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2 Department of Managed Health Care
3 Office of Legal Services
4 980 9th Street, Suite 500
5 Sacramento, CA 95814

6 RE: Proposed Rulemaking Action Concerning Claims Settlement Practices, Control No.
7 2006-0782

8 Dear Ms. Alvarez:

9 CAL/ACEP is hereby providing testimony on your department’s proposed regulations related to
10 a revision of the standards for the reasonable value of a non-contracted emergency care
11 provider’s services. In so doing, we use terms and statements previously referenced in our
12 testimony on the your department’s proposed regulations to prohibit balance billing and
13 promulgate an independent dispute resolution process. However, CAL/ACEP rejects the
14 Department’s authority to impose these regulations, hence this testimony is provided under
15 protest.

16 The California Chapter of the American College of Emergency Physicians (CAL/ACEP)
17 appreciates the opportunity to comment on the above-referenced rulemaking file, however,
18 CAL/ACEP wants to make it clear that we reject the notion that these regulations should be
19 modified by the Department of Managed Health Care in this way. CAL/ACEP represents more
20 than 2000 emergency physicians in California. Emergency Physicians provide emergency
21 services and care to more than ten million Californians every year, and are obligated by federal
22 and state law, and by our commitment to the health of our communities, to provide these services
23 without regard to our patient’s insurance status or ability to pay. This proposed change in AB
24 1455 regulations will have a profound impact on access to emergency care services in California,
25 on the financial viability of the emergency care safety net and our professional practices; and we
26 are gravely concerned that these regulations will have a disastrous effect on an already
27 overburdened and under-funded emergency care services system in our State. For the reasons
28 described below, we urge that Department of Managed Health Care (DMHC) NOT to adopt
29 these regulations, as this change in the current regulations would have significant and adverse
30 impacts upon the health of the citizens of, and visitors to, our state. Our comments are set forth
31 below.

32 I. There is No Authority for the Regulation

33 A. There Are No Valid Reasons to Modify the Gould Criteria

34 The Department of Managed Health Care lacks authority to expand the criteria used to delineate
35 the relevant information that constitutes “reasonable” payment beyond that which the court

1 carefully circumscribed in Gould v. W.C.A.B. No information beyond that listed by the Gould
2 decision is reasonably relevant for the purposes of determining whether a non-contracted
3 physician's billed charge for emergency services is reasonable. The DMHC has already
4 recognized that the Medicare and Medi-Cal fee schedules are inappropriate guideposts to
5 challenge the reasonableness of a physician's billed charge, and the other factors that the payers
6 have proposed, such as accepted charges and average contract rates, are equally inappropriate
7 and their consideration would be even more burdensome.

8 Emergency physicians are bound by the principles of medical ethics not to charge or collect an
9 excessive fee. They set their charges accordingly to reflect the reasonable value of their services,
10 and they are entitled to be paid the amounts they have billed in the absence of a contract to
11 accept a lower rate. The Gould Standard delineates general criteria under which providers and
12 the courts can determine reasonable fees. Unfortunately, the DMHC appears to have abandoned
13 the Gould Standard, despite its adoption in 2003 after an exhaustive three-year rule-making
14 process. As acknowledged by its own Director in legislative testimony, the Department has a less
15 than stellar track record for enforcement of its own regulations. Instead, the Department has
16 chosen to respond to anecdotal RBO complaints of provider overcharges; and has failed to use
17 existing mechanisms to deal with this issue, including referral to the courts or to the California
18 Medical Board.

19 Now, the Department proposes to add the term "any other relevant documentation" as an
20 additional criterion; however, by its very nature, such a subjective rule would defeat the purpose
21 of having a standard, and leave the entire matter open to interpretation. Under such a rule, Health
22 plans and RBOs would be allowed to submit Medicare, MediCal and historic contract rates into a
23 "reasonable rate" determination. Thus, expansion of the Gould criteria would likely undermine
24 the value of these services. This will only encourage payers to continue to take advantage of the
25 EMTALA obligation of emergency care providers to provide care first, and beg for payment
26 later; and discourage them from negotiating for fair contract terms with these providers for their
27 services.

28 Physicians voluntarily participate in government sponsored programs for the elderly, poor and
29 disabled as part of their professional commitment to their communities.. In so doing, they gain
30 the benefit of prompt payment and freedom from administrative hassles, but are forced to accept
31 rates far below the reasonable value of services. These programs aren't market based, and should
32 never be included in any consideration of the reasonable value of commercial services.

33 Historic contract rates are likewise separate and distinct from the determination of reasonable
34 value for a non-contract service, since these rates are negotiated between the provider and the
35 payer as one element of a set of terms that include additional mutual benefits. Traditionally in
36 California, they do not reflect arms length bargaining but rather the take-it or leave-it proposals
37 of the oligopolistic managed care industry, or the spoils of coercive contracting effected by the
38 payer's relationships with hospitals. Further, if the DMHC prevails and Health Plans and RBOs
39 gain access to this information, physicians will be forced to disclose proprietary information and
40 spend potentially untold hours in discovery and defense of their charges. Indeed, adoption of this
41 regulation would destroy market based norms for provider charges and would only promote
42 unfair payment practices.

