



Board Highlights

CMA Board of Trustees, Friday- Saturday, January 29-30, 2010

Important Note: The Board Highlights are designed to offer a brief summary of major action and informational items discussed by the CMA Board of Trustees at its January 29-30, 2010 meetings; the Board Highlights are not intended to be all inclusive of items discussed. This document is NOT official CMA policy.

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<http://www.cmanet.org/member/upload/policycompendiuminstructions.pdf>.

I. Dustin Corcoran Named CMA CEO

The CMA Board of Trustees appointed Acting CEO, Dustin Corcoran, as the new chief executive officer of CMA.

Prior to becoming Acting CEO, Mr. Corcoran was responsible for the day-to-day operations of CMA including CMA's legislative and political affairs as Deputy CEO. He is well known in the Sacramento political arena.

Mr. Corcoran previously served as Senior Vice President/Vice-President of Government Relations. He joined CMA in 1998 as the membership coordinator for CALPAC. When an opportunity arose to work as a lobbyist under the late Steve Thompson, he jumped at the chance. Over the next seven years, Thompson mentored Corcoran where he was responsible for bills primarily related to access to care, emergency medicine, hospitals, tobacco usage, public health and health care system reform.

Mr. Corcoran was named the most effective lobbyist under 40 in 2005 and in 2009 was named one of the top 100 political power brokers in California.

In addition to his work at CMA, Mr. Corcoran sits on the Board of Directors for the Neuropathy Action Foundation. He, his wife Glenda and their daughter Dylan, live in Sacramento. Glenda, a member of the California State Bar, works for California State Assembly Member Hector De La Torre (D-southeast Los Angeles County) as his policy director.

II. Executive Committee

A. Physician Quality Report (aka California Physician Performance Initiative (CPPI))

Summary of Issue

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In November 2009, the CMA Executive Committee (EC) discussed CPPI in light of Blue Shield's plans to publish the 2009 CPPI results notwithstanding significant concerns raised by the physician community. The EC directed CMA to research answers to the following questions:

- (1) What are other alternatives to physician ratings based on claims data and public reporting of physician performance (generally known as CPPI)?
- (2) What are CMA policies related to this issue?
- (3) Do we need an internal CMA committee to develop policies related to these issues?

Below is a discussion of alternatives to CPPI, relevant CMA policies, formation of the CMA Quality Technical Advisory Committee, and recommendations moving forward.

Background on Physician Rating, Concerns, and State Medical Society Efforts

There has been strong support for physician rating and public reporting of physician performance at the state and federal level for some time now. In 2007, Governor Schwarzenegger's health care reform proposal included creating a public reporting program for physicians, hospitals, and payors that would have required a fee from each group to fund the program. It is also important to note that the Office of Patient Advocate's (OPA) website provides public rating of health plans, hospitals, and medical groups already. At the federal level, the Center for Medicaid and Medicare Services (CMS) was an initial supporter of the CPPI. Furthermore, the level of interest in physician rating and public reporting of physician performance extends beyond the state and federal government. For example, in 2009 the University of California's Center for Health Care Policy and Research released a study¹ suggesting that many stakeholders in California believe that reporting at the individual physician level was crucial to consumers in choosing physicians.

The national trend is to rate physician performance at the individual level using claims data and publicly report physician results. Some version of the CPPI exists in states including Colorado, Maryland, Massachusetts, Texas, and Washington. There are generally two ways to measure physicians: quality measurements and/or utilization of services (cost). ***Here, CPPI has focused primarily on physician quality measurements for now.*** The purported rationale for physician rating based on claims data and public reporting of physician performance can be summed up as follows: (a) reporting of physician results helps gauge the level of care provided to patients; (b) consumers need a more systematic way to choose physicians rather than relying on word of mouth or random websites that allow consumers to randomly rate physicians (e.g., Yelp); (c) purchasers need information on the value of services received

¹ University of California at Davis' Quality Performance Measurement in California (2008)

by their employees, with the goal of curbing rising health care costs²; and (d) insurers prefer claims data because they are accessible and inexpensive to process.

