



Pennsylvania Issues

Legislation

- **H.B. 1064:** Medical Malpractice Reform for Emergency Room Providers. On May 6, 2015, State Representative Eli Evankovich (R-Allegheny, Westmoreland) reintroduced legislation which would heighten the standard required to prove the occurrence of medical malpractice arising from emergency medical care, including emergent care provided in an obstetrical unit or surgical suite following evaluation of a patient in an emergency department. The bill would provide that physicians and other providers would not be liable unless it is proven by clear and convincing evidence that the physician or other provider acted intentionally or recklessly, which is a much higher standard than negligence. Supporters of the bill, including the Hospital & Healthsystem Association of Pennsylvania (HAP) and the Pennsylvania Medical Society, argue that emergency providers should be protected when making quick decisions under difficult time constraints. Opponents assert that patients who have been victimized by medical error, in any venue, deserve appropriate financial compensation. Similar legislation has been enacted in Arizona, Texas, Florida, Georgia, South Carolina, Utah and West Virginia. Representatives Ryan Mackenzie (R-Berks, Lehigh) and Justin Simmons (R-Lehigh, Montgomery, Northampton) serve as co-sponsors of the bill, which has been assigned to the House Insurance Committee. A hearing on the bill is expected to be held in October.
- **H.B. 1329:** The Caregiver Advise, Record and Enable Act. On June 12, 2015, State Representative Harold English (R-Allegheny) introduced legislation requiring Pennsylvania hospitals to (1) provide each patient or the patient's legal guardian an opportunity to designate at least one lay caregiver, who would be identified in the patient's medical record; (2) request the written consent of the patient or the patient's legal guardian to release medical information to the patient's designated lay caregiver; (3) notify a patient's designated lay caregiver of any discharge order for the patient, the patient's actual discharge or the patient's transfer to another facility; (4) consult with the designated lay caregiver and issue a discharge plan that describes the patient's after-care assistance needs, if any, which would include contact information for any health care service, community resources, long-term care services and support services necessary to successfully carry out the patient's discharge plan, as well as contact information for a hospital employee who can respond to questions about the discharge plan; and (5) provide lay caregivers with non-technical instructions in all after-care tasks described in the discharge plan, including training and instructions conducted in person or through video technology at the discretion of the lay caregiver.

On June 17, 2015, the House Aging and Older Adult Services Committee held a hearing on the bill, and HAP testified in support of it. HAP asserts that the bill would reduce preventable hospital readmissions and would allow for better coordination of care between providers and caregivers. The bill, which is co-sponsored by Representatives Steve Samuelson (D-Northampton), Robert Freeman (D-Northampton), Mike Schlossberg (D-Lehigh) and Julie Harhart (R-Lehigh, Northampton), was drafted and introduced at the request of AARP. There are currently five states with caregiver laws, including New Jersey, and eight more state legislatures have introduced similar caregiver bills for consideration. On June 30, 2015, the bill was passed by the House, and it has been sent to the State Senate Aging & Youth Committee for consideration. On September 22, 2015, the Pennsylvania Chapter of AARP held a rally in the Capitol Rotunda in Harrisburg to urge the Pennsylvania Senate to approve the bill.

Federal Issues

Advocacy

- **Individual Accountability for Corporate Wrongdoing:** On September 9, 2015, U.S Deputy Attorney General Sally Yates issued a memorandum on “Individual Accountability for Corporate Wrongdoing” to attorneys at the U.S. Department of Justice (DOJ) and other federal agencies. The seven-page memorandum calls for a renewed government focus on combatting corporate misconduct by “seeking accountability from the individuals who perpetrated the wrongdoing.” It highlights several steps that the DOJ will be taking to strengthen its “pursuit of individual corporate wrongdoing.”
- **Two-Midnight Rule Challenges:** As previously reported, the final 2014 federal fiscal year Medicare inpatient prospective payment system rule established new criteria for determining the appropriateness of inpatient admissions. In general, the rule states that the Centers for Medicare & Medicaid Services (CMS) will presume that surgical procedures, diagnostic tests and other treatments provided in a hospital are appropriate for Medicare Part A inpatient hospital payments when a physician admits a patient based on the expectation that the patient will require a stay extending through at least two midnights. Following significant concern from hospitals and lawmakers, Congress temporarily halted application of the rule, and CMS delayed its enforcement through December 31, 2015.

On April 14, 2014, the American Hospital Association (AHA), the Greater New York Hospital Association, the Healthcare Association of New York State, the New Jersey Hospital Association, HAP, Wake Forest University Baptist Medical Center, Mount Sinai Hospital, Banner Health and Einstein Healthcare Network filed two related lawsuits against the U.S. Department of Health and Human Services (HHS) in the U.S. District Court for the District of Columbia. The lawsuits contend that several provisions of the rule burden hospitals with unlawful arbitrary standards and documentation requirements and deprive hospitals of proper Medicare reimbursement for caring for patients. In particular, the suits request that the “two-midnight” rule be invalidated.

On September 21, 2015, the U.S. District Court ruled that HHS must provide better justification for the cut to inpatient payments and allow for public comment prior to adoption of the rule. The court warned that vacating the entire rule may be a possibility if HHS fails to take corrective action quickly and give serious consideration to the comments it receives.

- **Medicare Readmission Penalties:** As reported previously, Medicare implemented the Hospital Readmission Reduction Program (HRRP) on October 1, 2012 as part of the Patient Protection and Affordable Care Act (ACA). The HRRP program penalizes hospitals with higher than expected readmissions of Medicare patients ages 65 and older with diagnoses of acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, or who undergo hip or knee replacement. A hospital’s expected readmission rate for each of the HRRP conditions is the national mean readmission rate, risk adjusted for demographic characteristics (for example, age and sex) and severity of illness of the hospital’s patients. The penalty is calculated using a complex formula based on the amount of Medicare payments received by the hospital for the excess readmissions. The penalties are collected from the hospitals through a percentage reduction in their base Medicare inpatient claims payments, up to a cap. The ACA set the penalty cap at one percent of aggregate inpatient base payments for 2013, increasing to two percent for 2014 and three percent for each year thereafter.

On August 3, 2015, CMS announced the fourth year federal readmission penalties. Over 2,500 hospitals will receive reduced payments for every Medicare patient beginning in October and incur a combined \$420 million in readmission penalties. The average reduction will be 0.61% per patient stay. 38 hospitals, including Coordinated Health Orthopedic Hospital, will receive the maximum penalty of 3% during the upcoming federal fiscal year.

The HRRP has faced criticism by health policy researchers and industry groups representing hospitals. These critics argue that many factors affecting whether a patient needs to be readmitted are beyond a hospital’s control. In particular, they argue that facilities in poor communities may be unfairly penalized. CMS has stated that it will continue to monitor the impact of socio-economic status on provider results within quality reporting programs.