1 Finally, there is no need for this change and the Department has failed to show one. The DMHC
2 has already authorized, albeit illegally, the automation of discounted payments to non-contracted
3 physicians by virtue of its September 2005 compliance statement. Under these circumstances, the
4 addition here does nothing but reduce the likelihood health plans will pay non-contracted
5 physicians fairly.

6 B. There Will Be Serious Consequences to Modifying the Gould Criteria

7 The California Association of Physician Groups (CAPG), an association of RBO payers has
8 suggested that the Gould criteria should be revised to additionally consider the “prevailing
9 provider rates paid and accepted in the relevant geographic area”, or in other words, the
10 prevailing discounted rates for contracted services. California’s emergency care safety net is
11 already in crisis, with massive overcrowding, underpayment and continuing ED closures. In
12 addition, our state suffers from a serious shortage of specialists to provide ED on-call backup. If
13 the Department implements this revision, it would lead to substantially lower payments to
14 emergency providers and on call physicians. In turn, these decreased payments would inevitably
15 lead to a reduction in physician staffing in Emergency Departments (EDs), and the replacement
16 of physicians with lower cost allied health professionals; and it would decimate our existing call
17 panels. Together, these impacts would cripple the provision of emergency care, increase
18 ambulance diversion and waiting times, and cause irreparable harm to patients and to our
19 emergency care infrastructure. There is no public benefit to the citizens of California for the
20 DMHC to participate in this HMO sponsored scheme, and it would only lead to the destruction
21 of our EMS safety net, and the transfer of millions of dollars from physicians to Health Plans and
22 capitated medical groups.

23

24 II. The Alleged Justifications for these Regulations are False or Inadequate

25 A. CAL/ACEP Did NOT Request Modification of the Gould Criteria

26 DMHC staff have shared with CAL/ACEP that they have introduced this regulatory revision not
27 only because CAPG made this request, but also because they believe CAL/ACEP is also
28 requesting that the regulations be revisited. In so doing, the staff specifically cited our request to
29 include public databases in the Department’s previously published safe harbor standards
30 clarifying existing AB 1455 regulations. CAL/ACEP suggested these modifications because we
31 believe that they would help minimize disputes between payers and providers, and ultimately
32 lead to a more successful and less overburdened independent claims dispute resolution process
33 (ICDR). We did not advocate any modification to the Gould Standard, and any statements to the
34 contrary grossly misconstrue our position.

35 CAL/ACEP is extremely concerned that the proposed ICDR, scheduled for implementation in
36 October 2006, will quickly become overwhelmed with thousands of payment disputes. Our
37 suggestions for the safe harbor standard, if implemented, would reduce these by as much as 50%
38 and were offered as part of a negotiation to design a workable ICDR process. Now, the
39 Department has proposed an unworkable ICDR process and turned our good faith proposal into

1 an unconscionable attempt to destroy the existing fair payment standard for non-contract services
2 (i.e. the Gould Standard).

3 B. The DMHC Previously Rejected the Proposed Modifications of the Gould Criteria

4 In response to historic complaints of Health plan claims, the California Legislature passed
5 AB1455. This measure required the DMHC to develop and implement regulations for fast, fair,
6 cost effective billing and claims payment, and was signed into law in 2000. The DMHC finally
7 adopted these regulations in 2002, after an exhaustive review and comment period involving all
8 stakeholders. One of the most important features in dispute was the non-contract fair payment
9 standard. After an exhaustive review of legal precedent, the Department adopted the Gould
10 criteria as the established legal standard. The current proposal to subvert this standard, first with
11 attempted emergency regulations, then with the current highly politicized process, stands in stark
12 contrast to the duly constituted review and adoption of the existing standard.

13 One of the most important intentions of the legislature in enacting AB 1455 was to ensure that
14 Health Plans and RBOs would not be able to take advantage of an emergency care provider's
15 obligation under Federal (and State) EMTALA statutes to provide emergency care to all patients
16 who present to the emergency department regardless of insurance status or ability to pay, and
17 regardless of the Plan's willingness to pay the provider the reasonable value of these services. In
18 fact, AB 1455 was double joined with SB 1177, a measure sponsored by CAL/ACEP to address
19 managed care payment delays, denials and down coding. Thus, AB 1455 was meant to ensure
20 that the emergency care providers receive fair payment for their services; and, according to the
21 Department, inclusion of the Gould criteria in these regulations was "designed to reiterate current
22 California law as embodied in Gould v. Worker's Compensation Appeals Board, City of Los
23 Angeles (1992) 4 Cal. App. 4th 1059; 6 Cal. Rptr. 2d 228", which "sets forth specific criteria that
24 should be considered by a payer when determining the fair and reasonable value of the services
25 rendered by a non-contracted provider". The Department also stated, in 2002, that "the intent of
26 this regulation is to establish a methodology for determining the reasonable value of health care
27 services provided by non-contracted providers or providers that that do not have a written
28 contract specifying the rate of reimbursement".

