

California and National News

DMHC Orders Health Net to Improve Payments for Noncontracted Physicians: In January, the Department of Managed Health Care fined Health Net \$250,000 for systematically underpaying noncontracted physicians' claims for emergency care provided to plan enrollees. Health Net—the state's fourth largest HMO—has also been ordered to reprocess noncontracted physician claims and correct claims that were underpaid.

DMHC determined that Health Net's payments violated the Unfair Payment Practices Law, whose regulations went into effect January 1, 2004. The law was sponsored by CMA.

Between January 1, 2004, and October 12, 2004, DMHC estimates that 65,000 Health Net claims were incorrectly paid, totaling more than \$6 million in underpayments. Health Net paid noncontracted physicians at 80 percent of Medicare.

Health Net is required by the ruling to automatically reprocess underpaid claims from noncontracted physicians who had previously appealed the underpayments. Even if you did not appeal an underpayment, you may still be eligible for reimbursement under this ruling. CMA will provide physicians with more information on the appeals process when it becomes available.

CMA has been insisting for years that DMHC investigate health plan underpayments for emergency and on-call care provided by uncontracted physicians. In September 2003, CMA asked physicians to submit clear-cut cases of health plan underpayment, and ER and on-call physicians sent more than 400 specific examples to CMA, which analyzed them and shared findings with the DMHC. For years, DMHC had been slow to act on physician complaints of unfair payment practices despite abundant evidence. CMA and the California Chapter of the American College of Emergency Physicians complained loudly in 2004 both to DMHC and to members of the Legislature, demanding enforcement of California's Unfair Payment Practices Law.

CMA applauded the action taken by DMHC and its new director, Cindy Ehnes. "This is a huge advocacy victory," says CMA CEO Jack Lewin, M.D. "This incredibly good news seems to indicate that the regulatory environment is finally changing to address our critical concerns."

"This action hopefully evidences the more balanced enforcement activity promised by Cindy Ehnes, the new director of DMHC," says Niles Verberen,

News–Cont’d

CMA’s vice president of Economic Services. Contact: Frank Navarro, 916/444-5532 or fnavarro@cmanet.org. (From *CMA Alert*, January 20, 2005.)

CMS Unable to Implement CMA’s Medicare GPCI Proposal by January 1:

The Centers for Medicare and Medicaid Services (CMS) were trying to implement CMA’s plan to address California’s Medicare geographic payment inequities by January 1. CMS was unable to meet that deadline. However, efforts to implement CMA’s proposal as a demonstration project are still moving forward. CMS has informed CMA that the agency is working to make the necessary payment systems and operational changes. CMS also needs to get approval from the federal budget office. Therefore, the original CMS-proposed updates to California’s geographic practice cost index—as described in the November 15 *Federal Register*—went into effect on January 1, 2005.

CMA’s proposal would improve access to care for thousands of Medicare patients in the state, by solving a long-standing payment inequity for 10 California counties (Santa Cruz, Sonoma, Monterey, Sacramento, Santa Barbara, El Dorado, Placer, San Luis Obispo, San Diego, and Marin).

The Medicare payment formula includes a geographic adjustment factor (GAF) that adjusts the payment rate for local geographic market conditions. The goal is to base physician reimbursement on what it costs to provide care in a particular geographic region. The formula calculates a geographic adjustment factor for each county in California and assigns each county to one of the nine California Medicare regions, called payment localities.

However, physicians in these 10 California counties have practice costs that are five to 12 percent greater than the average costs of other counties in their Medicare localities. The project would move these 10 counties (nine from Locality 99 and one from Locality 3) to their own individual payment localities, where they will receive five to 12 percent increases. By doing so, the reimbursements would more accurately reflect practice costs.

Because federal law requires changes in the Medicare program to be budget neutral, CMA proposed that all physicians in California participate in the solution by taking a one-time 0.4 percent payment adjustment, at a unique time when all physicians here are receiving net increases. Otherwise, physicians remaining in Locality 99 (the 38 most rural and valley counties) and Locality 3 (Napa and Solano) would face a four to six percent cut.

News–Cont’d

CMA understands that if reimbursement rate changes occur on March 1, it will make extra work for physician offices by requiring them to enter new Medicare fee schedules into their billing systems twice within a few short months.

