

California and National News



Medical Staff Vigilance the Only Way to Preserve Self-Governance:

CMA reminds physicians that it is important to pay attention to any proposed changes to their hospital medical staff bylaws. Physicians should never blindly accept changes, especially those sought by hospital administrators or hospital attorneys, without first considering the impact on the medical staff's self-governance rights.

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CMA provides a bylaws analysis service for member and nonmember medical staffs. Using this service, a medical staff recently learned that changes proposed to its bylaws would have undermined the protections of the new medical staff self-governance law (SB 1325), which took effect January 1. This CMA-sponsored law strengthens the self-governance rights of hospital medical staffs and helps to ensure patient care remains the top priority in all medical decisions.

Physicians should be aware that some bylaw changes that originate outside the medical staff may be intended to undermine the law. For instance, CMA has seen samples of proposed bylaw changes that would allow the hospital administration to make the "ultimate decision" in conflicts between the medical staff and the hospital when the dispute cannot be resolved in a joint conference committee. Had this bylaw change been approved, the medical staff might have lost its right to argue its case in court.

In other instances, nonprofit hospitals are putting seemingly innocuous language in medical staff bylaws that says while hospital medical staffs can have their own medical staff dues account, these funds must not be used in a way that would "jeopardize the nonprofit tax-exempt status of the hospital." If the bylaws do not also define what is meant by "jeopardize," the hospital would in essence have carte blanche to control how the medical staff uses its dues. Contact: Robin Flagg, (415) 882-5110 or rflagg@cmanet.org. (From *CMA Alert*, July 14, 2005.)

CMS Panel Agrees with CMA, Abandons Proposal to Require Mandatory ER Call as a Medicare Condition of Participation:

CMA testified at the March meeting of the Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group, urging the group to abandon a proposal that would require physicians to take emergency room call as a condition of participation in Medicare. In a big win for physicians, the group agreed with CMA and will not recommend mandatory call for Medicare physicians. The EMTALA Technical Advisory Group was commissioned by Congress as part of the Medicare Modernization Act to review and provide recommendations on the EMTALA regulations.

John Hill, M.D., chair of CMA's organized medical staff section, testified on behalf of CMA that a variety of "well-delineated issues" have affected physicians' willingness to provide emergency room call. "At the top of the list is the payment problem," said Dr. Hill. "In the past, we were paid fairly for the work that we had done, and we were able to continue to cover our office overhead when our nights and our regular appointment schedules were disrupted by having to attend to emergencies. This is no longer the case. Unfortunately, our overhead has continued to spiral and our reimbursement has continued to decrease to the point where these lines are almost ready to cross." Contact: Robin Flagg, (415) 882-5110 or rflagg@cmanet.org. (From *CMA Alert*, June 30, 2005.)

Physicians and Groups with "Individually Negotiated" Wellpoint Contracts Will Automatically Benefit from Prospective Relief: CMA and more than a dozen other state medical associations agreed in July to a settlement with Anthem/Wellpoint (Blue Cross of California), one of five remaining health plan defendants in CMA's class-action RICO (Racketeer Influenced and Corrupt Organization Act) lawsuit. The agreement mandates dramatic changes in Anthem/Wellpoint's heavy-handed business practices, which will result in prospective relief worth more than \$250 million to physicians and their patients.

The original settlement agreement contained language that would have prevented physicians with "individually negotiated" contracts from benefiting from the settlement's prospective relief, unless they send a letter to Wellpoint asking that their contracts be amended to include the court-ordered reforms. Wellpoint has agreed to update the settlement language so that physicians and physician groups with non-standard contracts will automatically benefit from the settlement provisions, assuming the provisions are better than what they already have in their contracts.

The settlement also provides \$135 million in cash payments to physicians. Even if you did not treat Anthem/Wellpoint patients, you are still likely eligible for a pro rata share of the \$135 million settlement fund. To be eligible, you need only have provided "covered" services to any patients covered by any of the defendants in this case—CIGNA, Aetna, Anthem, Coventry, Health Net, Humana, PacifiCare, Prudential, United Healthcare, and Wellpoint.