29 During the process used to establish these regulations, many of the arguments recently put
30 forward by CAPG to support modification of the Gould criteria and include prevailing
31 contracting rates in determining the value of the non-contracted provider's service were the very
32 arguments that were rejected by the Department in 2002. Presumably, revision of the existing
33 regulation is in response to the urgings of health plans and their capitated providers that the
34 criteria needed to be opened up to account for such contentious, legally irrelevant, and injurious
35 considerations such as contracted rates, rates paid by governmental programs (and thus subject to
36 budgetary constraints), and rates physicians may accepted under coercion by physicians.
37 Significantly, these changes were requested during the initial AB 1455 rulemaking period and
38 specifically were rejected by the Department on the grounds that it lacked statutory authority to
39 accept them. As the Department responded in the Third Comment Period to the AB 1455
40 regulations, ending April 30, 2003, in its response to Comment No. 43: "The criteria set forth in
41 this section accurately reflect current CA case law relating to non-contracted services.
42 Therefore, these criteria must be considered when properly adjudicating a claim. **The**
43 **Department has declined to unilaterally add any factors that were not enunciated in the**

1 **Gould decision because it lacks the authority to create new contract principles.** (Emphasis
2 added.) When the final regulations were adopted, the Department indicated that “No alternative
3 considered by the Department would be more effective in carrying out the purpose of the
4 proposed regulation, would be as effective and less burdensome to affected private persons, or
5 would lessen any adverse impact on small businesses.”

6 C. Discounted Contracting Rates do Not Reflect the Full Value of Contracted Services

7 If the intent of the proposed regulation is to ensure that non-contracted providers receive the
8 reasonable value of their services; there is one very obvious flaw in CAPG’s argument that
9 ‘prevailing contract rates’ should serve as one of the criteria for establishing the reasonable value
10 of these services. Even if one were to accept CAPG’s quantum meruit theory on the reasonable
11 value of a service, which CAL/ACEP specifically rejects, it should be obvious that **the value of**
12 **a contracting provider’s service (to the patient or the payer) is not equivalent to the**
13 **discounted rate the contracting provider agrees to accept as payment in full. The true**
14 **value of a contracting provider’s services is equal to the contract rate paid and accepted**
15 **PLUS the monetary value of the consideration exchanged for accepting a discounted**
16 **payment.** This consideration can take many forms, including exclusivity of referrals, volume of
17 referrals, expedited payment, and/or other considerations that have real value to the provider.
18 CAPG would have the Department ignore the value of these considerations that the contracted
19 provider receives, and look only to a discounted contract rate as a full measure of the value of his
20 service. In fact, the full value of a contracted provider’s service is most closely approximated by
21 considering the usual and customary fees charged by the provider, and other similar providers,
22 when they provide the same services, (i.e. services that are NOT covered by a contract).
23 Looking only to prevailing contract payments ignores the value received by the provider in
24 exchange for accepting the discounted rate.

25 In addition, hospitals reserve the right to review and approve emergency physician charges, but
26 they rarely consult with their medical staff before entering into these networks, and that many
27 hospital based providers are obligated by their staffing contracts with the hospital to participate
28 in these networks or risk losing their medical staff privileges or staffing opportunities, in
29 violation of Health and Safety Code Section 1322. ‘Coercive contracting’ is a well known
30 phenomenon in California (see **the CMA’s letter to the OIG Regulations Officer on coercive**
31 **contracting, Feb 1, 2003, attachment 1, and Riner, Coercive Contracting and Managed**
32 **Care, attachment 2**), but violations of Section 1322 are difficult to prove. These practices result
33 in artificially low contracting rates that have little to do with the value of the provider’s services,
34 and more to do with the artificial manipulation of the marketplace, and are another reason why
35 the Gould criteria should not be modified.

36 D. Usual and Customary Charges ARE the Appropriate Standard

37 Director Ehnes has stated that she felt that the Gould criteria are not suitable as an appropriate
38 payment standard because they criteria cannot readily be configured into a computerized claims
39 payment system. This is a bit of a misleading argument, as the Gould criteria were included in
40 regulation in order to establish usual and customary charges as the commercial standard for the
41 payment of non-contracted emergency care providers, and to serve as a benchmark for the
42 adjudication of payments when the provider and payer disagree on the reasonable value of the

