

# On Your Behalf ...

## Legislative and Practice Affairs Division

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### Nursing Board Withdraws CRNA Practice Definition

By David E. Willett, Esq., CSA Legal Counsel



The last issue of the *Bulletin* reported on CSA's suit against the California Board of Registered Nursing, challenging a BRN policy statement issued last December 2004. That statement asserted that California CRNAs are "licensed independent practitioners" who are not subject to legal requirements for physician supervision. The same policy statement, which appeared in a document titled NPR-B-10, "Practice of the Certified Registered Nurse Anesthetist," also claimed that CRNAs may provide unsupervised pain management services, for both acute and chronic pain, in both inpatient and outpatient settings.

CSA's suit asks the court to declare that these policy statements are legal nullities, and require their withdrawal. CSA also asks the court to prohibit BRN from asserting similar policies unless the BRN first complies with California's Administrative Procedure Act. The APA requires the BRN to show that there is a legal foundation for such policies, which can only be adopted after notice, hearing, and opportunity for judicial review.

The BRN, confronting CSA's suit, has now withdrawn the CRNA policy statement. Following a special November 2005 Board session, the BRN's Web Site was modified to contain the following notice (<http://www.rn.ca.gov/practice/nas.htm>):

- (a) The BRN has withdrawn, as of March 2005, NPR-B-10 ("Practice of the Certified Registered Nurse Anesthetist") as revised and dated December 2004.
- (b) No reliance should be placed on the December 2004 revision of NPR-B-10.

This language was originally proposed by CSA in response to a BRN request for possible settlement of the suit. While the BRN has adopted this portion of the CSA response, the BRN ignored requests for assurances that the BRN would not adopt the same policy all over again, without APA compliance, or refrain from other attempts to maintain the policy as an "underground

regulation.” BRN has also stonewalled a CSA request for the production of documents that would shed light on the genesis of the December promulgation. CSA will continue to pursue both its document request and the original lawsuit.

Until the BRN issued its new statement, organizations and individuals relied on the December 2004 promulgation as the basis for practice arrangements which would allow CRNAs to assume responsibility for unsupervised patient care. The March 2005 issue of the *CANA Newsletter*, which trumpeted BRN's promulgation of the December 2004 statement, contributed to interest in such arrangements. Although the BRN has sought to unring the bell, its recent action has not received the same publicity as did its December 2004 promulgation. As the BRN statement makes clear, no reliance should be placed on BRN's December 2004 description of CRNA scope of practice. Practice arrangements following the withdrawn BRN December 2004 Policy Statement on the Practice of the CRNA can result in liability and potential legal sanctions.

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### The Initiative Process, A Reform Corrupted by Money

*By William E. Barnaby, Esq., CSA Legislative Counsel*

**T**ake the initiative! That is an admonition usually reserved for a lazy or unambitious child or workplace subordinate. These days California voters seem to be saying “Take the initiative(s) away.” “Enough already” may be the implicit consensus.



The recent November “special” election is a strong case in point. All eight ballot propositions were defeated, most by wide margins. The closest was Proposition 73, mandating parental notification of minors seeking abortions, which lost by a margin of 53 percent to 47 percent. The next closest was Proposition 75, requiring annual member approval of public employee union political contributions. It went down 54 percent to 46 percent. The rest did worse.

No doubt many voters felt the entire “special” election was unnecessary. It has been termed a “debacle” for Governor Schwarzenegger, who since has conceded it was a big mistake.

And it was not just a relatively small number of angry voters who took the trouble to cast ballots. Turnout was far higher than expected, in excess of 50 percent. In fact, Republican strategists publicly hoped their traditionally loyal partisans would turn out in force and carry the Governor's "Year of Reform" to victory. It was not to be. Voter turnout among large counties was high in the Democratic bastions of San Francisco (53.7 percent) and Alameda (54.7 percent), and low in Republican-dominated Orange (43.8 percent), Riverside (44.3 percent) and San Bernardino (42.9 percent).