Physicians who did treat Anthem/Wellpoint patients will be paid based on the total volume of Anthem/Wellpoint claims they submitted during a three-year period. Physicians with less than \$5,000 in Anthem/Wellpoint claims will receive one share; those with \$5,000 to \$49,999 will receive five shares; and those with \$50,000 or greater will receive 10 shares. The dollar amount of each share will be determined once all proof-of-claims have been submitted. Because Anthem/Wellpoint covers more than 6 million patients in California, many California physicians are expected to receive substantial settlement payments.

Physicians should have recently received information on the claim submission process from the settlement administrator. Physicians have until November 17 (90 days from the date the settlement notices were mailed) to claim their share of the \$135 million cash settlement. Contact: CMA's legal information line, (415) 882-5144 or legalinfo@cmanet.org. (From *CMA Alert*, September 8, 2005.)

CMA Physicians Mount Grassroots Effort to Halt 26 Percent Medicare Cut:

House Ways and Means Health Subcommittee members "vowed" not to allow Medicare payments to physicians to be reduced by 4.3 percent in January, but it is uncertain how they will accomplish the reversal. If Congress doesn't act now to fix the Medicare payment formula, payment rates to physicians will begin to nosedive 4 percent to 5 percent a year in January 2006, plummeting 26 percent to 30 percent in real dollars by 2012. Physician practice costs are expected during that same time period to rise 15 percent, according to MedPAC, the independent commission established by Congress to advise on Medicare payment issues.

The physician payment cuts are an unintended consequence of a Medicare formula created by Congress that was supposed to establish a "sustainable growth rate" (SGR) for spending on physician services. The formula allows Medicare spending on physician services to grow at the rate of the gross domestic product (GDP), but it actually penalizes physicians because the cost of physician services rises more rapidly than the GDP.

Some lawmakers have proposed addressing the problem by altering the existing formula to include a pay-for-performance component, in which doctors would receive financial incentives for improving quality.

CMS Administrator Mark McClellan said the current physician-payment system is not sustainable and expressed support for a so-called Pay for Performance (P4P) system. However, health subcommittee Chair Nancy Johnson (R-Conn.) said that combining a P4P system with the SGR funding formula would not "protect doctors against major payment cuts." Johnson has proposed repealing the SGR formula and instead increasing Medicare physician payments each year based on changes in the Medicare Economic Index (MEI), which tracks changes in the costs of physician care.

Johnson and House Ways and Means Committee Chair Bill Thomas (R-Calif.) said McClellan should act administratively to remove the cost of physician-administered drugs from the formula used to calculate physician payments, which they said would help address the payment issue. McClellan said it is not clear that he has the authority to make such a change. However, he "did not rule out the possibility" that Medicare attorneys might ultimately remove drugs from all calculations.

Responding to Johnson's call for an MEI-based formula, McClellan noted that the 10-year cost of switching from the SGR formula to an MEI-based formula would be \$183 billion over 10 years, up from a previous estimate of \$163 billion.

John Armstrong, a spokesperson for the AMA, testified that “physicians cannot absorb these draconian payment cuts, and unless Congress acts, physicians may be forced to avoid, discontinue or limit the provision of services to Medicare patients.”

Underscoring its efforts in Congress, AMA “launched a barnstorming tour across Iowa”—home state of Senate Finance Committee Chair Chuck Grassley (R), who has endorsed efforts to reverse the cuts—to protest the planned payment reductions. AMA trustee William Hazel said, “Physicians want to serve senior patients, but they cannot accept an unlimited number of new Medicare patients into their practice if Medicare payments do not keep up with the cost of providing care.” AMA cited an internal survey showing that 38 percent of AMA members said they would stop taking new Medicare patients if the first of the six scheduled cuts goes into effect in January.

CMA in May surveyed California physicians and found that 60 percent of physicians will no longer accept new Medicare patients, and 40 percent would be forced to stop treating Medicare patients completely, if Congress fails to replace the Medicare SGR formula. Though the question was not asked in the survey, 10 percent of the 490 physicians responding to the survey wrote in that they would quit practicing medicine altogether, citing rising costs and decreasing Medicare reimbursements. Another third said they would be forced to reduce the time spent with Medicare patients.

The House and Senate are considering separate bills—both called the Preserving Patient Access to Physicians Act of 2005—that would provide a physician payment increase for 2006 of at least 2.7 percent, as recommended by MedPAC. The Senate bill (S 1081) would also provide an estimated 2.6 percent increase in 2007. The House bill (HR 2356) would provide a permanent fix to the Medicare payment formula, calculating physician rates in 2007 and beyond with a new formula based on the MEI. (From *Congressional Quarterly Health Beat*, July 21, 2005; *Congress Daily*, July 22, 2005; *CMA Alert*, August 18, 2005.)