1 services. The DMHC apparently believes it has the discretion, and perhaps the obligation, within
2 existing regulations to establish a safe harbor standard and payment methodology for payers. It
3 apparently had no reasons to reopen the regulations, or modify the Gould criteria, in order to
4 develop and promulgate these safe harbor standards for payers. CAL/ACEP believes that the
5 safe harbor standards should be derivative of the current regulations. It is clear from Director
6 Ehnes' questions at the DMHC hearing on September 13, 2006, that the Department is struggling
7 to find a way to apply the Gould criteria to identify the appropriate safe harbor standard for the
8 initial payment of a non-contracted emergency care provider's claim. If so, the Department has
9 mis-framed the public discourse with this regulation. The debate should not be about whether
10 the Gould criteria appropriately define the reasonable value of a non-contracted provider's
11 services. The courts have already sanctioned this concept. The discourse should be around a
12 different issue: considering the current fragility of the emergency care safety net; the unraveling
13 of our on-call specialty rosters; the closure of numerous ERs; the increased waiting times and
14 ambulance diversions; the well below average cost of living adjusted incomes of emergency
15 physicians in California; the difficulty providers experience with claims disputes; the under-
16 enforcement of fair claims payment statutes; the ability of HMOs and RBOs to rely on non-
17 contracted providers to serve the emergency care as safety net providers for their enrollees; the
18 complexity of billing in the delegated model; and the steadily increasing profits of health
19 insurance plans: what should be the standard for the initial payment of a non-contracting
20 emergency care provider's claim? CAL/ACEP believes that this safe harbor standard should be
21 designed so that a significant majority of these claims are paid at the provider's usual and
22 customary charge; and, so that these providers do not constantly need to dispute underpayments,
23 while payers are protected from having to pay exorbitant fees. CAPG and the Plans, of course,
24 would like to see this safe harbor standard be based on rates far lower than usual and customary
25 fees: but from a health care policy perspective, given all of the considerations mentioned above;
26 the weight of the evidence is overwhelming in favor of a safe harbor standard based on usual and
27 customary charges.

28 E. An ICDR Can Not be Relied Upon to Establish a Reasonable Rate Standard

29 The DMHC seems to be aiming for a safe harbor standard that supports the initial payment of
30 most claims far below usual and customary fees. Based on comments from the Director, the
31 Department appears to be concerned that the application of the 50th percentile of usual and
32 customary charges (per the HealthNet consent agreement) as an industry-wide standard, might be
33 interpreted as rate setting. It appears that the Department would prefer to substitute the ICDR
34 process as a proxy for the marketplace to establish a range of reasonable values for non-
35 contracted provider services. This strategy assumes that the ICDR would actually function with
36 complete efficiency and fairness; however, emergency providers, as captive servants for all payer
37 classes, know that our services will never be adequately compensated under such a 'care and
38 chase' artifice, and we are convinced that the need to dispute most of our claims would in and of
39 itself seriously compromise the process, and undermine the value of our services. The
40 Department's concern about rate setting is unwarranted: an initial payment based on usual and
41 customary charges would be subject to dispute by either the party, and such a payment would not
42 be viewed as a set fee but simply as a place to start, predicated on health care policy designed to
43 maintain our under-funded and EMTALA obligated safety net.
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45 |

1 III. CAPG’s Request to Modify the Regulations are Based on False Assertions

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3 A. The Gould Criteria are Not Restricted to Workers Compensation Payments

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5 In addition, CAL/ACEP wishes to make the following points in response to CAPG’s letter of
6 March 12, 2006 requesting that the Gould criteria be revised: presumably the primary
7 motivation for the regulation now under consideration. In reference to Page 2 & 3 of CAPG’s
8 request, relating to the allegation that the Gould Criteria are only applicable in the context of
9 workers’ compensation services; the Gould case did involve the workers compensation appeals
10 board and their attempt to determine whether a physician may charge more than an official fee
11 schedule. While this is the beginning premise of the case, the court struggled to determine the
12 general parameters of what is a reasonable physician fee. The courts conclusion as to what is a
13 reasonable fee is equally applicable in any non-contracted circumstance in which a provider bills
14 for services performed. Other courts have cited the Gould criteria as being a reasonable
15 benchmark to determine the value of a non-contracted provider’s services. Courts have
16 referenced the Gould criteria in both Bell vs. Blue Cross and in the Prospect case. Therefore, it
17 is disingenuous of CAPG to argue that the Gould criteria should be restricted only to workers
18 compensation cases, when the courts have repetitively referenced the Gould criteria as a
19 reasonable barometer of physician fees.
20

21 B. For Non-contracted ER Providers, Quantum Meruit Means Usual and Customary
22 Charges

23 Regarding Page 4 & 5, and the Quantum Meruit Standard: In the Bell vs. Blue Cross of
24 California decision, the court of appeal reiterated the position that “non-contracted emergency
25 providers have an implied in law right to reasonable compensation under a Quantum Meruit
26 Theory. In Bell v. Blue Cross appeals decision, the court opined “First, the health care plans’
27 duty to reimburse arises out of the providers’ duty to render services without regard to a patients’
28 insurance status or ability to pay. California’s Legislature expressly acknowledged, in a bill
29 sponsored by CAL/ACEP, that “it is necessary for the protection of the health and safety of
30 Californians that a comprehensive and high quality system of emergency medical services be
31 provided” and that “the costs of emergency medical services are greater than the costs of
32 delivering other forms of medical services in the state, as emergency services must be readily
33 available on a 24-hour basis and must be provided to all, regardless of ability to pay, which is
34 required by existing laws.” The Legislature further understood the severe financial burdens that
35 the costs of emergency services place upon medical providers and, “the breadth of the
36 uncompensated and under-compensated care problems facing California providers,” that, if
37 allowed to continue, “could force many physicians to reduce the quality and availability of
38 emergency medical services, to the detriment of Californians.” (Historical derivation to Health
39 & Safety Code §1317.) The Bell vs. Blue Cross court also said: “Because Blue Cross’s
40 interpretation of “reimburse” would render illusory the protection the Legislature granted to
41 providers, the duty to reimburse must be read as a duty to pay a reasonable and customary
42 amount for the services rendered. (Cf. Stevenson v. San Francisco Housing Authority (1994) 24
43 Cal.App.4th 269, 283; Stoneson Development Corp. v. Superior Court (1987) 197 Cal.App.3d
44 178, 180.) Second, Blue Cross’s interpretation would mean the emergency care providers could
45 be reimbursed at a confiscatory rate that, aside from being unconscionable, would be
46 unconstitutional.” The basic premise of the Gould court, and the courts that cite the Gould