“Despite these hurdles, CMA’s proposal has widespread support from physicians across the state. We are still very hopeful that we will be able to solve this difficult, long-standing reimbursement problem,” says CMA CEO Jack Lewin, M.D. “With CMS so close to implementation and so many physicians supporting the plan, it may make the short-term difficulties worthwhile to solve the larger reimbursement and access problems in the state.”

CMA will be making a final determination this month on the feasibility of a spring implementation date for the demonstration period. Contact: Elizabeth McNeil, 415/882-3376 or emcneil@cmanet.org. (From *CMA Alert*, January 13, 2005.)

Ninety Percent of U.S. Wounded in Iraq and Afghanistan Survive: A study by Atul Gawande, a surgeon at Harvard Medical School, showed that better and more timely medical care has reduced the mortality of the more than 10,000 war injuries in Iraq and Afghanistan to 10 percent, the lowest percentage of any war in American history. This compares favorably with the figure of 24 percent encountered in the Persian Gulf War of 1990-1991. The darker side of these data also shows that injuries from suicide bombs and land mines often leave the survivors with lifetime disabilities, such as blindness and amputations. Questions therefore arise as to how the survivors and their families will adapt and survive. This reduced mortality has occurred despite the limited number of medical personnel available in the war theater. The Armed Forces keep approximately 30 to 50 general surgeons and 10 to 15 orthopedic surgeons in Iraq for a fighting force of 150,000. The surgeons are deployed in small teams of 20 people (Forward Surgical Teams= FST) who move directly behind troops and establish a functional hospital with four ventilator-equipped beds and two OR tables. These FSTs stabilize patients and try to limit surgery to two hours. Patients are then moved to one of the two Combat Support Hospitals (CSH) in Iraq for the next level of care, these facilities being 250 bed hospitals with six OR tables. The maximal hospital stay is limited, if possible, to three days. From there the patients are transferred to larger hospitals in Germany, Kuwait or Spain. Should treatment be anticipated to last more than a month, then the patients are transferred to Walter Reed or Brooke Army Medical Centers. The average time from battlefield to US Hospital is four days, in stark contrast to 45 days during the Vietnam War (1961-1972) when over 200,000 soldiers were wounded or killed in action. There is a problem with keeping enough medical personnel at these facilities in Iraq, the cur-

News–Cont’d

rent solution being second and possibly even third deployments for surgeons. Of note, the Selective Service recently has updated a plan to allow the rapid registration of 3.4 million health care workers from 18 to 44 years of age. (Abstract of “Casualties of War—Military Care for the Wounded from Iraq and Afghanistan” by Atul Gawande, M.D., M.P.H., from the *New England Journal of Medicine*, December 9, 2004.)

Extended Shifts for Residents Are Risky for Patients: The Accreditation Council for Graduate Medical Education now limits residents’ hours of work to 80 per week. However, recent studies reported in the *New England Journal of Medicine* (October 28, 2004) show that an 80-hour work week still causes significant fatigue and errors in house staff. An intervention that divided shift times in half decreased signs of fatigue in interns and effected a concomitant drop in serious medical errors in patient care. The fact is that long shifts, even within the 80-hour guidelines, can stretch to 30 hours. One of the studies assigned a group of “intervened” interns in an ICU to have shorter shifts (16 hours) and fewer total hours (65) of work per week. These “intervened” interns slept an average of six hours more per week than their controls, and experienced less than half the rate of both “attentional failures” at night and slow-rolling eye movements caused by sleepiness during waking activities. The second study noted that the interns with the traditional work schedule (the “non-intervened”) committed 36 percent more serious medical errors, including 21 percent more medication errors and more than five times as many serious diagnostic errors. Historically, when the residency system was created to have them available in hospitals for overnight emergencies, there were fewer numbers and lesser acuity of patients. Current hospital populations and acuity often demand that entire shifts be consumed with work and no sleep. The cost and complexity of adding more residents has prevented serious consideration of alleviating this situation. Moreover, there is a tradition in medicine of a “siege mentality” in which staying up late with patients is considered both heroic and professional. Furthermore, a study in 1994 had shown that the loss of continuity care caused by shift changes resulted in a six-fold increase in adverse patient events. This problem can be largely rectified by current information technology such as a computerized patient sign-off system (as has been initiated at the Brigham and Women’s Hospital in Boston). In fact, it now has been shown that even with more frequent patient handoffs, fewer errors occurred when interns were better rested by the reduced shift and total work hours schedule. (From *Focus* (Harvard Medical School), Winter 2004/2005. Both *NEJM* papers are available at <http://workhours.bwh.harvard.edu>. This new information is an extension of the seminal work in this field by our esteemed colleague, Steven Howard, M.D., at Stanford University.)