So why did voters reject every measure on the statewide ballot? Perhaps it was the \$50 million cost of holding the election, mostly borne by cash-strapped counties. Or maybe it was the \$250 million plus spent by various campaigns, largely on TV ads.

Professional political consultants and campaign fundraisers discovered some years ago that the real money in California politics is in ballot propositions. Anybody or any special interest with enough money can put anything on the ballot. Gathering voter signatures for initiatives is the first cost item. There are businesses out there that do nothing else. Usual fees range from \$2 to \$5 per signature on up, depending on supply and demand.

When then-Governor Gray Davis first tried to block the recall effort against him in 2003, his supporters hired as many signature-gathering firms as possible to keep them busy on measures not seriously intended to ever make the ballot. The effort to corner the signature-gathering market obviously was unsuccessful, but it probably drove up the price for signatures for the recall. The price also goes up as the deadline approaches for submitting the signed petitions.

Another cost driver is television advertising for ballot measures. The Federal Communications Commission limits TV charges for candidate ads to the lowest available rates for nonpolitical commercial advertising. For ballot measures, however, it is whatever the market will bear. Big money interests, like the pharmaceutical industry, make early buys of big chunks of time, especially around newscasts and prime time broadcasts for periods close to election dates.

Some of the well-heeled interests put initiatives on the ballot not necessarily to win, but to confuse voters in order to defeat a competing measure. The pharmaceutical industry counted its \$78 million well spent in the election, not because its sponsored Prop. 78 (voluntary drug discounts) failed, but because competing Prop. 79 (mandatory drug discounts) also lost.

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The regularly scheduled November 8<sup>th</sup> election in the State of Washington provides another interesting example. Competing measures dealing with medical malpractice were on the ballot. Measure 330, sponsored by physicians, proposed to “cap” non-economic damages at \$350,000. Measure 336, sponsored by personal injury lawyers, proposed revocation of physicians’ licenses for three “malpractice incidents absent mitigating circumstances.” The most expensive issue campaign in the state's history was the result. Both were overwhelmingly defeated. “No” evidently was in the West Coast air.

Professional campaign consultants/strategists do not come cheap. Many are legends in their own minds and demand fees accordingly. Most take commissions on all the advertising they place, whether it's direct mail, TV, radio or print media. The bigger the campaign advertising budget, the more they rake in on top of their fees.

Frequent elections and constant campaigning are the life blood of these folks. Several of them remained in the Governor's retinue following his recall election victory. Did they have anything to do with convincing him to call the “special” election? You think?

In the end, California's 2005 “special election” cost upwards of \$300 million, and not a single state law was changed. Counting that sum all the way to the bank were the campaign consultants on both sides and the state's television stations.

There are other problems with initiatives, of course, but money skews the process worse than it does for candidate elections. The initiative process began as reform intended as a safety valve for voters when special interests clearly dominated the legislature.

It all began under reform-minded Republican Governor Hiram Johnson, the son of a lawyer, born and raised in Sacramento. In his 1911 inaugural speech, he urged adoption of a state constitutional amendment to establish the initiative, referendum and recall processes to “arm the people to protect themselves” and “prevent the misuse of the power temporarily centralized in the Legislature.” He clearly did not see the future abuses that have occurred with increasing frequency. In the same speech, Johnson advocated a short ballot. “The most advanced thought in our nation has reached the conclusion that we can best avoid blind voting and best obtain the discrimination of the electorate by a short ballot.”

Today there are 30 proposed initiatives in circulation for signatures to qualify for the ballot on either June 6 or November 7, 2006.