1 criteria, is that a significant majority of provider’s charges ARE reasonable. Contracted payment
2 rates cannot be used as a benchmark because in some cases they represent whatever the payer
3 chooses to pay the provider, and in some instances the rate is based upon coercion. Lastly, the
4 contracted payment rate is based upon a discounted rate for large volumes or expedited
5 payments. Non-contracted providers do not reap any of these benefits.

6 C. Commercial Insurers Must Support a Safety Net for All Patients

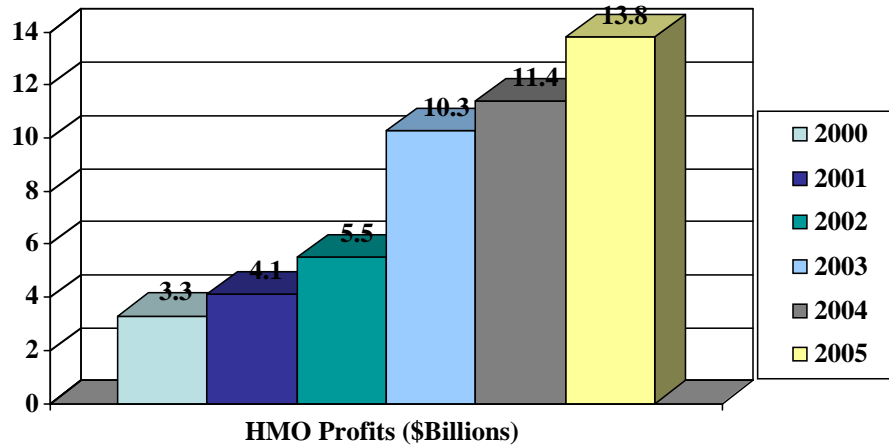
7 Regarding Page 5, and Reasonable Value: CAPG alleges that “Quantum Meruit claims measure
8 the value of services to the recipient rather than the cost to the provider and therefore the
9 plaintiffs alleged lost profits and costs are not recoverable.” CAPG further argues that the value
10 of the emergency physician’s services should be measured from the perspective of the payer, and
11 that cost-shifting is a health policy argument that has no place in disputes between providers and
12 payers over the value of the provider’s services. This is the most insidious and fallacious
13 argument they put forward. Although emergency care is not really a commodity, every
14 government regulator understands that in a market where the availability of a product or service
15 is not readily assured; government imposed price controls merely lead to even tighter supply and
16 reduced quality. Over sixty emergency departments in California have closed in the last decade,
17 ED waiting times are getting longer in many hospitals, ED physician staffing positions remain
18 unfilled for months and years, ambulances are being constantly diverted from the closest ED
19 because of overcrowding, on-call rosters are crumbling around us, and recently trained
20 emergency physician residents are leaving the state. This is directly related to policy decisions by
21 the state and federal governments to put the financial burden for caring for the uninsured, the
22 poor, and the elderly on the backs of physicians, and in particular, emergency care providers.
23 HMO’s and RBOs reap a huge benefit by having an emergency care safety net to care for their
24 enrollees, with no commensurate requirement for RBO affiliated physicians to cover ED call. To
25 pretend that HMOs and RBOs should be financially immune from the social consequences of
26 these policies is absurd. To pretend that the market for emergency care services in California
27 can withstand a restriction on recovery of un-reimbursed costs, is unrealistic.. HMO and RBO
28 management may not value emergency care services very highly; but their working physician
29 members, and our mutual patients, their policy-holders, certainly do.

