California and National News

Don't Procrastinate: CIGNA Claim Period [under RICO lawsuit] Closes Feb. 18: Physicians should begin—if they haven't done so already—carefully considering their options under the CIGNA settlement. The claim period closes February 18.

Members should have recently received their free copy of CMA's RICO Recovery Guide CD-Rom. This step-by-step tool will help physicians maximize their financial recovery under the CIGNA settlement. The guide also helps physicians understand their rights under the CIGNA and AETNA settlements, both of which require the plans to make significant changes in the way they work with physicians. If you did not receive a copy, please contact CMA's legal information line at (415) 882-5144 or legalinfo@cmanet.org for assistance.

CMA's legal department has also published a three-page guide to help physicians and medical group administrators navigate the claim filing process.

CMA encourages physicians to get started now. As previously reported in *CMA Alert*, CMA has an arrangement with Managed Care Advisory Group (MCAG) to provide claims analysis and filing assistance to CMA members. MCAG, which provides its service to CMA members at a significant discount, maximizes recovery by using computer analysis to identify all eligible claims and streamlines the claims submission process for physicians. Contact: CMA's legal information line, (415) 882-5144 or legalinfo@cmanet.org. (From *CMA Alert*, December 9, 2004.)

Florida Votes for Three-Strikes Malpractice Law: Florida voters approved a "three-strikes" law for physicians. This constitutional amendment would automatically revoke the medical license of any physician who suffers three malpractice judgments against them. The law was backed by the trial lawyers. Legal experts say the law will prompt a flood of malpractice suits. Physicians say it will drive them out of Florida while forcing others to reach quick settlement to avoid a "strike." Florida already ranks among the most costly malpractice insurance rates in the nation. A physicians' ballot measure also passed and limited the percent of malpractice awards that an attorney would receive. It was hoped that this law would make the trial lawyers more

selective in taking cases. It is possible, however, that the lawyers trumped the physicians, because lawyers will rush to sue in hopes that physicians will settle to avoid a "strike." It has been predicted that the "3-strikes" law will result in every physician in Florida being sued within a few years. This law has been placed on hold by a judge who said that the Legislature needs to spell out just how it will work. It is probable that none of these actions will protect patients from the few bad physicians in the state. (From *The New York Times*, November 24, 2004.)

Hospitals Make Fewer Errors, but Fall Short on Safety Goals: In 1999, the Institute of Medicine issued a controversial report that estimated that as many as 98,000 people die from medical errors each year, 7,000 from medication errors. This lead to two safety surveys that are reported below.

American hospitals are improving at prevention of patients from receiving the wrong operation or the incorrect drug. However, there remains plenty of room for improvement in other safety programs such as informing patients about risks of procedures, ensuring adequate nursing care, and preventing complications such as bedsores. Yet, many hospitals have not developed a new "culture of safety," perhaps because of financial constraints or lack of will to do such. Nor have there been any financial punitive measures levied at hospitals for mistakes.

The Leapfrog Group, a coalition of large employers aiming to contain healthcare costs by decreasing errors, produced its first Hospital Quality and Safety Survey, and noted that only one-fifth of hospitals are fully compliant with 27 safety practices developed by the non-profit National Quality Forum that, in turn, was formed to develop a national strategy for healthcare quality measurement and reporting.

The nonprofit Institute for Safe Medication Practices (ISMP) reported that since 2000, there was a 20 percent increase in hospital implementation of its safe practice recommendations. These included minimizing problems related to drug names that look or sound alike. ISMP did find a 43 percent increase in the use of nonpunitive, system approaches to error prevention, including programs to encourage hospital employee [to report] errors and "near misses" without fear of reprisal. The ISMP warned, however, that the government has yet to develop new standards for design and labeling to prevent errors.

Nor has any patient-safety legislation advanced in Congress. (Excerpted from an article by Laura Landro in the *Wall Street Journal*, November 17, 2004.)

Racial and Ethnic Disparities among Physicians and Nurses: Physicians and nurses don't resemble the diverse populations they serve, according to the Sullivan's Commission on Diversity in the Health Professions, "Missing Persons: Minorities in the Health Professions." The report even asserts that a lack of diversity may be a greater cause of health disparities than is lack of health insurance for minorities. Though African Americans, Hispanics and American Indians as a group constitute nearly 25 percent of the population, they account for less than nine percent of nurses, six percent of physicians and five percent of dentists. Recommendations to correct the disparity include shifting from student loans to scholarships, reducing dependency on standardized tests for admission to medical school, and enhancing the role of two-year colleges. The Association of American Medical Colleges responded that because of the relatively small number of academically well-prepared minority students who apply to medical schools, there should be more attention paid to developing an interest in science among minority students from an early age. (Excerpted from *FOCUS*, Fall 2004, Harvard Medical School Office of Public Affairs.)

High Economic Costs of Medical Education Result in Major Debt: A report from Harvard Medical School, a private institution, reports that the average cost for the 165 entering freshman students for 2004-2005 will be $53,900, including tuition and fees of $37,400. In order to address this burden, Harvard grants an average yearly scholarship of $20,742, and provides an annual unit loan of $24,000 per year. Seventy-one percent of medical students receive financial aid. The average loan debt on graduation for the class of 2004 will be $95,648, the range being $14,500-$242,648! (Data from "Basic Facts for 2004-2005," Harvard Medical School.)

