



California Society of
ANESTHESIOLOGISTS
Physicians for Vital Times

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Mary Watanabe
Deputy Director, Health Policy and Stakeholder Relations
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

RE: AB 72 Implementation

Dear Deputy Director Watanabe,

The California Society of Anesthesiologists (CSA) appreciates the opportunity to continue an iterative process on the implementation of AB 72 (Bonta) with the Department of Managed Health Care (DMHC). CSA represents more than 3,000 physician anesthesiologists who believe that patients should not be in the middle of balance billing situations when physicians are unable to come to contract terms with health care service plans and any entity to which a plan delegates responsibility for payment of claims (hereafter collectively “plans”). We aim to provide the best care and coverage for our patients and appreciate DMHC’s concern that anesthesia services are available and accessible and that AB 72 does not jeopardize our ability to come to fair contract terms with our plan partners.

CSA believes the most critical aspects of ensuring the success of AB 72 include:

- What factors should be included in the final Average Contracted Rate methodology;
- Ensuring plans correctly report the Anesthesia Conversion Factor for all contracts and that the Anesthesia Conversion Factor is accurately calculated into the Average Contracted Rate.

Constructing a Fair Average Contracted Rate (ACR)

We greatly appreciate the opportunity to meet with DMHC representatives on September 8, which we feel was a constructive and thoughtful conversation on how to best continue implementing AB 72. We also applaud DMHC’s public stakeholder presentation on September 12, which provides the definitions and calculations for setting the Average Contracted Rate (ACR).

The ACR methodology DMHC is contemplating is of key concern to CSA, as our members will almost all certainly receive the ACR as opposed the 125% of Medicare. As DMHC has become well aware, anesthesia services are billed differently from other specialties. Additionally, Medicare rates tend to be reimbursed at approximately one-third of the commercial rate. As such, 125% of Medicare will virtually always be the lower rate. In order to maintain robust, adequate anesthesia networks, the default anesthesia rate must not be able to be construed in a way that favor plans, but rather encourages contracting in a fair and meaningful way. We agree with the California Medical Association and support DMHC’s ACR methodology that takes into account the volume of

claims paid at a specific contracted rate – this is the only accurate way to assess market-based payments. We would also concur with the CMA that DMHC’s ACR calculation should include the total number of all paid services or procedures. Claims are sometimes made in the aggregate and include multiple services or procedures. If we are truly attempting to gauge payments for accurate payments, this is a distinction that should be made.

Ensuring Fair Payments Prior to 2019

In Health & Safety Code 1371.31 (a) (1), AB 72 states that “effective July 1, 2017, the plan shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis”. In terms of developing and knowing what the ACR will be, this process favors a health plan. The plans’ obligation to pay the average contracted rate started July 1, 2017, the Independent Dispute Resolution Process (IDRP) started September 1, 2017, and the ACR methodology developed in the regulatory process may not become effective until January 1, 2019. It is possible that in the 18-month gap, initial payments could be significantly lower than the true ACR. Physicians and physician groups are not in possession of any of the financial data that would allow them to know what the ACR is, but plans are. A plan that pays 125 percent of Medicare reasonably believing the ACR is three times this amount which is ultimately confirmed through the IDRP months or years later should be penalized.

Blended Contracts

Blended contracts, which many of our members have with their plan partners, should not be included in the ACR calculation. Section 1371.31 (a) of AB 72 specifically states that the ACR means the average of the contracted commercial rates paid by the health plan. Many of our members use blended contracts (a mix of commercial and government payors) as a means to ensure they are serving the greatest number of patients. California is amongst the lowest rates paid for physician services under Medicaid nationally – being able to blend Medi-Cal patients into larger contracts allows our members to treat all members of their communities. However, these rates are not strictly commercial, and as such, not in the spirit of AB 72. We urge DMHC to discard blended contracts in the ACR methodology.

Construction of the ACR for Anesthesia and the Anesthesia Conversion Factor (ACF)

We appreciate the time and effort spent by DMHC to understand the ACF and how to use it correctly in calculating the ACR. As CSA has discussed with DMHC, virtually all anesthesia services are paid under a formula that includes a base unit, a time unit, a physical status modifier for the patient, and an anesthesia conversion factor (“ACF”) expressed in “dollars per unit”. It is calculated thusly:

- (Base units+ Time units+ Physical status modifier) x ACF = Reimbursement rate

The Base, Time, and Physical status modifiers are all standard measures. The Base unit is a measurement published by the American Society of Anesthesiologists (ASA) annually and corresponds to the complexity and intensity of the anesthesia service. Time is measured in 15-minute increments. The Physical status modifier describes the physical status of the patient and is used to distinguish between various levels of complexity of the anesthesia service provided. DMHC should require plans in their methodology for anesthesia services to use the ACF when determining contracted commercial rates for the ACR calculation. A conversion factor is commonly used in contracts for surgical and evaluation and management services, but the three

component Base units + Time units + Physical status modifier formula is unique to anesthesia services.

On Slide 22 of the September 12 presentation, DMHC states that the ACF will be used in place of the allowed amount to calculate the ACR. We request DMHC provide the calculation template for review to ensure this is an accurate incorporation. Should this not reflect the precise manner in which to incorporate the ACF, we would appreciate the opportunity to continue working with DMHC to correct this.

AB 72: A Rough Start

To reiterate, almost immediately following passage of AB 72, CSA started to hear from anesthesia groups in different parts of the state that some plans were using AB 72 as a reason for refusing to renegotiate contracts. In fact, the bill seemed to provide the plans with cover to relieve them of any need to negotiate in good faith with physicians. This was CSA's chief concern as the bill moved through the Legislature and has been born out in reality, even prior to the effective date of any of the provisions of the legislation. Just these cases provide CSA with great concern that the trend will continue, and we ask DMHC to implement this bill in a way that increases access to care and maintains robust provider networks.

Thank you for considering our points. If you have questions or require additional information, please contact either one of our CSA Legislative Advocates, Bryce Docherty at bdocherty@ka-pow.com or Vanessa Cajina at vcajina@ka-pow.com or (916) 448-2162.

Sincerely,



Jeff Poage, MD
Chair, Legislative and Practice Affairs Division
California Society of Anesthesiologists

cc: Diana Dooley, Secretary, Health and Human Services Agency
The Honorable Jim Wood, Chair, Assembly Health Committee
The Honorable Ed Hernández, Chair, Senate Health Committee
Donna Campbell, Officer of Governor Edmund G. Brown Jr.