30 D. CAPG’s Request is an Attempt to Maximize Profits, not Protect Patients

31 This effort by CAPG needs to be understood for what it really is; It is a cleverly disguised and
32 misguided effort to retain more of its share of premium dollars by undermining the payment
33 standard for physician services. It is aimed in the wrong direction. The Department
34 understandably is focused on preserving California’s managed model of care, but putting
35 pressure on emergency care providers to accept a significant reduction in revenues will not
36 stabilize the delegated model; this will merely destabilize an already tenuous emergency care
37 safety net. If CAPG is successful in this effort, they will simply shift the burden for preserving
38 the access to emergency care physician services from health plans to hospitals, many of which
39 are struggling, unsuccessfully, to stay in business and keep their Ends open. If there were a
40 surplus of qualified physicians available in California to fill these roles and if ED on-call rosters
41 were well subscribed to, then CAPG’s approach might seem reasonable. The only surplus in this
42 market is in the egregious profits that health plans are currently retaining and sending to Wall
43 Street or spending on outrageous CEO compensation (**See below**); while in California

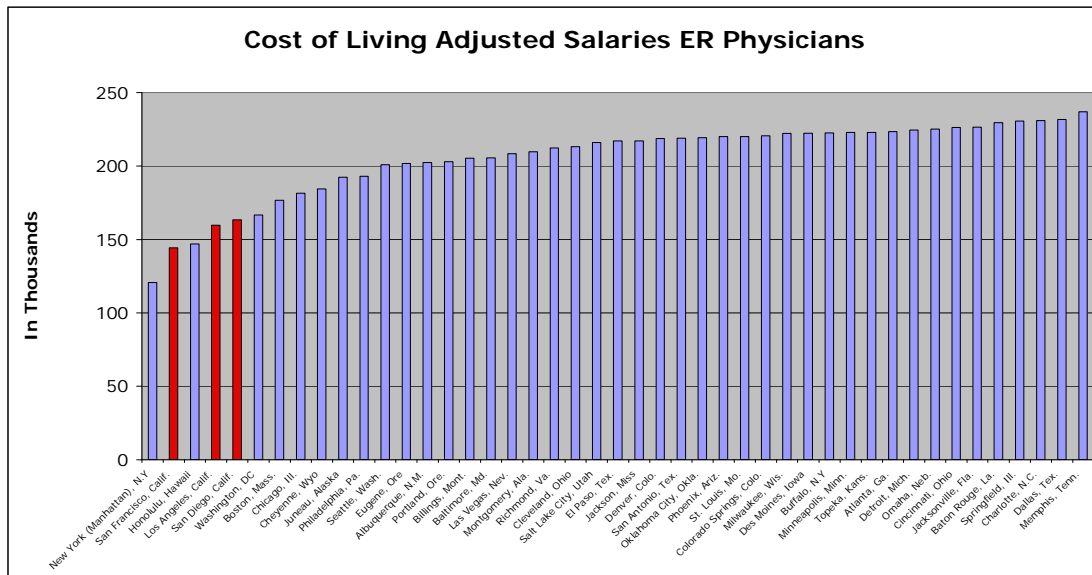
- 1 emergency physician incomes (in red) are well below the national average when adjusted for the
- 2 average cost of living (see below). Changing the fair payment regulations will only hasten the
- 3 degradation of one of the most critical resources upon which managed care relies.

HMO Profits are Soaring



Data from Weiss Ratings, Inc, 2005 projected from first half-year.

Comparing ER physician salaries by US Cities



ACCRA Cost of Living Index 2005

Certified Compensation Professionals' Survey; updated August 2006.

1 E. The Courts Have Rejected Medicare Rates as a Surrogate for Reasonable Value

2 Inclusion of Medicare or MediCal rates into the Gould criteria, as surrogates for the reasonable
3 value of a non-contracted provider's services, as suggested by CAPG, has likewise been rejected
4 by the courts. The recent decision in the Bell and Prospect case demonstrates that the courts
5 have determined that reasonable value and payments are essential, and that reimbursing
6 providers at Medicare rates for services to commercially insured patients is not appropriate. The
7 Prospect court stated: "Prospect has provided no authority, statutory or otherwise, for this court
8 to conclude that it (Prospect) can set the rates of emergency rooms physicians pursuant to any
9 across-the-board rate mechanism, whether the Medicare rate or any other rate." The courts
10 findings that there should not be relationship construed between the 'reasonable value' of non-
11 contracted provider's services and Medicare rates is in stark contrast to CAPG's persistent claim
12 that Medicare rates should be applied in this way.

13 The Department has suggested that the current Gould criteria need to be modified if providers
14 want to allow for the consideration of such issues as the rate of increase in health care premiums,
15 or the increasing discrepancy between Medicare rates and premium rates, when determining the
16 reasonable value of a non-contracted emergency care provider's services. There really is no
17 reason why these larger economic issues should be factored into this determination for a
18 particular service or payment. Premium rate increases, soaring health plan profits, and Medicare
19 payment disparities are appropriate considerations for the much larger policy issues here. With
20 respect to emergency care services, these include: 1) what can we do to restore our ED call
21 panels?, 2) should non-contracted emergency care providers should be paid their usual and
22 customary fees in the overall context of a system that underpays so many other claims for the
23 care of the poor and uninsured?, and 3) why peg commercial emergency care provider claims to
24 Medicare rates in the face of the rising cost of providing cost of providing these services, and the
25 likely reduction in the Medicare fee schedule? In a political environment where caps on Health
26 Plan profits are being considered, the issue of this undisguised attempt to restrict emergency
27 provider reimbursement must be identified for what it is: a smokescreen for preserving enormous
28 HMO profits.

