California Medical Association Specialty Delegation

March 2005

By Michele E. Raney, M. D., CSA Delegate to the CMA Specialty Delegation

On March 18-21, 2005, the 134th CMA House of Delegates (HOD) convened in Anaheim. During four days of testimony, deliberation and debate, the CMA reviewed activities set in motion at previous meetings and addressed a wide range of issues.

The CSA was represented in the Specialty Delegation by Drs. Mark Singleton, R. Lawrence Sullivan, Jr., and Michele Raney. CSA's influence at the HOD was further extended by members active in other delegations. These included Dr. Bob Hertzka, outgoing CMA president; Dr. Rebecca Patchin, AMA trustee; CMA trustees Drs. Edgar Canada, Benjamin Shwachman, and Lee Snook; and delegates Drs. Virgil Airola, James Futrell, Jr., Thelma Korpman, Jack Moore, Lynn Rosenstock, Hugh Vincent, and James Willis. Dr. Patchin chaired the reference committee on Membership, Finance and Governance, and Dr. Raney chaired the reference committee on Ethics, Quality, and Legal Issues.

Hugh Vincent Receives Speaker's Recognition Award

Hugh Vincent, M.D., chair of the CMA Delegation to the AMA and previous member of the CSA Board of Directors and ASA Delegation, received the "Gary Krieger, M.D., Speaker's Recognition Award" for exemplary service to the CMA. We extend our most sincere congratulations to Dr. Vincent.

Schiavo Resolution Passes Unanimously

As the United States Congress was convening in special session to pass emergency legislation regarding the medical care of Terri Schiavo, the HOD unanimously resolved that "CMA expresses its outrage at Congress' interference in medical decisions."

MICRA Defense

CMA will increase its dues by $50, with those additional monies earmarked specifically to the preservation and protection of MICRA. In accordance with state law, that money will be transferred directly to CALPAC unless the CMA member specifically requests that the amount be deposited to a restricted CMA MICRA Education Fund.

Medicare Payment Reform and the GPCI Report

Medicare Sustained Growth Rate (SGR): Fix It! The CMA HOD voted that in order to prevent further Medicare payment reductions, fixing the SGR formula should have the highest federal legislative priority.

Geographic Practice Cost Index (GPCI): Fix it, but don't jeopardize SGR! For many years, CMA has been working to address inequities in Medicare payment created by grouping several different counties within a given Medicare payment locality. This has resulted in counties with high practice costs being lumped with counties having substantially lower practice costs, with some counties being penalized and others subsidized by their locality-mates.

Key to understanding this problem are two terms, GPCI and Geographic Adjustment Factor (GAF), and how they affect Medicare payments (and, by implication, all other contracted fees based on a percentage of Medicare rates). In the Medicare Fee Schedule (MFS), every service or procedure is assigned a CPT code which, in turn, is assigned three sets of relative value units (RVU) to reflect the value of physician work, practice expense, and malpractice expense associated with delivering that service. Then, a GPCI is applied to adjust the RVUs to reflect geographic practice cost differences. This is then multiplied by the conversion factor to obtain the MFS amount for each service. Ultimately, the GPCIs are used to determine a GAF for each county in California, and the GAF is directly applied to the conversion factor to yield the amount reimbursed.

However, for payment purposes, Medicare assigns a single, average GAF to each locality, not each county. In California, where there are more counties (58) than there are Medicare payment localities (9), some counties comprise their own payment locality (Los Angeles, Orange, Ventura, Santa Clara, San Mateo, and San Francisco), and others are grouped. One locality, Locality 99, or "Rest of California," is composed of 47 counties, and within Locality 99 there is a 16 percent difference between the highest (Santa Cruz) and lowest (Trinity) county GAFs. San Diego, Sonoma, Santa Barbara, and Sacramento are some of the other counties in Locality 99 whose GAF exceeds the locality GAF, whereas most of the other counties in Locality 99 are rural counties with much lower GAFs. How this applies to anesthesiology can be seen in the annual report on Medicare conversion factors published by the ASA.

To address the issue of the Medicare inequities within Locality 99, to remain in compliance with federal law mandating that all changes constitute a zero sum transaction and maintain budget neutrality, to avoid further decreases statewide

and/or in rural (lower GAF) counties, and to forestall further exodus of physicians from rural and urban areas, CMA proposed multiple options.