News–Cont’d

Senator Poochigian Introduces Workers’ Compensation (WC) Reform

Legislation: Every employer in California is required to maintain WC coverage either in the form of traditional insurance or as a self-insured employer. The State, however, is legally uninsured under the law. As such, it pays for medical and indemnity costs as they arise. In 2001-02, California government spent more than \$429 million for WC claims of state employees, the figure increasing by 19 percent to \$509 in 2003-04, and projected to leap to \$686 in 2005-06! This latter estimate reflects that the State is experiencing a “bubble” resulting from the payment of claims filed under the old system that predated the Poochigian reforms. Costs are also compounded by the fact that former Governor Davis’ administration expanded presumptions (the process whereby a worker’s injuries are statutorily presumed to be work-related). Senator Poochigian led last year’s WC system overhaul (SB 899) in an attempt to reduce the crippling costs of the currently flawed system. SB 899 aimed at making WC fairer to injured workers while creating a more objective, medical evidence-based system that is less litigious. His three new bills (SB 177, 178, 179) aim to enhance the efficiency of WC by using an alternate dispute resolution process in managing claims, expand opportunities for medium-sized businesses to join together and self-insure, and improve WC fraud enforcement effectiveness. (From Senator Charles Poochigian’s *Capitol Update*, February 10, 2005.)

Residency Training for Victims of Weapons of Mass Destruction

(WMD): A recent study found that an increasing number of anesthesiology residency programs have mandatory training in treating victims of WMD. Of the 135 programs that were polled, 90 responded, and of those, 37 percent had a formal WMD training program (42 percent of these were mandatory). The programs were concentrated east of the Mississippi River, and all began after September 11, 2001. In many models of mass casualty management, anesthesia personnel are responsible for treating patients immediately on arrival at the hospital. If the hospital does not have a patient management system that ensures decontamination or protective gear for physicians to wear, they can be exposed to toxic substances. The ideal checklist for programs that are trying to expand or build a WMD-training program include a patient management program, a decontamination area with shower facilities, chemical protective gear with a breathing device, and a stockpile of antibiotics and medications to treat WMD exposure. (From the *Newsletter of the Connecticut State Society of Anesthesiologists* (February 2005), “Interview with Keith Candiotti, M.D., Assistant Professor of Anesthesiology and Internal Medicine, University of Florida, Miami, Florida.”)

Balance Billing Prohibition Legislation Opposed by CMA: In February, Assemblyman Leland Yee introduced a bill that would prohibit hospital-based

News–Cont’d

physicians from balance billing patients under any circumstances. The bill (AB 1321) would require physicians “to seek reimbursement solely from the enrollee’s health care service plan or its contracting medical group.”

CMA is asking members—especially those from Assemblyman Yee’s district (San Francisco and San Mateo)—to let him know that physicians oppose this bill, which gives health plans carte blanche to underpay physicians for services provided to their enrollees.

Assemblyman Yee can be contacted by phone (916/319-2012 or 415/557-2312), fax (916/319-2112), or e-mail (assemblymember.yee@assembly.ca.gov). Contact: Rachel Doherty Smith, 916/444/5532 or rsmith@cmanet.org. (From *CMA Alert*, February 24, 2005.)

CMA Objects to Public Disclosure of Medical Board Citations without Due Process: At the Medical Board of California’s quarterly meeting, CMA objected to the public disclosure of citations before physicians have been given the opportunity to appeal. The board issues approximately 500 citations each year. Currently, all citations are posted on the Medical Board’s Web Site before physicians have had a chance to exercise their legal right to dispute the allegations through either an informal interview with investigators or a full administrative hearing.

“It is clearly not fair for a physician who makes a timely objection to the citation and asks for a full due process hearing on the matter to have the citation nonetheless disclosed to the public without any qualification as to its validity,” wrote CMA President Robert E. Hertzka, M.D., in an earlier letter to the Medical Board on this matter.

The Board’s Division of Medical Quality agreed that the process should be fair to physicians and has agreed to revise its procedures. Contact: Sandra Bressler, 415/882-5171 or sbressler@cmanet.org. (From *CMA Alert*, February 24, 2005.)