Physician ratings based on claims data and public reporting of physician performance has raised significant concerns because of inaccurate data. Recently, the Center for Studying Health Systems Change questioned methodological shortcomings associated with physician performance measurement such as complete reliance on claims data, inadequate sample patient size attributed to physicians, non-standardized set of measures used by insurers to assess physician performance, and lack of insurer support to improve physician performance³. Also, prior to joining United Health Care, Dr. Robert Greene suggested that physician ratings are generally ineffective because they are judgmental, motivate through blame and fear, and engender adversarial relationships rather than effectively engage practitioners in change⁴.

State medical societies have generally approached physician ratings based on claims data and public reporting by pursuing safeguards to protect physicians via legal and/or legislative routes. For instance, the Massachusetts Medical Society (MMS) sued insurers for measuring physicians based on compliance rate with a set of clinical guidelines. Similarly, the Washington State Medical Association⁵ (WSMA) sued Blue Cross for using claims data, small samplings, and inaccurate records. It should be noted that WSMA's allegations mirror some of CMA's CPPI findings (e.g., the physician failed to provide screening for cervical cancer on patients who had already undergone a hysterectomy). Other states like Texas and Maryland advanced legislation that generally allowed physicians to have appeal rights when rated by insurers. According to the Texas Medical Association, legislators were particularly sympathetic to the message that "physicians should have the right to tell their side of the rating," which prompted them to push for appeal rights⁶. Also, the Colorado Medical Society successfully sponsored legislation that included appeal rights for physicians plus a private right of action.

CMA Policy

² Pacific Business Group on Health's Presentation, "Transparency & Health Care Reform- Private and Public Paths to Improvement (2008), and CPPI Goals.

³ Physician Performance Measurement: "A key to higher quality and lower cost growth or a lost opportunity." (2009)

⁴ Health Affairs: "Beyond the Efficiency Index: Finding a Better Way to Reduce Overuse and Increase Efficiency in Physician Care." (May 2008)

⁵ MMS and WSMA raised similar causes of action: defamation, interference with advantageous relations, and breach of covenant of good faith and fair dealing, and procedural due process.

⁶ CMA successfully advocated for a reconsideration process (appeal) as part of the CPPI, but many physicians found the 10 to 12 hours of scrubbing insurer claims data too burdensome.

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Historically, CMA has attempted to establish itself as a recognized authority and resource for information on quality issues based on the rationale that “if [CMA] does not act quickly and assertively define quality, the [HMOs] will continue to assert their financial power and influence to drive health care for their benefit...” Thus, in 1999, CMA Committee on Workers’ Compensation recommended and the Board of Trustees (BOT) adopted the following policy: That CMA move forward with a data collection/outcomes project that electronically links employers and CMA physicians, so that treatment methods and outcomes in workers’ compensation can be studied and best approaches determined. This project is dependent upon employers, large medical groups and other outside sources funding the project. (BOT 5-14-99:2) Based on existing CMA records, it appears that this project stalled due to insufficient funding.

As to the specific issue of physician rating based on claims data and public reporting, there is no policy on point but there are a number of related policies. CMA is generally supportive of the Coronary Artery Bypass Graft (CABG) program that uses hospital clinical data, produces outcomes report, and rates hospitals and cardiac surgeons publicly (CMA supported CABG’s enabling legislation SB 680 (2001)). It is also CMA policy to build on CABG instead of creating new programs allowing the state to collect data, and that CMA advocate for the CABG technical advisory committee and clinical panel structure as they provide a number of safeguards for physicians. (BOT 7-18-08:6) It should be noted, however, that CABG’s use of “worse” and “better” ratings have raised concerns from the Alameda Contra Costa Medical Association in 2008.