CMA Rebuts Health Plan Allegations of Unfair Physician Billing Practices: At a recent meeting of the Department of Managed Health Care's (DMHC) Financial Solvency Standards Board, CMA urged the department to reject health plan complaints of "unfair" physician billing practices and see them for what they are–a calculated effort to divert attention from the health plans' fraudulent payment practices. According to health plan testimony, their primary complaint is that physicians are not complying with plans' coding methodologies. But CMA pointed out that most plans use nonstandard coding

methodologies, which often have no clinical justification and are never fully disclosed to physicians. Until health plans comply with California's unfair payment practices regulations–which require that health plan payment rules follow AMA's CPT guidelines and that plans fully disclose their rules and fee schedules to contracting physicians– there is no way to determine the extent of the "unfair billing" problem or if there even is a problem, CMA said.

"Absolutely no concrete evidence was presented to the Financial Solvency Standards Board detailing the number and types of claims that payers consider to be "unfair." All that was provided were generalized and potentially hypothetical examples of what payers subjectively deemed to be 'unfair,'" wrote CMA Legal Counsel Astrid Meghrigian in an October 15 follow-up letter to DMHC.

The evidence of health plans' underhanded payment practices, however, is so overwhelming that CMA in 2000 filed a class action RICO lawsuit against some of the nation's largest for-profit health plans. CMA's RICO suit has already resulted in multimillion-dollar settlements with Aetna and CIGNA, two of the HMO defendants. Both Aetna and CIGNA have agreed to make significant changes to the way they do business with physicians. But the class-action case against five of the health plans is still in court and many of the plans continue to regularly and sometimes intentionally underpay physician claims. Contact: Astrid Meghrigian, (916) 444-5532 or ameghrigian@cmanet.org. (From *CMA Alert*, November 11, 2004.)

CMA Applauds Garamendi's Action on Anthem/Wellpoint Merger: State Insurance Commissioner John Garamendi on Tuesday dropped his opposition to the Anthem/Wellpoint merger, but only after reaching a deal with the plans that will assure that California health care consumers will benefit from the transaction. CMA applauds state Commissioner Garamendi for his work on the merger.

"When other states rolled over in the face of this merger, Garamendi acted responsibly," said CMA CEO Jack Lewin, M.D.

CMA in July called upon state regulators to approve the merger only if patients are guaranteed substantial protections. Such protections, CMA said, should include a requirement that the new merged company spend at least 85 cents of every premium dollar on patient care. Wellpoint currently spends

less than 79 cents of every premium dollar on patient care, with the rest going to administration, marketing, and profits. In contrast, Kaiser Foundation Health Plan spends 98.3 percent of every dollar on patient care.

Commissioner Garamendi agreed with CMA that the new plan must devote more premium dollars to patient care. To ensure this happens, Garamendi has created a "medical care ratio" that he will use to audit the new health plan.

"I want California premium dollars to be spent for medical services, early detection and prevention of diseases, outreach, and health education, not for unreasonable executive compensation, wasteful overhead, corporate jets and payment for mergers," said Commissioner Garamendi. "My department will monitor this ratio every six months to assure that Anthem/WellPoint maintains their commitment to improve this ratio and thereby ensure that a larger percentage of premium dollars will be spent on treatment and quality assurance investments."

Commissioner Garamendi is also requiring that the new health plan spend several hundred million dollars to provide health care for underserved Californians, protect the health of California children, and increase nurse training. (From *CMA Alert*, November 11, 2004.)

Rural Physicians to Receive Five Percent Medicare Bonus: To address a shortage of physicians in medically underserved rural communities, the Medicare program will pay physicians a five percent bonus for treating Medicare patients in "physician scarcity areas" (PSAs). These new bonuses take effect January 1 and were approved as part of the 2003 Medicare Modernization Act. The payments are in addition to the existing 10 percent bonus payments for physicians in "health professional shortage areas" (HPSAs).

Congress created the bonuses in the hope that they would both attract new physicians to these areas and encourage those already there not to leave. PSAs are rural areas with physician-to-beneficiary ratios in the bottom 20 percent. There are separate PSAs for primary care and specialty care. Medicare will automatically pay five percent bonuses on a quarterly basis to both primary care and specialty physicians practicing in designated PSAs. Only professional services are eligible for an incentive bonus. Physicians serving

HPSAs will receive 10 percent bonuses. Physicians in communities that are both PSAs and HPSAs will receive 15 percent.

Most physicians will not need to use special modifiers on their Medicare claims to receive either bonus. Physicians practicing in zip codes that do not fall entirely within an officially designated shortage or scarcity area may need to use a claim modifier to ensure that they receive their bonus payments.

CMA will continue to work with Centers for Medicare & Medicaid Services to qualify as many California areas as possible for these increased payments. Contact: Elizabeth McNeil, (415) 882-3376 or ecmneil@cmanet.org. (From *CMA Alert*, November 18, 2004.)

CMA Comments on DMHC's Access-to-Care Regulations: CMA recently submitted comments on access-to-care regulations proposed by the Department of Managed Health Care (DMHC). Although the purpose of these regulations is to ensure that health plan enrollees have timely access to primary care physicians, specialty physicians, and other medically necessary and potentially lifesaving health care services, CMA is concerned that the regulations will limit rather than improve patient access.

CMA pointed out that the problem is not that there are too few physicians in California, but rather that a growing number of physicians are leaving managed care. "Unfortunately, the proposed regulations fail to address the larger systemic issues," said CMA Legal Counsel Astrid Meghrigian. "This will likely result in more physicians leaving managed care, making the physician supply problem worse."

CMA believes that the best way to ensure adequate access is to enforce existing state law (Health & Safety Code Section 1367), which requires among other things that physician contracts be fair and reasonable. CMA also urged the department to assess the access-to-care problem by reviewing health plan contracts for compliance with existing law; determining whether there are enough physicians in health plans' networks; and conducting relevant and meaningful patient satisfaction surveys. Contact: Astrid Meghrigian, (916) 444-5532 or ameghrigian@cmanet.org. (From *CMA Alert*, November 18, 2004.)