

On Your Behalf ...

Legislative and Practice Affairs Division

The ASA in Action

*By Linda J. Mason, M.D., ASA Director
for California*

The ASA Annual Board of Directors Meeting was held at the Westin O'Hare in Chicago, Illinois, August 22-23, 2009. The CSA members attending this meeting included Linda B. Hertzberg, President; Kenneth Pauker, Chair, LPAD; Mark Singleton, Alternate Director; Narendra Trivedi, President-Elect; and Christine Doyle, Assistant Secretary.



The CSA submitted a resolution—Disposition of Resolutions Approved by the ASA House of Delegates: Accessibility to Membership. This resolution proposed that all future resolutions (and those dating back ten years) adopted by the ASA House of Delegates be categorized and made easily retrievable on the Web site. This resolution was disapproved by the Board of Directors Review Committee. As Director, I spoke against the disapproval and asked that it be reconsidered, and it was referred to a Committee of the President's choice.

A resolution for the ASA to designate \$10,000 for 2010 for an approved educational experience for anesthesiology residents in governmental affairs and legislative advocacy in the ASA Washington office was approved. This was introduced by the Texas Society of Anesthesiologists.

The Committee on Performance and Outcome Measurements has proposed a number of quality measures that could be submitted to the National Quality Forum (NQF) for endorsement and also to the Centers for Medicare and Medicaid for adoption as part of the Physician Quality Reporting Initiative (PQRI). New proposals pertain to multimodal therapy for the prophylaxis of postoperative nausea and vomiting, treatment of postoperative hypothermia, and intraoperative antibiotic redosing. Other measures that are currently in development involve muscle relaxant reversal, cardiac stents and aspirin, cardiopulmonary bypass time-out, MRI procedures, transfer of care and transesophageal echocardiography.

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The Committee on Standards and Practice Parameters is currently developing or revising three practice parameters: Practice Guidelines for Chronic Pain Management, Practice Guidelines for Transesophageal Echocardiography, and Practice Advisory for Prevention, Diagnosis and Management of Infectious Complications Associated with Neuraxial Techniques. The revised transesophageal echocardiography guidelines are posted on the ASA Web Site for comments. The ASA statement on TEE will be revised to cover additional scenarios, including those for congenital heart disease. A new task force for guidelines on central venous catheter insertion has been appointed.

There was considerable discussion about the proposal to establish a registration fee for ASA members for the ASA annual meeting beginning in 2010. This would have to be submitted to the 2009 House of Delegates for approval prior to distribution to the membership.

There were new recommendations on guidelines for directors of liver transplant anesthesia programs. The director should have fellowship training in critical care medicine, cardiac anesthesiology and/or pediatric anesthesiology that includes perioperative care of at least 10 live liver transplants, or, within the last five years, experience in perioperative care of 20 liver transplant recipients in the operating room or the intensive care unit.

The afternoon session started with a candidate's forum in which there are three contested elections for ASA officers. Presentations were given by all candidates:

- 1st Vice-President: Dr. Jerry Cohen, Director for Florida, and Dr. Chuck Otto, current Vice President for Scientific Affairs.
- Vice-President for Scientific Affairs: Dr. Arnold Berry, the Alternate Director from Georgia, and Dr. Jeffrey Gross, Alternate Director from Connecticut.
- Assistant Secretary: Dr. Gerald Maccioli, Director from North Carolina, and me.

There was an educational session on health care reform in the United States led by our own Dr. Rebecca Patchin, Chairman of the AMA Board of Trustees. She specifically discussed H.R. 3200 and the AMA support of this House resolution. She stated that the AMA guidelines for health care reform are pluralism, freedom of choice, freedom of practice, and universal access for patients. Other issues of import to the AMA is to include tort reform and repeal of the sustainable growth rate (SGR) formula for Medicare, which if not repealed in the beginning of 2010, will result in a 20 percent decrease in physician payments. Dr. Patchin explained what has transpired in Washington with the AMA's negotiating for medicine and what kind of health care reform may occur. It is unlikely that a public plan based on Medicare rates will go forward; however, she noted that

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the current Medicare rate for anesthesiologists is only 32 percent of private insurance, and this would not be acceptable in any health care reform. She stated that there is a long way to go and that we must work together with the AMA to get the best possible plan for the physicians and patients in this country.