There is no policy on point about use of claims versus medical data in quality measures. One of the arguments against CPPI is that medical or clinical data should be used in measuring the quality of care provided to patients by physicians. A component of that principle includes collection (submission) of medical or clinical data to third parties. CMA is generally supportive of collection and use of aggregated medical information provided certain principles apply: 1) requiring entities who collect these data to establish physician oversight advisory body to review the use of information and interpretation methods; 2) imposing confidentiality protections for physicians and patients; 3) providing physician access to aggregated information; and 4) and allowing physicians to contest results and conclusions drawn from the aggregation of medical information. (HOD 704a-03) However, recent CMA policy opposes legislative proposals requiring physicians to pay for submission of their health care data to the state. (BOT 7-18-08:6)

In 2008, CMA Committee on Medical Services recommended a robust policy on economic profiling—any physician evaluation (rating) based on economic costs or utilization of services. It should be noted that quality rating of physicians can be paired with economic profiling, and thus some of CMA economic profiling policies may be applicable. For example, CMA economic profiling policies call for involvement of actively practicing physicians in the development of any profiling policy, use of valid, accurate, and objective data, and physician opportunity to make a timely appeal of any designation. (D-3-08)

CPPI and Alternative Quality Initiatives Analysis

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CPPI is an ongoing project with work for the 2010 quality ratings set to commence in February 2010. Based on CMA's conversations with the Pacific Business Group on Health (PBGH) and Blue Shield, they are willing to make minor adjustments to the CPPI such as removing the colonoscopy measure and re-opening the physician reconsideration process. It appears, however, that reliance on claims data will continue because insurers are unwilling to review medical data themselves, and it is cost efficient for insurers to have physicians pull their own chart to correct the claims data. Below is a discussion of different alternatives to physician rating based on claims data, and public reporting of physician performance.

Alternative A: Coronary Artery Bypass Graft Outcomes Program (CABG): As discussed above, the Office of Statewide Health Planning Department (OSHPD) publishes risk adjusted outcomes reports on CABG surgeries performed in hospitals by individual cardiac surgeons. CABG uses clinical data, allows physicians to review the report prior to publication, and uses a clinical panel (comprised of mostly physicians) that approves risk-adjustment models used to prepare the outcomes report and reviews physician appeals. CABG is a process that has been around for nearly 10 years and is the largest public reporting program in the nation. Expanding CABG to other surgical or non-surgical procedures is feasible because OSHPD already has the statutory authority to do this. However, CABG does publicly rate individual surgeons using "worse" or "better" standards, and expanding CABG could be burdensome to physicians because it can lead to more clinical data collection. Also, some consumer groups are critical of CABG because they deem it as industry driven and a slow process.

Alternative B: Joint Registry Programs: The Joint Registry Program (JRP) is a new partnership among the California Health Care Foundation (CHCF), the California Orthopedic Association and PBGH to establish a registry program (data bank) for joint replacement surgeries. It will attempt to collect clinical data from surgeons who are willing to voluntarily submit their data on patient pre-operative characteristics, post surgical complications, and patient-reported outcomes to evaluate the long-term effectiveness of joint replacements. CHCF believes that sharing of the registry data could help physicians improve care and reduce expensive joint replacements. It does plan to publicly report physician performance, but it is unclear in what manner at this point.

Alternative C: Colorado Collaborative Quality Improvement Project (CCQIP): CCQIP is a partnership among the Colorado Medical Society (CMS), the American Medical Association (AMA), and United Health Care. CCQIP will use United claims data to help understand which medical conditions and interventions show the most significant variation from recommended clinical guidance and that also show variations in the cost of care. The CMS, AMA, and United physician experts will then identify best-practices for the treatment of those conditions based on measures created by the AMA Physician Consortium for Performance Improvement. The third prong will be to share the best practices with physicians to help them improve their practice. CMS, AMA, and United believe this is a "win win" approach because while it uses claims data it does not judge or rate physicians. Also, it aims to address care and cost variation rather than random measurement of physicians based on certain measures.

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Consequently, the Board approved formation of a Quality TAC (QTAC) whose charge will be to restart efforts to establish CMA as a recognized authority and resource for information on quality issues in California.