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For a while there were two competing proposals for a \$1.50 increase per pack of cigarettes. One was sponsored by the California Hospital Association (CHA) and supported by CAL-ACEP, the emergency physicians, with most of the expected \$1.5 billion per year to pay for emergency care of uninsured patients. The California Medical Association and CSA opposed this proposal because it would give hospital administrators too much control over on-call physician reimbursement. The other was sponsored by the Cancer Society along with the California chapters of the American Heart Association and the American Lung Association. Its proceeds would pay for cancer research and healthcare for children without health insurance.

As this is written, a coalition combining the two groups has agreed to go forward with a proposed \$2.60 per pack increase that hopes to raise \$2.7 billion annually at first. Tobacco sales, due to higher prices, including \$3.47 tax per pack, would be expected to decline by 8 percent a year. CHA plans to withdraw its earlier proposal after spending \$4 million to gather signatures for next June's ballot. CMA is examining the coalition proposal that is intended to boost funding for hospital emergency care, nursing education, cancer research and a variety of other health programs.

We may be wrong, but we sense "initiative fatigue" among voters. Quadrupling the tobacco tax to the highest in the nation in one jump may be overreaching as well. One can only imagine how much the tobacco industry will spend in opposition. If a long ballot is produced by a number of the other 30 proposals in circulation getting on the ballot, that alone may drag them all down.

Hiram Johnson, who went on to be a Vice Presidential candidate (on the 1912 Progressive Party ticket with Theodore Roosevelt) and U.S. Senator for nearly 30 years, would be spinning in his grave to see his well-intentioned reforms corrupted by money.

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### Grinch Crew Cuts Medi-Cal Provider Pay

*By William E. Barnaby III, Esq., CSA Legislative Counsel*

**I**n a move worthy of the Christmas-stealing Grinch, the Schwarzenegger Administration on December 12th formally announced an across-the-board Medi-Cal provider reimbursement reduction of five percent for services rendered on and after January 1, 2006.

The move dashed provider hopes that urgency legislation enacted last September, plus an informal understanding with top administration officials, would hold off any cuts at least until next July when a new 2006-07 state

budget takes effect. As it turns out, the two sides differ on the “understanding” to the extent that Medi-Cal officials felt it necessary to engage in a holiday rush to impose the cuts. Who says government is incapable of acting quickly?



It is the latest chapter of an issue that goes back to a 2003 enactment of a three-year cut to begin January 1, 2004, as part of the 2003-04 budget package dealing with a \$38 billion state deficit. The cut was blocked by a federal court injunction in a lawsuit initiated by the California Medical Association. The injunction was overturned on appeal. The lifting of the injunction was issued on November 30<sup>th</sup>.

A 50-member coalition of health care and consumer organizations, Californians United for Quality Care, is mounting a grass roots campaign to have the cuts cancelled or to seek urgency legislation for the same purpose. CMA also is trying to reach a negotiated settlement with the administration. CSA representatives are actively involved in these efforts.

Medi-Cal provider rates already are the lowest in the nation. A reduction now, when a \$4 billion deficit expected earlier has been virtually erased by a like amount of unexpected state tax revenues, would be a telling statement of administration priorities. Provider participation and patient access will suffer.

A bipartisan group of Senators and Assemblymembers have signed on to support urgency legislation to halt the cuts. The issue will provide an interesting opening as the Legislature reconvenes next January 4<sup>th</sup>.

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## Projected Changes in the Economic Climate of Anesthetic Practice — Questions and Answers and Commentary

*By Kenneth Y. Pauker, M.D., Associate Editor, Vice Chair for Practice Affairs, and Director, District 13 (Orange County)*

**D**r. Orin Guidry, in his inaugural speech as president to the 2005 ASA House of Delegates, emphasized how critical it is for anesthesiologists to be attentive to the future: those at the watch on the great Ship of Anesthesiology must be vigilant to discern icebergs in the mist and thereby be able to steer away from a catastrophic collision—a Titanic-like scenario—in a

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turbulent sea of change. Many of our leaders, including Drs. Ron Miller and Mark Warner, have articulated their visions of what we may expect the face of anesthesia to look like in the future. The ASA has developed a wealth of material on Practice Management, much of which is easily accessible on the ASA Web Site. Taking our vigilance to the next level, we must also understand what hospitals and insurers, with whom we compete economically, are thinking with respect to what appears to be the growing problem of a shortage of anesthetic services relative to an exponentially increasing need. We may then be able better to come to terms with what they are doing to optimize their own situations. Hospitals and insurers have indubitably spent considerable resources analyzing the field of anesthesia.