A survey that was sent out to ASA members had a 12 percent response rate. The two things that the members want the most from their ASA membership are clinical information and professional advocacy. The overall feeling about the ASA is positive; yet if members do not feel good about their component society, then they will be less supportive of the ASA.

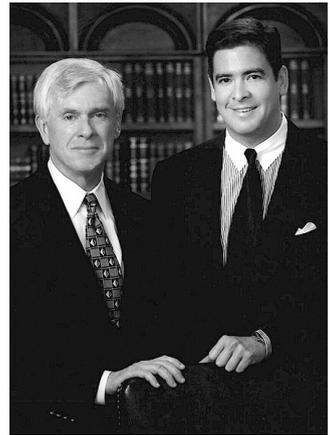
The final session of the day was given by Mr. Ron Szabat, who further defined what is happening with health care reform and how important advocacy is. We must make contact with our congressional representatives to share our views on health care reform and what is important for us as physician anesthesiologists and for our patients.

Legislative Update

*By William E. Barnaby, Esq., Legislative Counsel,
and William E. Barnaby III, Esq., Legislative
Advocate*

CRNA Opt-Out

Overshadowing all developments affecting CSA this year was the sudden and surprising action of Governor Schwarzenegger in signing a letter to the U.S. Centers for Medicare and Medicaid Services (CMS) opting California out of the Medicare rule requiring physician supervision of Certified Registered Nurse Anesthetists (CRNAs). The circumstances surrounding the Governor's letter remain murky. His office insists it was **not** done at the request or behest of any interest group or individual and was based totally on their "internal research." To date, there has been no rationale, explanation or description of why this was done or its intended purpose. Discussions with the Governor's legal staff indicated that they will produce a formal response, but none has arrived. It has been signaled there will be no voluntary reversal or withdrawal of the opt-out at this point in time.



The opt-out was contrary to the advice of the Medical Board of California. From the moment its existence was discovered, it has been strongly contested by CSA and the CMA. The first condition of the federal opt-out rule is that it must be “consistent with state law.” The California Nursing Practice Act limits registered nurses, including CRNAs, to administering “medications when ordered by, and within the scope of practice of, physicians, dentists and podiatrists.” The same law makes it unprofessional conduct for a nurse to administer dangerous drugs or controlled substances “except as directed by a physician or a dentist.” The matter may have to be resolved in court.

Despite the Governor’s “dedication to transparency,” proclaimed on his office’s Web site, silence has enveloped this issue. Nothing substantive has been forthcoming from policy and political advisors of the Governor who normally are open with us. Discussions also have taken place with officials of the MBC and the Board of Registered Nursing. In conjunction with CMA General Counsel Francisco Silva and his associate, Astrid Meghrijian, formal Public Records Act demands are being served to obtain as much information as possible from relevant agencies, a form of discovery that could focus pursuing legal action that has been approved by the CSA Board of Directors.

Overview of the 2009 Legislative Session

State budget deficits have dominated California legislative attention. A budget solution was enacted in February to “fix” the \$42 billion deficit through June 2010. It fell apart within a few weeks. Tax receipts continued to plunge while, on May 19, state voters rejected five ballot propositions that were key parts of the February “fix.” Despite an array of difficult program cuts, fee increases and temporary hikes in sales and top income tax brackets, another \$26 billion deficit faced lawmakers. Just two years ago, state general fund revenues exceeded \$100 billion. By 2009, it was \$85 billion with some experts looking at yearly tax collections skidding to \$68 billion. Ouch!

With the State’s credit at an all-time low and its treasury out of cash, it was forced to issue IOUs to pay \$2 billion of its bills. Medi-Cal providers were paid with regular checks, however, due to a federal regulation. A 2009-10 budget revision finally passed on July 24. Even with more painful program cuts, state worker furloughs, tax accelerations, questionable projections of federal funding, and a host of other gimmicks, some observers don’t expect this plan to last the year. One assumed “savings” is the \$1 billion sale price of the State Compensation Insurance Fund’s book of business. No takers have yet surfaced.