29 Again, the Gould criteria were adopted under AB 1455 to help adjudicators define the reasonable
30 value of non-contracted emergency care services in the commercial arena, and to peg the value
31 of those services in the context of the current health care system to usual, customary and
32 reasonable charges. Destroying this standard in order to drag down the cost of care cannot be
33 justified by linking the commercial health insurance market to government payers operating on a
34 deficit budget, or to historically exploitative managed care payers imposing deeply discounted
35 contract rates. The effort to amend the AB 1455 regulations in this way is bad public policy with
36 potentially disastrous consequences, not simply a minor tweak to an existing carefully defined
37 and well established standard.

38 F. CAPG's Allegations of Excessive Charges are Unsupported

39 Regarding Page 9: The CAPG Survey: CAPG purports to have conducted a survey in late 2004
40 revealing a 'stark and dramatic contrast' between contracted and non-contracted emergency
41 physician charges'. As the Department is well aware, CAL/ACEP also conducted a survey and
42 followed FTC guidelines to ensure that the data was greater than 3 months old: was collected and

1 reported by an independent third party, and that no single respondent contributed greater than 25
2 percent of the survey results. Our survey reported the 50 most commonly used ED codes and
3 was gathered from over 142 emergency departments, and totaled 4.5 million visits. It should be
4 pointed out that CAPG has never explained if its data was obtained independently by an
5 objective third party, or how much of its data was contributed by a single group. CAPG states
6 that 13 of its member groups participated, although they have 400 members (less than 3%
7 participation). CAL/ACEP had participation from over 140 emergency departments out of 280
8 EDs eligible to complete the survey (over 50% participation). CAPG reported on 35,600 claims.
9 CAL/ACEP reported on 4.5 million claims. On page 9, CAPG states “claims data covering
10 approximately 1million commercial lives were collected and analyzed, detailed information was
11 obtained and analyzed on 35,600 claims including 4, 324 claims reflected on the attached report
12 made on the ten most frequently performed services in the emergency department.” However,
13 three of CAPG’s ten most common emergency department codes (99307 Echo of Heart, 93510
14 Left Heart Catheterization, and 99254 In Patient Consultation) are procedures and services that
15 are never performed in the ED, except 99307 which is performed there only rarely, and usually
16 by cardiologists. Hence, these codes do not even appear within CAL/ACEP’s top 50 codes and
17 demonstrate the absurdity of CAPG complaints regarding ED costs. If CAPG had data covering
18 one million commercial lives, and collected data on 35,600 claims, why did they chose to report
19 data on only these 4,324 claims. Could it be that they manipulated their data to support their
20 erroneous conclusions?

21 On the issue of emergency provider fees, the comparison of CAPG’s 10 most common codes to
22 CAL/ACEP’s survey likewise shows wildly discrepant figures. (**See attachment 3**). By means
23 of example, CAPG claims that the average billed amount for a one view chest x-ray is \$88.23.
24 CAL/ACEP’s survey shows that the average fee charged by ED physicians is \$28.99. Another
25 example of a marked discrepancy is CPT code 99291 Critical Care 1st Hour, typically a
26 lifesaving level of service. CAPG claims that the average billed amount for this service is
27 \$849.43. The CAP/ACEP survey shows that the average charge is \$564.46 representing a
28 discrepancy of almost \$300.00. Again, to any serious reviewer of this data, it is clear that there
29 is no relationship whatsoever between CAPG’s flawed analysis, and the real fees as
30 demonstrated in the recently completed CAL/ACEP survey. When the data retrieved from this
31 survey is compared to data from the Ingenix survey of usual and customary charges (a database
32 owned by a health plan), it is clear that emergency physician fees in California are quite
33 comparable to the fees charged by other physicians whose charges were included in the Ingenix
34 database, many of whom are affiliated with CAPG medical groups and IPAs. (**see attachments 4**
35 **and 5**). It should be noted that most of the physicians whose charges are included in the Ingenix
36 database do not have the uncompensated care burden assumed by emergency physicians, and in
37 fact many of these physicians rarely treat MediCal patients, or patients who are underinsured, in
38 their offices.

39 CAPG has said that non-contracted emergency physicians take advantage of their ‘exclusive
40 contracts’ with hospitals to charge exorbitant fees to our patients, who have little choice but to
41 use our services. CAL/ACEP acknowledges the possibility that there may be outlier physicians
42 who overcharge, but where is the validated and independently derived data that proves this. And
43 how can the DMHC reasonably consider such flawed data to justify its position that the Gould
44 criteria should be abandoned, and that most emergency care providers’ charges are excessive?

1 Again, this allegation of excessive fees ignores the fact that there are many constraints on
2 emergency physician charges: hospitals would not contract with an ER group whose fees were
3 excessive, and the hospital often has the right to approve these rates. Many hospitals, desperate
4 for insured patients, coerce their ER groups to accept whatever discounted rates the health plans
5 offer. Illegal coercive contracting is rampant in California, but difficult to prove or prosecute. If
6 the DMHC wants to collect some interesting data on the value of non-contracted provider
7 services, they should survey the charges that CAPG members submit to insurers when they are
8 not contracted.

