



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 engage in 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 and other providers 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 remain concerned that the construction of AB 72 will put physicians in a situation where it will become more difficult to negotiate fair contracts with plans. Hence, we take the implementation of this legislation very seriously. As such, our comments are focused on the development of fair interim payments that will not artificially diminish provider networks, which plans are required to maintain at a statutorily adequate level.

Uncertainty Abounds

With current federal debates as to the future of the Affordable Care Act (ACA), we are concerned that additional disruptions in the state markets could have negative impacts on patients’ access to their provider of choice. The implementation of the ACA in California ensured all Californians would be able to access affordable coverage with certainty in the benefits package. The unintended consequence, however, was that of plans increasing the use of narrow networks. As we implement the laudable goals of AB 72, we believe that the rulemaking processes in regards to the Average Contracted Rate (ACR) and the Independent Dispute Resolution Process (IDRP) should always hold the concept on network adequacy at the forefront.

AB 72: A Rough Start

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.

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

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:

- $(\text{Base units} + \text{Time units} + \text{Physical status modifier}) \times \text{ACF} = \text{Reimbursement rate}$

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.

In regards to the initial July 1 filing, we appreciate that DMHC has pointed out the unique components of reimbursing for anesthesia and that a consideration of the "Anesthesia Conversion Factor" (ACF) is explicitly required in DMHC's ACR Methodology Checklist and Instructions (Attachment 3 in the filing packet) on question 15. The ACF is present in virtually every contract for anesthesia services and should plans report that they did not consider an ACF, that would be highly unusual and should be cause for further questions. In addition to requesting plans to explain the ACF calculation, DMHC should ask if the plan did NOT consider the ACF, WHY they did not do so, and a description of what method they do use to determine payment for anesthesia services.

Additionally, CSA concurs with the California Medical Association (CMA) in regards to claims volume and the need to calculate based on full and final contracted rates (not disputed payments) to ensure fairness and accuracy.

Development of the Independent Dispute Resolution Process

We concur with CMA that DMHC should employ a "baseball style" arbitration process, though the Department has indicated it will be using "true arbitration". Baseball style is already used in the existing IDR and requires the arbitrator to consider all information

relevant to the dispute and then to choose from the two final offers. As a function of having both parties bring a settlement concept at the beginning, by default this format forces the parties to introduce reasonable figures for settlement. New York has had success with this style and we ask the Department to reconsider. We also maintain that the cost of the arbitration should be paid by the losing party, as there is no incentive for either party to resolve the dispute by negotiating a payment that reflects the market.

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,

A handwritten signature in cursive script that reads "Jeff A. Poage, MD". The signature is written in black ink and is positioned above the typed name.

Jeff Poage, MD
Chair, Legislative and Practice Affairs Division

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.