As discussed above, there is CMA policy precedence for CMA to lead quality initiatives in California (e.g., CMA partnering up with employers to study treatment and outcomes in Workers' Compensation in 1999). Indeed, CMA's Committee on Workers' Compensation's 1999 prediction—that if CMA does not act quickly and assertively define quality, HMOs will drive health care for their benefit—is today referred to as CPPI. A component of the QTAC's mission is to find quality initiatives that will have the support of physicians, patients, and payors, or stated differently, to move quality initiatives from the zero-sum game approach implemented today by many insurers (e.g., CPPI). This mission will include QTAC's development of guiding principles on physician quality ratings and alternative quality initiatives on the following areas of concern⁷:

- Use of claims data in physician ratings, aggregation of data among payors for statistical validity, transparency and access to data, time-frame of data used, and accuracy and reliability of claims data;
- Physician involvement in the process, appeals in quality ratings, insurer pre-scrubbing of claims data, physician payment for reviewing claims data, and collection of physician clinical data;
- Attribution of patients to physicians in HMO and PPO setting, and patient non-compliance to a physician recommended procedure;
- Physician ratings by practice or group versus individual ratings, public reporting of physician performance, physician incentives and recourse in public reporting, use of clinical quality measures (e.g., colonoscopy screening) versus outcome measures; and
- Coronary Artery Bypass Graft Outcomes Program, Joint Registry Programs, and the Colorado Collaborative Quality Improvement Project.

Once formed, the QTAC can quickly engage the CPPI to identify common goals between physicians, insurers and payors. This process will include meeting with PBGH and insurers (e.g., Blue Shield), AMA, and other relevant entities that may be able to help bridge the gap between physicians and insurers. After these meetings, the QTAC will provide its findings and recommendations to the Board of Trustees. It should be noted that this is contingent upon Blue Shield allowing sufficient time for this process to take place before it publishes the 2009 CPPI results.

The QTAC will also consider referred HOD Resolution 410-09, Pay for Performance for Patients.

⁷ Staff notes that this is only a partial list of the areas of concern; there may be many other issues that may need to be considered moving forward.

B. Resolution 401-09: Payment for Emergency Care Services

Resolution 401-09 states:

PAYMENT FOR EMERGENCY CARE SERVICES

RESOLVED: That CMA pursue enactment of legislation to require health plans, and not their subcontracted IPAs and medical groups, to pay the claims of emergency physicians and emergency department on-call specialists for EMTALA-obligated medical screening and stabilizing emergency care; and be it further

RESOLVED: That this legislation require health plans to develop emergency care risk pools or similar arrangements to provide incentives to their sub-contracted medical groups and IPA to maintain the health of chronically ill enrollees, and offer expanded access to unscheduled care appointments, so as to reduce the need for these enrollees to use emergency department services.

Action: Referred for decision

Priority: 2.0

Background and Analysis

Generally, health plans are allowed to delegate their responsibility to risk bearing organizations (RBOs) (e.g., medical groups). RBOs are then charged with the responsibility of providing health care services to patients and contracting with individual physicians. Resolution 401-09 proposes to change the delegated model by allowing emergency physicians and on-call specialists to contract directly with health plans for emergency care services (de-delegation).

CMA policy states “that insurance companies and licensed health care service plans directly reimburse [emergency services] except for Kaiser and other IPAs or medical groups that have appropriately contracted for these services, [and that] health plans may not delegate responsibility for payment for emergency and back up physicians.” (BOT Min 1-19-01:15b) However, there is no policy on point about requiring health plans to develop emergency care risk pools or similar arrangements to maintain the health of chronically ill enrollees.

The Resolution’s author claims that RBOs have consistently underpaid emergency physicians and on-call specialists for emergency care. RBOs receive a smaller portion of the premium dollar from health plans, and thus, they have a greater financial incentive to underpay for emergency care. The author further

contends that RBOs can easily monopolize local markets forcing physicians to accept low market pay, and that they offer convoluted contracts contributing to unpaid claims. Also, according to the author, there is no real recourse for emergency physicians and on-call specialists on these issues; for example, DMHC has done very little in ensuring that physicians are paid fairly and reasonably based on the number of unanswered complaints submitted to the department by emergency physicians. At the judicial level, the courts have sided with health plans and RBOs when it prohibited balance billing in 2009. In sum, the author believes that direct contracting with health plans for emergency services will yield to better rates for emergency physicians and on-call specialists.