**Q:** Why don't our professional organizations aggressively investigate what our economic competitors are being told by their own paid consultants so that we may incorporate this information into our own views of how we can and should behave in our own individual negotiations?

**A:** There is information available to our leaders, at many levels, from the AMA and ASA to the CMA and CSA, and even to our own medical staffs. Much of this does filter down to individual anesthesiologists and their groups, but the quality of the data available is highly dependent on how effectively they have organized themselves. Moreover, there seems to be reluctance on the part of professional organizations, perhaps because of generally nebulous and sometimes specific federal anti-trust concerns, concerning just what can be shared and how it is done.

*It would be helpful for the Professional Affairs Division of the ASA to investigate the specific tactics used by insurers and hospitals to negotiate in the current climate, including the specific information upon which they rely to form their judgments.*

**Q:** What are the sources of the analyses used by hospitals in the development of their strategies in negotiating with anesthesiologists?

**A:** There are perhaps many expert consultants, but one that has been particularly pervasive with hospital associations is an organization called the Clinical Advisory Board, a Washington think tank, which has undertaken extensive research in many areas related to the organization and economics of health care. The fee to join and to receive these reports depends on the size of the organization, and the fee quoted to the CSA was on the order of \$39,000 yearly.

*The CSA found this level of expenditure extreme, but the ASA has many more resources and the expertise to gain access to many different kinds of economic analyses.*

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**Q:** Has the Clinical Advisory Board prepared a report concerning projected changes in the economic climate of anesthetic practice?

**A:** Yes, it has published a document, 80 pages long, which it calls a “Flashpoint Handbook” entitled “Navigating the Anesthesia Shortage: Ensuring Sufficient Coverage to Enable Procedure Growth,” copyright 2004 by the Advisory Board Company.

**Q:** What are the salient points made in this handbook and used by hospitals and insurers with whom we negotiate concerning how the market for anesthesia services is changing?

**A:** The handbook lists five observations in this regard:

1. Growth in the volume of procedures at hospitals is already being limited by anesthesia coverage, as evidenced in the past year by greater than 50 percent of all hospitals closing at least one OR for this reason.

*There is constant pressure to lengthen the times ORs are staffed and to use them in the evenings and on the weekends. Shortages of nursing staff and ancillary personnel exist in parallel with anesthesiologists and further compound hospitals aspirations to care for more patients.*

2. Payments for anesthesia services are being pushed upward by two market forces: First, the relative shortage in anesthesia coverage drives the “price” up. Second, as a consequence of escalating case complexity and duration, each anesthesiologist is physically able to participate in fewer cases per year. Therefore, the concept of “revenue per hour of coverage” has become a relevant concern.

The shortage appears to have been engendered by more anesthesiologists practicing part-time, by considerable increase in the numbers of anesthetizing locations outside of hospital ORs, by increasing migration of anesthesiologists to pain management practices, and by increased duration of surgical cases in hospitals. Nationwide supply is estimated as 36,591 versus a demand for 40,461 in 2004. Almost 50 percent of hospitals nationwide report difficulty in recruiting anesthesiologists.

*Hospitals need to support anesthesiologists in their negotiations with insurers in recognition of these forces. Attempts to bully anesthesiologists into accepting insurance contracts below the market only exacerbate problems of recruitment and retention.*

3. Because of egregiously low Medicare payment rates, hospitals with a large proportion of Medicare patients are being threatened with defections by anesthesiologists who can earn substantially more elsewhere.