More Physicians Choosing “Lifestyle Friendly” Specialties: An increasing number of graduating medical students are choosing “lifestyle friendly” specialties that allow them to have more control over their work hours (e.g., radiology) and eschewing “uncontrollable” specialties (e.g., general surgery), according to a study published in the September issue of *Academic Medicine*.

The study found that interest in specialties with “uncontrollable” lifestyles—including primary care, general surgery, and surgical subspecialties with high on-call demands such as neurosurgery—has declined significantly among both men and women. The number of men choosing controllable specialties increased from 28 percent to 45 percent between 1996 and 2003. Thirty-six percent of women chose controllable specialties in 2003, compared to 18 percent in 1996.

The most significant decline was in family practice, which saw a 54 percent decline, dropping from 18.2 percent in 1996 to 8.4 percent in 2004. Other specialties with

significant declines were obstetrics-gynecology (down 26 percent), internal medicine (down 18 percent), and pediatrics (down 15.5 percent). Contact: Patty Frisk, (916) 444-5532 or pfrisk@cmanet.org. (From *CMA Alert*, September 1, 2005.)

CMA Defeats Depression CME, Adverse Drug Reporting Mandates: A grassroots campaign by CMA physicians and lobbyists led to the defeat of two CMA-opposed bills, one that would have created a new CME mandate and another that would have required physicians to report all adverse drug events to the FDA.

In response to CMA's calls to action, physicians throughout California contacted their legislators and asked them to vote against both of these bills. A big thank you to all CMA physicians who contacted their legislators on these bills.

The CME bill (SB 524) would have required all physicians who treat patients for depression to complete mandatory CME on the subject. CMA opposes all mandatory CME. While CMA does not question the importance of properly diagnosing and treating depression, we believe strongly that CME requirements must remain flexible.

The other defeated bill (SB 380) would have required physicians to report all adverse drug events to the FDA's MedWatch. Physicians already *voluntarily* report adverse events. CMA told legislators that the cause of adverse events is not always apparent, and this bill would force doctors to make a report regardless of the degree of certainty on the cause of the adverse event. This would lead to incorrect data that will not help us better understand and treat our patients.

Although both bills have been granted reconsideration by the Assembly, it is unlikely that they will move again this year. Contact: Dave Ford, (916) 444-5532 or dford@cmanet.org. (From *CMA Alert*, September 1, 2005.)

Medi-Cal Provider Reimbursement Cuts: In 2003, CMA successfully obtained a court injunction to block a cut in Medi-Cal reimbursement rates. Unfortunately, on August 2, 2005, the Appeals Court overturned this ruling. This ruling opens the door for the Administration to reduce Medi-Cal reimbursement rates by 5 percent, even though the State Budget has already been approved. CMA is sponsoring AB 1735 (De La Torre and Aghazarian), which would block implementation of Medi-Cal provider reimbursement cuts retroactively or in the current year. The current State Budget does not include the rate reduction. The Legislature passed, and the Governor signed, the State Budget for this year without the Medi-Cal provider cuts included. There is no fiscal reason to reduce rates. AB 1735 also will protect access to care for Medi-Cal recipients because low reimbursement rates force providers out of the Medi-Cal program. Currently, more than 60 percent of Medi-Cal recipients report difficulty finding a physician willing to see them. Any provider reimbursement cut will only exacerbate this problem. Lack of access to basic care forces Medi-Cal recipients into emergency room care. Although only 15 percent of the population are Medi-Cal recipients, they comprise 27 percent of emergency room visits, a number that would rise as more primary care physicians leave the Medi-Cal program.

Indeed, the CMA recently reached a firm agreement with the Schwarzenegger administration not to cut Medi-Cal physician reimbursement rates this year, despite the court ruling that would have allowed those cuts. The Governor also agreed to work with CMA to avoid Medi-Cal rate cuts in future years. “We are extraordinarily pleased that Governor Schwarzenegger has agreed to protect health care for the most vulnerable Californians,” says CMA President Michael Sexton, M.D. “Medi-Cal rates are already low and further cuts would have devastated this program, which provides care to the neediest.”