Conversely, RBOs argue that emergency physicians prefer “excessive billed charges” rather than negotiate a reasonable contract rate. Also, RBOs point to prompt pay rules and unfair payment patterns under Health & Safety Code § 1371.37 for emergency physician recourse on payment issues. RBOs further argue that emergency physicians can sue health plans or its delegate for billing disputes. (e.g., *Bell v. Blue Cross* (2005) 131 Cal.App.4th 121) RBOs have also argued that the 2009 DMHC initiative to ensure claim payments for non-contracted emergency services should be given an opportunity to work. Under the initiative, the department intends to audit, investigate, or pursue enforcement actions on any health plans and RBOs that have substantially lowered their payment methodologies and have repeated complaints filed against them after the California Supreme Court ruling on balance billing.

HOD Reference Committee D recognized that both sides have compelling arguments on whether emergency health care services should be de-delegated. At one point, members of the committee were inclined to adopt a substitute resolution that would have supported the recent DMHC initiative. However, based on testimony from emergency physicians, members of the committee concluded that the DMHC initiative was insufficient given its lackluster track record on these issues. On its face, many members of the committee interpreted 401-09 as a mandate for CMA to carry legislation in 2010 to address the de-delegation issue. A CMA staff lobbyist advised committee members and the author that such legislation would likely be vetoed by Governor Schwarzenegger in 2010. Subsequently, members of the committee decided to refer 401-09 to the BOT for a decision.

Consequently, the Board approved convening a workgroup of interested parties to address the issues contained in Resolution 401-09 and develop potential solutions within the House of Medicine, with a report back at the April 2010 Board of Trustees meeting.

If a convening of interested parties has not occurred by the April 2010 Board of Trustees meeting, the Board Chair will appoint a TAC to address the issues contained in Resolution 401-09.

C. CMA Strategic Planning

One of the primary goals CMA asked the new CEO to develop is an overall organizational strategy for CMA. As a result, an RFP was sent out in early December 2009 to strategic consultants. In the RFP, it was noted that the Association has a set of “core issues” that are not supported by an operational plan at the staff level designed to make progress in achieving these goals. Furthermore, there is no statement of vision or an overall strategic plan for the organization with realistic and achievable goals

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and objectives, nor are there detailed operational plans to guide the work of the staff. It also appears that budgeting is based on programs and projects developed independently by different operating "Centers" within the Association.

The Association is fundamentally reactive to external events and to initiatives developed within its own operating centers. The governing body wants a more proactive, centralized and integrated strategy that will address agreed-upon common goals, thereby making the Association more effective in bringing value to members, and thus providing further incentive for non-members to join.

In seeking a successful consultant, that individual will provide advice, counsel, technical assistance and administrative support to assist CMA in:

- Defining the problem(s)
- Identifying strategies and goals necessary to address the problem(s)
- Articulating the vision and strategies to achieve the goals
- Selling and implementing the plan

The successful consultant will need to be:

1. a great facilitator;
2. a good listener;
3. experienced with a proven track record of success; and,
4. a sage counselor

The successful consultant also needs to develop a process that creates deep buy-in, Association-wide.

As a result of CMA's RFP, a team consisting of Alfred Gilchrist, Dustin Corcoran, Rachel Smith, Ginnie Yee and Medical Executive Tom Gehring, interviewed six strategic consultants and identified two finalists to be vetted with the CMA Vice-Presidents. After both candidates met again with the CEO and Vice-Presidents the Executive Committee received a unanimous recommendation to work with Michael Ward as the consultant for this effort.

Consequently, the Board unanimously approved engaging Michael Ward as CMA's strategic consultant to assist in the development of an overall CMA organizational strategy.

D. Letter to President Obama and Members of the California Congressional Delegation

CMA remains strongly committed to achieving comprehensive, meaningful health care reform that provides universal access to care for the 6.7 million uninsured Californians. CMA seeks federal legislation that builds on what works and fixes what is broken.

