STAT News

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STATE UPDATE: Med Mal Proposals Not Reasonable

A handful of medical malpractice proposals are making their way through the state legislative process. In particular, hospitals take issue with proposals that would amend the statute of limitations (A.1056, Weinstein and S.7130, Libous) and pre-trial Liability determinations (A.1085, Weinstein and S.887, Bonacic).

Statute of Limitations: These bills seek to change the start date for the statute of limitation timeframe from the point when the act is alleged to the discovery of the alleged act. This could add months, even years to the timeline.

Pre-Trial Liability Determination: This legislation concerns defendants and co-defendants in a wrongful death or injury settlement. In cases where one co-defendant has agreed to settle before trial and the other co-defendant has not agreed to settle, this bill would require the non-settling co-defendant to elect how his/her liability would be determined before going to trial. This could result in situations in which a plaintiff, the party bringing suit, receives more than the total damages award by the jury.

Other medical malpractice bills on the radar include Arons Decision repeal (A.2365, Weinstein and S.1046, DeFrancisco) and Contingency Fees (S.554, DeFrancisco). The Arons Decision bill would overturn the current Court of Appeals 2007 *Arons v. Jutkowitz* decision and prohibit defense counsel from privately interviewing a plaintiff's treating physician. Meanwhile, a plaintiff's attorney could continue to interview treating physicians. This bill would result in an unfair practice of allowing one set of attorneys more access than the other. The Contingency Fees legislation would allow attorneys to receive unlimited compensation in medical, dental, and podiatric malpractice lawsuits, rather than retain the current sliding scale.

While the hospital industry agrees that there is a pressing need for medical malpractice reform, these proposals do nothing to reasonably re-structure the current system or curtail exorbitant malpractice insurance premium costs. The industry supports reforms such as malpractice courts, wherein cases are tried by judges and juries with health knowledge, and limits on non-economic damages.

FEDERAL UPDATE: DC Eyes Short Inpatient Stays

The Centers for Medicare and Medicaid Services (CMS) issued a proposed payment rule earlier this month for federal fiscal year 2015. Among the suggestions noted is one related to CMS' "two-midnight" rule. CMS is considering a short-stay payment mechanism. The hospital industry is pressing for such a payment category in response to the CMS "two-midnight" rule that says a patient's stay must span two full midnights for it to be considered an inpatient stay and be reimbursed at the inpatient rate. The "two midnight" rule does not consider all of the medically complex patients, even some ICU patients, who do not need to stay in a hospital for two midnights, but nonetheless need inpatient care. Historically, hospitals in other parts of the country placed patients on observation level care as opposed to admitting them for short-inpatient stays because the CMS had ramped up its auditing of short-inpatient stays. Recovery Audit Contractors, known as RACs and hired by CMS, often and without substantiating evidence denied these short stays. Observation status allowed physicians and the care team to diagnose and treat patients without worry of short-stay denial. Patients on observation care, however, are liable for outpatient-based co-pays and deductibles. These costs add up and are often a surprise to Medicare beneficiaries. The "two-midnight" rule was instituted as a remedy for the short stay vs. observation care designations. However, the rule overlooks a category of medically valid short inpatient stays. CMS has not indicated any intent to adopt a short-stay payment category at this time, but has indicated it is open to discussion. A House Subcommittee will soon examine the rule and RAC practices. Meanwhile, some New York Hospitals last month filed a suit in federal court challenging the legality of the rule and an arbitrary 0.2 percent inpatient payment cut.

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