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*Beyond just government payers, hospitals that attempt to augment their case volume by contracting with unreliable and low payers, expecting their anesthesiologists just to “play ball,” do so at their hazard during these changing times.*

4. As baby boomers age, the insurance mix for both inpatients and outpatients will shift more toward Medicare, and therefore, pressure on hospitals for stipends, already common in some practice settings, will only increase.

*Hospitals for several years have been receiving performance incentives by Medicare. Achieving their performance targets has been made possible by cooperative medical staffs and individual physicians who may increasingly ask to share in this “Pay for Performance.” However, this is a slippery slope, particularly if anesthesiologists become overly reliant upon stipends. Hospitals predictably will make additional demands for services and time and control.*

5. For hospitals to recruit and retain anesthesiologists, they will need to view their surgery schedule as the anesthesiologist does, maximizing anesthesia revenue per hour of coverage by improving efficiency, integrating CRNAs, and “(in select instances) providing direct care subsidies to anesthesiologists.”

*Relations between the ASA and AANA have deteriorated of late because of the clandestine lobbying of the AANA leadership against ASA's clearly stated priority to fix the Medicare teaching rule. How CRNAs view these potential “economic efficiencies” may be quite different from how they are seen by anesthesiologists. Also, hospitals in California can hire CRNAs, but not physicians, and this distinction certainly may play into how this notion might develop here.*

**Q:** What does the handbook advise hospitals to do to ensure coverage for anesthesia services?

**A:** The handbook describes five “levers for ensuring coverage”:

1. It suggests that improving efficiency, defined as incremental cases per shift, increases revenue for the anesthesiologist and leverages this resource for the hospital, perhaps obviating the need for subsidies.

*This sounds good, but cases in hospitals are getting longer, and making room for a half case means nothing.*

2. The handbook argues strongly that boosting revenues for anesthesiologists is most effectively accomplished by using teams that integrate CRNAs, allowing a “fully leveraged team ... to nearly double anesthesia revenues per hour of coverage.” The analysis acknowledges the political hurdles to surmount, both with surgeons and anesthesiologists.

*The economic analysis presented in the body of the handbook is quite interesting, but politics is a “funny thing,” and, as we are reminded over and over again, all politics are local.*

3. It notes that hospitals with an insurance mix with less than 40 percent commercial patients may not be able, just with increased efficiency, to retain anesthesiologists without stipends, particularly in situations where there are other local opportunities with an economically better patient mix.

*Most hospitals cannot, for the most part, control their patient mix, but surgicenters surely can and do, and some are quite successful economically for their physician investors by using the tactic of accepting no insurance contracts at all. Case volume may be low, but reimbursement per case, just by accepting the non-contracted insurance payments as full payment, can be sufficient to produce remarkable return on investment.*

4. The handbook suggests that subsidies are best productivity based, perhaps to incentivize each additional case, perhaps to create “slack capacity” to open low volume ORs for surgeons trying to build their practices.

*The length of anesthesiologists' workday in the hospital, something which is prized in many practices, may become considerably more variable and unpredictable, particularly when OR schedulers attempts to use this vehicle more frequently.*

5. Although stipends may reduce marginal return for the OR because of its additional cost, nonetheless overall income and capacity to service more cases with ensured coverage for anesthetic services is the great benefit.

*Although anesthesiologists in large groups and in sophisticated practices with professional managers have appreciated this for some time, many other anesthesiologists have not yet addressed why and how they can improve their payments per hour of coverage by applying this simple principle.*

There is nothing earth shattering about the observations and suggestions presented here. However, the gist of this analysis might help to inform how groups of anesthesiologists approach negotiations with their hospitals and with insurers. At the very least, it should suggest to individual practitioners and loosely affiliated groups, even in small practice locations, that making themselves “bigger” through business integration, perhaps paying for professional managers and negotiators, is essential, if they wish to succeed economically as the big icebergs approach.