CMA Makes Workers’ Comp Recommendations: Last year’s Workers’ Compensation Law requires the state to adopt treatment standards for injured workers. CMA is working to protect physicians’ interests as the new law is implemented.

In comments recently submitted to the Division of Workers’ Compensation (DWC), CMA recommended that the division adopt treatment rules based on the

News–Cont’d

American College of Occupational and Environmental Medicine (ACOEM) guidelines and supplemented by national specialty society guidelines. CMA also recommended that the medical decisions of the treating physician be presumed correct in cases where the treatment is not specifically addressed by the guidelines.

CMA urged DWC to establish a physician advisory committee to develop “best practice” protocols for treating patients with chronic conditions. “Chronic conditions are the real cost drivers in the workers’ comp system, yet chronic care is not addressed in any of the guidelines under consideration,” said CMA President Robert E. Hertzka, M.D. “It is an area in desperate need of attention.”

CMA also urged DWC to implement a clinically based preauthorization system for “physical modalities” (physical therapy, acupuncture, and chiropractic care).

Last year’s workers’ comp law mandated the use of the ACOEM guidelines for payment purposes. CMA notified DWC of these complaints and will work with the division to make sure that payers are appropriately following the ACOEM guidelines. Contact: Elizabeth McNeil, 415/882-3376 or emcneil@cmanet.org. (From *CMA Alert*, February 24, 2005.)

CMA Makes Sure Physicians Receive Prop. 99 Money: An administration mistake in last year’s state budget has delayed the allocation of \$24.8 million in tobacco tax funds to reimburse emergency and on-call physicians for uncompensated emergency care. CMA has been working with legislators to expedite the passage of a bill (SB 29) that will correct the mistake and allow the funding to be distributed as soon as possible to physicians, via the counties that administer the program.

The Assembly this week passed the bill, with some minor amendments. It will now go back to the Senate for a vote; then it is expected to be signed by the governor. Contact: Lisa Folberg, 916/444-5532 or lfolberg@cmanet.org. (From *CMA Alert*, February 24, 2005.)

Governor’s \$112 Billion Budget Proposal Includes Long-Anticipated Medi-Cal “Redesign”: The Schwarzenegger administration Friday released its proposed 2005-2006 budget. Despite an estimated \$9 billion budget deficit, the governor’s spending plan does not cut Medi-Cal physician reimbursement or contain any direct cuts to Medi-Cal eligibility benefits.

News–Cont’d

The budget proposal does, however, contain the governor’s long-anticipated Medi-Cal “redesign.” The plan would move many elderly and disabled recipients into managed care, institute monthly premiums for more than 550,000 beneficiaries who are at the federal poverty level (\$15,610 for a family of three), and cap dental benefits at \$1,000. The administration expects the changes to save the state \$12.3 million in 2005-2006, with savings reaching \$139.1 million/year with full implementation in 2008-2009.

Below are details of the governor’s \$112 billion spending plan as it relates to health care.

- **Medi-Cal Managed Care:** The proposal would expand the Medi-Cal Managed Care program to up to 13 new counties, affecting 262,000 enrollees from El Dorado, Placer, Imperial, Madera, Merced, Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura, and possibly Kings and Lake Counties. The proposal also would require 554,000 elderly and disabled beneficiaries currently enrolled in fee-for-service Medi-Cal to switch to the managed-care program.

CMA opposes mandatory managed-care enrollment. The association is concerned that forcing enrollees into a managed-care system would restrict access to care and disrupt patients’ relationships with their current physicians.

- **Imposing Monthly Premiums:** The plan would require 550,000 beneficiaries to pay monthly Medi-Cal premiums beginning in FY 2006. Premiums would be \$10 for adults and \$4 for children, with a family cap of \$27. Premiums would not be imposed on beneficiaries with family incomes below the federal poverty level (\$19,590/year for a family of four) or elderly and disabled beneficiaries with monthly incomes less than the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program levels (\$812/month for a single individual, \$1,437 for a couple).

CMA is concerned that the new premium program could reduce enrollment, forcing people to delay care and not get checkups, while increasing use of emergency rooms by the uninsured. The administration has estimated that 110,000 beneficiaries would lose coverage for failure to pay premiums. About 6.6 million Californians are eligible for Medi-Cal.