Selecting what seemed to be the best statewide solution, CMA presented its proposal to the Centers for Medicare and Medicaid Services (CMS). A demonstration project was scheduled to begin January 1, 2005, but was subsequently delayed until April, and has been postponed yet again, possibly until January 1, 2006. The demonstration project would have moved any county whose GAF exceeds its locality GAF by five percent to a new payment locality (preferably its own), divided any reductions in Medicare GAFs and payments equally among all payment localities in the state, maintained the reimbursement levels for the counties remaining in Locality 99 (and Locality 3) at their current 2004 GAF payment levels, and replaced the statewide adjustments made in 2005-2006 by GAFs assigned by CMS in 2007. Because of the 1.5 percent increase in Medicare reimbursement this year, no locality would suffer a drop in reimbursement in 2005.

Were the problem as simple as adjusting the California GPCI payment inequities, its resolution would still be a daunting task. Some county medical societies have asked Congress for a California GPCI fix. Other states, however, are promoting their longstanding proposal for a single national GPCI, which would be at the expense and to the detriment of California physicians.

Furthermore, raising such an issue nationally would divert attention and undermine the efforts needed to correct the SGR formula–a huge problem. If the SGR is uncorrected, CMS has predicted five percent rate reductions per year over the next seven years, resulting in an overall 35 percent rate reduction from current levels! Hence, it is critical that the California GPCI problem does not trigger dissension within the house of medicine or dilute efforts in the MFS fight, for it would surely sabotage any hope of success.

The following recommendations were adopted by the House of Delegates:

- Make the highest federal legislative priority to revise the Medicare SGR formula in order to prevent Medicare payment reductions;
- Sponsor legislation to change the Medicare budget neutrality requirements to apply to a state rather than to a geographic payment locality and then develop a solution to the Medicare geographic locality payment disparities;
- Continue to advocate for a long-term solution to the California Medicare payment locality issues, particularly to minimize the impact on counties remaining in Locality 99; and

- Work to change the Medicare GPCI data sources and methodology to achieve a more equitable GPCI formula.

Silent PPOs

"Silent PPOs" (Silent Preferred Provider Organizations) result when contracting agents, such as health plans, insurers, and PPOs, **sell or rent** their directly contracted physician networks to third parties, giving the third party the advantage of the discounted reimbursement a managed care organization has negotiated with the physician. Bills are being unfairly discounted even though the physicians believe that they never agreed to such discounts. Many physicians *unknowingly* authorized a PPO, IPA, health plan or other managed care organization to enter into future discount agreements with other PPOs or payers on their behalf.

The CMA On-Call Document "Silent PPO Action Guide" discusses this issue in detail. In response to the problem of "Silent PPOs," the HOD voted to:

- Oppose the practice of third-party payers utilizing a physician's discounted rate without that physician's knowledge and consent;

- Consider litigation to seek redress for egregious business practices, including unfair discounting, engaged in by health plans, PPOs and other organizations;

- Take all appropriate steps, including legal and legislative action, to ensure that a physician's contract with a PPO (or any other entity that contracts on the physician's behalf) has safeguards to protect against unfair discounting practices, and that all contracts, including existing contracts, not containing these safeguards be declared null and void;

- Such safeguards should include: there shall be a direct contract between the physician and the PPO that proposes to sell or lease the physician's name and contracted rate to any payer; any payer seeking eligibility to claim a discounted rate must be disclosed to in a clear and separate section and affirmatively agreed to by the signature of the physician prior to any payer's use of that rate; the physician has the right to decline the sale or lease of his/her name to any payer for any reason and will be free to allow or decline such sale, lease or transfer without penalty, sanction, or retaliation; no claim shall be discounted after termination of the underlying contract; and contracts will have a maximum duration of 24 months; and

- Investigate the amount of fees and resulting profits made from the lease or sale of physician names and contracted rates and take all appropriate steps to ensure that any such fees do not reduce or limit access to care.

To further document the pervasiveness and unfairness of "Silent PPOs," all CSA members are asked to notify the CSA and/or the CMA of any "Silent PPO" activity they have encountered.

Tax Credits for Services to Medi-Cal Patients

A resolution directing the CMA to sponsor legislation that will provide state income tax credits for services rendered to patients on Medi-Cal, determining the value of that service by applying the federal RBRVS CPT codes and conversion factors for that calendar year, was referred for further study.