As stated above, in 2003, CMA won a federal court injunction blocking the 5 percent Medi-Cal rate cut that was passed as part of the 2003-04 budget. Unfortunately, that injunction was overturned in August when a panel of the U.S. 9th Circuit Court of Appeals in San Francisco found that “neither Medicaid recipients nor providers have a private right to challenge California’s compliance with Medicaid.”

The court ruling, which CMA is appealing, opened the door for the administration to cut Medi-Cal reimbursement rates by 5 percent. The CMA-sponsored bill (AB 1735) received wide bipartisan support in both houses of the legislature, and Governor Schwarzenegger told CMA officials that he will support the bill.

California already ranks near the bottom of all states when it comes to physician reimbursement. Physicians are paid \$22.80 for the average patient visit. Inadequate reimbursement has already forced many physicians out of the Medi-Cal program, and additional cuts would worsen the problem. Patients unable to find care when they are ill will be forced into emergency rooms, where the cost of care—and eventual cost to the state—is multiplied three or four times. Contact: David Ford at (866) 462-2819 or dford@cmanet.org. (From *CMA Government Relations Legislative Alert*, September 3, 2005, and *CMA Alert*, September 8, 2005.)

HHS Scheduling Physician Volunteers for Short-Term and Long-Term Gulf Coast Assignments through December: Many physicians have contacted CMA to find out how they can assist in Hurricane Katrina relief work. CMA has formed a task force that is in direct touch with the five Gulf Coast state medical societies to learn how physician volunteers can best help alleviate the suffering caused by Katrina. Currently, licensed physicians who can commit to short-term, long-term, or rotating coverage are urgently needed in Louisiana, Mississippi, Alabama, Florida, and Texas.

The best way to volunteer is through the U.S. Dept. of Health and Human Services (HHS), which is managing a national medical relief effort. Physicians can volunteer at the HHS Health Care Professionals and Relief Personnel Volunteer page at <https://volunteer.ccrf.hhs.gov> or call its hotline at (866) 528-6334. HHS is currently scheduling physician volunteers for short-term and long-term assignments through December via its web site and hotline.

Relief workers will be nonpaid temporary federal employees and will therefore be eligible as HHS employees for Workman's Compensation and also for liability coverage under the Federal Tort Claims Act. Although there will not be any salary, travel and per diem will be paid. Assignments may last 14 days or longer. All physician volunteers must bring their medical license, valid photo ID, DEA license, and prescription pads. Contact: CMA Communication Center, (916) 551-2072 or ntatlonghari@cmanet.org. (From *CMA Alert*, September 8, 2005.)

California Postpones Medi-Cal Managed Care Plan: Due in large part to CMA advocacy and the negative reaction by physicians statewide, the Schwarzenegger administration this week postponed its plan to force more than 500,000 elderly, blind and disabled Medi-Cal patients into managed care programs. The administration conceded that the plan wasn't ready for implementation and that more time is needed to determine the plan's impact on this fragile patient population.

The administration this summer reached a five-year agreement with the federal government that would provide up to \$18.4 billion in federal matching funds for California hospitals during the next five years. However, more than \$300 million will be available only if the state moves forward with the governor's plan to force more than 500,000 elderly, blind and disabled Medi-Cal patients into managed care programs. By postponing the shift, the state may forfeit up to \$90 million of that new money.

CMA policy opposes mandatory enrollment in managed care for elderly, blind and disabled Medi-Cal patients, a population for which continuity of care is vital. Physicians are concerned that the governor's managed-care plan would disrupt long-standing physician-patient relationships, further restrict patient access to specialists, and place unsustainable financial burdens on physicians who provide care to these vulnerable patients.

"Physicians must be intimately involved in the development of any plan to expand Medi-Cal managed care," says CMA CEO Jack Lewin, M.D. CMA is pleased that the governor has recognized that forcing an ill-conceived plan on patients and physicians could disrupt care to thousands of elderly and disabled Californians. CMA will work closely with the governor to ensure any future plan protects patients and physicians. Contact: Lisa Folberg, (916) 444-5532 or lfolberg@cmanet.org or Robin Flagg, (415) 882-5110 or rflagg@cmanet.org. (From *CMA Alert*, September 8, 2005.)