Legislative Organization

Budget battles produced casualties among Republican legislative leaders and complicated an already disjointed process. Senator Dave Cogdill of Modesto fell victim to a coup after accepting income and sales tax increases during “Big 5” negotiations with Democrats and Governor Schwarzenegger. His successor, Dennis Hollingsworth of Murietta, is an anti-tax hardliner. In the Assembly, personally popular GOP Leader Mike Villines campaigned for the five compromise budget-related propositions that were decisively defeated. He voluntarily stepped down and was replaced by Sam Blakeslee of San Luis Obispo.

Legislation of Interest

A summary of some of the top issues of CSA interest follows. A more complete listing of bills of our involvement on behalf of CSA can be accessed in the members-only section of the CSA Web Site (www.csaqh.org)

Peer Review

As the session began, considerable pressure existed for major changes in the way peer review is conducted by hospital medical staffs. In 2008, the MBC published a “Comprehensive Study of Peer Review in California” by Lumetra, a healthcare consulting service headquartered in San Francisco. The Lumetra Report strongly criticized existing peer review efforts for resulting in too few hospital reports of physician discipline as required by Business and Professions Code 805. Conflicts of interest and difficulty in faulting staff colleagues were reasons cited for recommending that peer review henceforth be conducted by “independent” organizations outside the institution being reviewed.

The Senate Business, Professions and Economic Development Committee held a hearing on peer review where the report was presented, praised and probed. Praise came from consumer advocates and health planners who feel peer review is failing to effectively detect and correct substandard care and practitioners. Other testimony found evaluating peer review on the number of 805 reports to the MBC to be overly simplistic. Physician and hospital witnesses noted the existing challenge to recruiting staff physicians to volunteer for peer review activities, and they questioned the practical logistics of how peer review teams would be formed and financed. Examples were cited of peer review being used unfairly to limit business competition among practitioners and the need to monitor objectivity and enforce due process protections. A disciplinary 805 report to the MBC must also be reported to the National Practitioner Data Bank. Only some minor changes acceptable to medicine were enacted on peer review.

The Corporate Bar

California is one of three states that, by statute, bar the corporate practice of medicine. The practical effect is to prohibit the direct employment of physicians by hospitals and other health facilities. Exemptions are allowed for county hospitals, teaching institutions and, subject to the approval of the MBC, certain foundations or charitable facilities where there is no charge for professional services rendered to patients. The purpose of the corporate bar is to ensure physician independence in treating patient needs free of administrative interference. In recent years, however, a number of public and private studies have called the bar into question in light of other regulatory mechanisms and the changing needs for recruiting physicians to rural and underserved areas. Hospital trade associations long have sought the ability to directly employ physicians to replace existing independent contractor relationships. Organized labor has joined the effort. The Union of American Physicians and Dentists (UAPD) has long been in this camp, but a stronger push has been mounted of late by the American Federation of State, County and Municipal Employees. All three bills proposing changes to the corporate bar were blocked and can be taken up next year.

Physician Wellness

Assembly Bill 526 (Fuentes) is the CMA proposed “wellness” program for physicians having substance abuse or mental health problems. It is similar to AB 214 of 2008 which was vetoed. An increase in physician license fees would cover the cost of the program. The bill has been put over until 2010.

Chiropractic Manipulation Under Anesthesia (MUA)

The Board of Chiropractic Examiners continues to press ahead with a regulation to authorize MUA. The latest push began in January. After a public hearing on February 24, at which past CSA President Mark Singleton, M.D., testified, the proposal has been readjusted twice. Written comments on the third modification were due September 14. A similar effort was rejected by the Office of Administrative Law (OAL) in 2005. After receiving the written comments, the OAL will have 30 working days to reach a decision. Besides CSA, opposed are the CMA and the Osteopathic Physicians and Surgeons of California. The Chiropractic Initiative Act of 1922 defines the scope of practice and expressly prohibits the use of drugs. In stating its objections, CSA has emphasized the integral role of anesthetics in producing the physiological changes that enable the manipulation to have the intended therapeutic effect. Regulations may not go beyond underlying statutory authority. Here, the underlying statute specifically bars the “use” of drugs.