- **Dental Benefits:** The redesign would limit annual dental benefits to \$1,000 (excluding some emergency procedures).

News–Cont’d

- **Medi-Cal and Healthy Families Enrollment:** The governor’s budget proposes modest funding increases to facilitate enrollment in Medi-Cal and Healthy Families, providing \$14.5 million to reestablish application assistance fees and \$5.6 million for programs to help children transition from Medi-Cal to Healthy Families.
- **Obesity Prevention:** The Governor announced that obesity prevention is a priority for his administration. His budget proposal allocates \$6 million for obesity prevention efforts, including work- and school-based prevention programs, and increasing access to obesity prevention services in public and private health insurance programs.
- **Prescription Drugs:** The Governor’s budget includes \$4 million for the California prescription drug program, which would provide prescription drug discounts to uninsured Californians with incomes below 300 percent of the federal poverty level (\$27,930/year for an individual, \$56,550/year for a family of four).
- **Border Health:** The budget would eliminate \$700,000 in state funding for the Office of Binational Border Health. The administration has indicated that the border health office would still receive \$500,000 in federal funds. Contact: Lisa Folberg, 916/444-5532 or lfolberg@cmanet.org. (From *CMA Alert*, January 20, 2005.)

United Kingdom (U.K.) Study Linking Power Lines to Childhood Leukemia Allegedly Withheld for Three Years: The U.K. Department of Health allegedly withheld a study on children who lived within 100 meters of a power line having double the risk of developing childhood leukemia. However, Dr. Gerald Draper of the Childhood Research Group in Oxford denied that he had suppressed the results of his study of 35,000 cases of childhood leukemia between 1962 and 1995. The Trentham Environmental Action Campaign, an activist group, first disclosed word that the Department of Health was sitting on this study several months earlier, but its press release was not picked up by the mainstream media. (From *Microwave News*, October 29, 2004.)

Mobile Phones Again Linked to Cancer Risk: Mobile phones may present a cancer risk. Epidemiologists at the Karolinska Institute in Stockholm have found that mobile phones can increase the incidence of acoustic neuromas. The nerve is exposed to radiation during the normal use of a cell phone. Those who used mobile phones for at least ten years had twice the risk. For those acoustic neuromas that were on the same side of the head as the phone was used, the risk was

News–Cont’d

fourfold, when compared to controls, the data being statistically significant. This study, which appears in the November 2004 issue of *Epidemiology* is part of a 13-nation interphone study coordinated by the International Agency for Research on Cancer. Acoustic neuromas account for less than 10 percent of all brain tumors. Whereas this study detected 12 acoustic neuromas, an earlier study from Copenhagen had found no increased risk, but this study detected only two neuromas in people using cell phones for more than 10 years. In the United States, the American Cancer Society has dismissed the possibility of brain cancer arising from cell phone use. However, other investigators at the Karolinska Institute reported research that found no increased risk for glioma or meningioma related to cell phones. (From *Microwave News*, October and December, 2004.)

Education: Charter Schools’ Longevity Improves Student Achievement: Nationwide, a higher percentage of students in charter schools are judged proficient on state reading and mathematics examinations than their peers in the nearest traditional school, according to a recent study by Caroline Hoxby, professor of economics at Harvard University and the Kennedy School of Government. In fact, if a charter school has been operating for more than nine years, then 10 percent more students are scoring at or above the proficiency level in both reading and mathematics. Charter schools had the largest impact on the achievement of students who are poor or Hispanic. The amount of funding charter schools receive relative to traditional schools has a positive impact on student achievement. (From the *Harvard Gazette*, December 2004.)

On Broadening Access to Higher Education: A central purpose of the university is to ensure that everyone in the United States has a chance to participate in higher education. However, seldom has this American dream appeared so distant for so many Americans. Inequality is widening. The transmission of inequality is on the rise from generation to generation, so much so that the gap between the life-chances in children of the fortunate and those of the less fortunate are increasing. A student from the top income quartile is more than six times as likely as is a student from the bottom income quartile to graduate with a B.A. within five years of graduation from high school. At “selective” universities, only 10 percent of students come from the bottom half of the income scale, meaning that children whose families are in the lower half of the American income distribution area are underrepresented by 80 percent. It appears that students in professional schools have even more affluent parents than those in college. Restoring education to its proper role as a pathway to equal opportunity in our society should be a continuing national priority. (From *Harvard Magazine*, January/February 2005.)