Medi-Cal Payment for Labor Epidurals

The CMA specifically reaffirmed a policy established in 1995, stating that the CMA support and endorse the CSA's ongoing efforts in working with the Department of Health Services to establish appropriate Medi-Cal CPT coding and appropriate reimbursement for labor epidurals for pain relief.

Health Insurance

The CMA will support legislation that grants Californians with Health Savings Accounts the same state tax preferences (e.g., tax credits, deductions) as the federal tax code.

Further policy was established that all Americans should be required to have, at a minimum, catastrophic and preventive health care coverage and that refundable tax credits be available for those whose income is up to 400 percent of the federal poverty level and who are ineligible for Medicaid or the State Children's Health Insurance Program. (See article by Kenneth Pauker, M.D., on page 39.)

Within California, all health care insurers should be required to offer at least one product that is a standardized catastrophic and preventive health care policy and whose features (e.g., deductibles, copayments, coinsurance, providers' reimbursement rates) are clearly defined and understandable.

Workers Compensation

The crisis with workers' compensation reform remained a high priority at CMA. CSA members continued to point out how the adoption of a Medicare rate-based fee schedule would be detrimental to anesthesiologists. The CMA voted to oppose all efforts to coerce physicians to accept fees lower than the Workers' Compensation Official Medical Fee Schedule (OMFS) as a condition of participation in a Workers' Compensation Medical Provider Network. CMA will consider intro-

ducing legislation intended to restore the OMFS as the minimum standard fee schedule for Workers' Compensation.

Preservation of the Medical Board Diversion Program

(Resolution introduced by CSA member Mark Singleton, M.D.)

In response to an independent auditor's recommendation to abolish the Diversion Program (DP) of the Medical Board of California (MBC), the CMA endorsed (and committed to preserve) the Diversion Program as both vital in the rehabilitation of impaired physicians and successful in protecting the public.

CMA will work to ensure the future viability of the program and the establishment of a model of appropriate medical decisions regarding physician participants, by promoting a collaborative relationship between the DP and physician specialists in addiction medicine willing to provide medical evaluation and ongoing medical supervision to DP participants. CMA will continue to work with representatives of the California Society of Addiction Medicine, the Society of Addiction Psychiatry, the California Psychiatric Association, as well as the DP of the MBC, to realize these goals.

Physician-Assisted Suicide

The House of Delegates was asked to consider supporting AB 1622, "Death with Dignity," which would permit physician-assisted suicide in California (similar to legislation in effect in Oregon). Unequivocably, the House reaffirmed its existing policy in opposition to physician-assisted suicide, stating that physicians are healers, not killers.

Officers and Elections

Robert Hertzka, M.D., an anesthesiologist from San Diego, completed his term as CMA President, Michael Sexton, M.D., an emergency medicine physician from Santa Rosa, was installed as CMA President, and Anmol Mahal, M.D., was elected to be the CMA President-Elect.

Within the Specialty Delegation, leadership remained unchanged, with Catherine Moore, M.D., (Psychiatry) and Romie Holland, M.D., (Family Medicine) serving on the Board of Trustees; Ruth Haskins, M.D., (OB-GYN) and Don Prolo, M.D., (Neurosurgery) re-elected as Delegation Chair and Vice-Chair; and CSA member Michele Raney, M.D., re-elected as one of the Members-at-Large on the Delegation Executive Committee.

The House of Delegates ratified the CMA committee appointments which included several CSA members:

CMA Specialty Delegation–Cont'd

Stephen Jackson, M.D.	Council on Ethical Affairs
Rebecca Patchin, M.D.	Council on Legislation
Virgil Airola, M.D.	Committee on Medical Services
Edgar Canada, M.D.	Committee on Quality Care
Linda Hertzberg, M.D. and Lee Snook, M.D.	Committee on the Well Being of Physicians
Lee Snook, M.D., and Tom Specht, M.D.	Subcommittee on Physicians' Confidential Line
Robert Hertzka, M.D. and Lee Snook, M.D.	Committee on the Medical Board of California
Patricia Dailey, M.D., James Futrell, M.D., and Lorna Yamaguchi, M.D.	Committee on Professional Liability

Speaking for myself, it was a pleasure and privilege to participate in the Specialty Delegation and in the CMA House as a representative for the CSA and to chair a reference committee. My CSA delegation colleagues–and other CSA members representing different constituencies–are highly regarded within the CMA and extremely effective in shaping appropriate CMA policy.