Consequently, the Board approved sending a letter to President Obama and Members of the California Congressional Delegation urging our federal leaders to continue to work to provide universal access to care for the millions of uninsured and underinsured Californians this year. The letter encourages the enactment of federal health reform legislation that is consistent with the following principles:

- Universal access to physicians
- Affordable insurance for low-income individuals and families
- Respect for the physician-patient relationship
- Insurance industry reforms that protect patients
- Increased health plan competition and choice for patients
- Sufficient resources to deliver on the promise of improved access to health care

III. Resolution 217-09: EMS (Maddy) Fund Accountability

Background

Resolution 217-09 states:

Resolution 217-09

EMS (MADDY) FUND ACCOUNTABILITY

RESOLVED: That CMA support the implementation of a standard accounting for dollars collected under applicable fines and forfeitures and deposited into the Emergency Medical Services Funds across all participating counties, and work with the appropriate state agency and/or the Legislature to make sure that the fines and forfeitures collected are properly accounted for and allocated to the EMS Fund and disbursed appropriately.

Action: Referred for decision

Priority: 2.4

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County Maddy Funds

In 1987, the Legislature passed SB 12, which created the Emergency Medical Services (EMS) Fund, also known as the “Maddy Fund.” Under this bill, counties were given the authority to levy an additional \$1 for every \$10 of fines levied for most offenses. The monies collected from these fines are used to help reimburse physicians for the costs of providing emergency treatment to uninsured patients.

The monies in the Maddy Funds are collected and administered locally through the counties. Counties are required to report to the Assembly and Senate Health Committees every April 15th as to the amount collected in their Maddy Funds, and the amount that has been paid out to physicians.

Counties are also restricted in the uses of their Maddy Fund monies. By law, 58% of each county’s Maddy fund must be paid out to physicians, 25% to hospitals, 17% for other emergency and trauma care services, and the balance for administration.

The amount counties are allowed to collect for the fund has been increased by the Legislature twice. SB 612 of 1988 allowed counties to increase their Maddy Fund collections to \$2 for every \$10 of the base fine. SB 1773 of 2006 added an additional \$2 for every \$10, with 15% of the new money reserved for pediatric trauma services.

Counties keep funds collected pursuant to SB 12/SB 612 and SB 1773 in separate accounts. They are thus reported separately.

Resolution 217-09

The author of Resolution 217-09 is Rodney Borger, MD, an emergency physician and the president of the San Bernardino County Medical Society. Dr. Borger is also currently chair of San Bernardino County’s EMS Funds Committee. San Bernardino County is now almost three years into implementation of the additional fines allowed under SB 1773.

Given that the SB 12/SB 612 account and the SB 1773 accounts are based on the same surcharge amount (\$2 for every \$10 of the base fine), the two accounts should have the same amount in them. As the attached background shows, however, the SB 1773 account is consistently less than the SB 12/SB 612 account, and generally by a large margin.

The San Bernardino County Medical Society has been unable to obtain raw data directly from the courts about the amount of fines collected, or the number of fines imposed.

In talking with his colleagues throughout the State, Dr. Borger has discovered that similar problems appear in other counties as well. Dr. Borger authored Resolution 217-09 to engage CMA’s help on bringing some accountability to the County Maddy Funds.

CMA Actions

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Working with Legislative Staff, CMA has obtained copies of the all of the Counties' Maddy Fund Reports to the Legislature for the past year. CMA staff notes that, while the Assembly and Senate Health Committees collect this information, there appears to be no standard accounting of the funds, and no oversight thereof. Counties are not required to submit an independent audit of their funds, and many counties simply do not report.

To address the issues described above, CMA staff has been working with Dr. Borger and the California Chapter of the American College of Emergency Physicians (Cal/ACEP) to develop a concept for a bill that the two organizations could co-sponsor this legislative session.

Consequently, the Board unanimously approved CMA co-sponsoring legislation with the California Chapter of the American College of Emergency Physicians (Cal/ACEP) in the 2010 Legislative Session to:

- Enhance and standardize county reporting to the State regarding Maddy Fund balances;
- Report random audits of county Maddy Funds;
- Require a comprehensive audit of all Maddy Funds, 2005-present; and
- Institute penalties for non-compliance.