uninsured, are now enrolled in Commonwealth Care, legislators had to examine ways to increase access to care in the face of a primary care physician shortage. Now the number of providers is dramatically increased, since all of the state's health insurers are required by law to recognize nurse practitioners as primary care providers.

Ohio APRNs Seek Prescriptive Authority for Schedule II Medications

In 2000, after taking four years for the legislation to get through the General Assembly, **Ohio** became the last state to allow APRNs to prescribe drugs. The law covered all drugs, except for those known as Schedule II medications, which include narcotics. For those drugs, the law allows APRNs to prescribe a one-day supply of pain medications to a terminally ill patient, but only if a doctor wrote the original prescription. Now the state's APRNs are lobbying lawmakers to let them prescribe the other drugs, including the pain management drug percocet, and

ritalin, which is prescribed for children with attention deficit disorder.

Last year, it seemed that **Ohio** was about to join the 31 other states that allow APRNs to prescribe Schedule II medications without restriction. Legislation allowing that authority passed the House Health Committee in March. But the measure is still awaiting a full vote by the House and, if it doesn't pass before the end of this year, it would have to be reintroduced next year.

The state's shortage of primary-care doctors will make nurse practitioners even more vital, so not all **Ohio** doctors are against the bill. But the **Ohio** State Medical Association (OSMA) is. "Our concern really has to do with the types of drugs we're talking about," said Tim Maglione, OSMA's senior director for government relations. "These are highly addictive, very dangerous drugs." Maglione said OSMA offered a compromise that allowed APRNs to write Schedule II drugs, but only in doctor-approved settings. "What that definition did was exclude certain locations . . . like those retail clinics that are popping up now. We thought that was a pretty reasonable compromise."

Jacalyn Golden's, legislative chair for the **Ohio** Association of Advanced Practice Nurses, response is that the compromise is a red herring because the retail clinics don't take seriously ill patients who would need powerful narcotics. She stressed that the need for APRNs having prescriptive authority is particularly acute in rural areas where there are not only shortages of primary-care doctors, but specialists as well. "We just want to be able to provide care we've been trained to do," she said.

*Have a Peaceful Holiday Season
and a Healthy and Prosperous
New Year!*