9 G. Fair Payment of Non-contracted Providers Does Not Undermine Contracting

10 Regarding Page 10, and CAPG's allegation of 'powerful and deeply troubling incentives for
11 providers to discontinue contracting': CAL/ACEP has repeatedly stated that establishment of
12 safe harbor provisions which ensure a fair and reasonable initial payment will promote
13 contracting. CAL/ACEP has repetitively shared with the Department that after the safe harbor
14 provisions were established in the Health Net consent agreement, ER groups have subsequently
15 contracted with Health Net. CAPG contends that they continue to receive anecdotal reports that
16 there is a trend in contract termination. CAL/ACEP has provided proprietary data from some ER
17 physician groups that indicate that contracting between payers and emergency physicians is
18 robust, in part because of coercive contracting, and in part because ED physicians strive to be
19 good economic partners with their hospitals and their patients by participating in managed care
20 networks. Absent any legitimate verifiable data, CAPG's anecdotal stories and their contention
21 cannot be given serious consideration. There is no evidence whatsoever that the HealthNet
22 consent agreement, and the use of the Gould criteria to develop an initial claims payment
23 standard based on usual and customary fees, has resulted in the cancellation of contracts between
24 HealthNet and emergency physician groups. These allegations simply hide the truth that such
25 enforcement actions only level the playing field for well-motivated participants. Where is the
26 data to show that any of the other payers that use a UCR payment standard, such as Kaiser, have
27 lost contracts with ER physicians, or struggled to make these payments? Some of these plans are
28 posting record revenues and/or profits, and paying their CEOs obscene levels of compensation.
29 Where is the data that demonstrates that paying non-contracted emergency care providers fairly
30 is responsible for IPA or health plan bankruptcies, or skyrocketing premiums? Emergency care
31 providers account for less than 2% of plan costs for professional services. Why are non-
32 contracted emergency care provider payments the target for this assault on the regulations? The
33 answer is: because we won't and can't say no to caring for the health plan's members, and when
34 you can't say no, you are a tempting target, the first in a series of dominos to be knocked down
35 in a Health Plan profit-driven strategic assault on physician compensation.

36 IV. Why Patient Involvement in Third Party Reimbursement is Necessary

37 A. The Current System Favors Payers

38 The DMHC has asked if it is absolutely necessary to 'keep patients in the middle of these
39 disputes' in order for providers to receive reasonable terms in contracting with Knox-Keene plans
40 and RBOs? The answer is that in the ideal world, the right to balance bill would not be a
41 significant factor in the negotiations for discounted emergency care services. However, this
42 particular part of the 'third party payer system' is very far from ideal. The balance of forces in

1 these negotiations for discounted contracts covering emergency care services at networked
2 hospitals leans significantly in favor of the payers. The payers claim that the 'exclusive
3 contracts' of hospital providers gives the providers an unfair advantage, but in fact, these
4 exclusive contracts usually aren't all that exclusive (all physicians on the medical staff can come
5 in to manage their patients in the ER), and they usually expose the emergency care provider to
6 coercive contracting pressures by their hospitals.

7 B. Providers Must Have the Right to Decline Contracts

8 The delegated payer model had the perhaps unintended consequence of allowing plans to
9 consolidate their bargaining power under a limited number of RBOs that have greater overall
10 market share in order to control a local market and constrain the cost of physician services, rather
11 than the plans having to compete with each other to get physicians to join their network. In the
12 context of coercive contracting, lax DMHC enforcement for fair payment, and the lack of direct
13 enforcement authority over RBOs, Health Plans and RBOs have great economic power in their
14 service areas. In contrast, emergency care providers have no leverage to obtain fair contracting
15 rates, especially considering their EMTALA mandate. Indeed, the possibility of billing the
16 patient and the patient in turn passing these costs and complaints onto their Health Plan and to
17 the DMHC is the only true incentive for Health Plans to agree to fair contracts. An untried,
18 unworkable, and overwhelmed IDRPs will never substitute for our right to remain non-
19 contracting, especially when the DMHC insists that EMTALA and 1371.4 creates an implied
20 contract and turns us to indentured servants to every Knox-Keene payer, regardless of their
21 interest in contracting with us or using our hospitals.

22 C. Paying Usual and Customary Rates to Non-contracting Providers Promotes Fair 23 Contracting

24 The DMHC has also asked if payment of non-contracting providers at usual and customary fees
25 discourages emergency care providers from contracting. The answer is: No, it will just mean
26 that payers will have to contract at more reasonable rates. Having a reasonable standard for the
27 initial payment of the non-contracted payer doesn't eliminate all the other reasons, good and bad,
28 that induce emergency care providers to contract. CAL/ACEP has demonstrated on more than
29 one occasion that the frequency of contracting between emergency physicians and RBOs has
30 INCREASED since adoption of AB 1455. Where is the data that indicates otherwise? On the
31 contrary, the most significant deterrent to fair contracting is DMHC's continued assertion that
32 emergency providers are subject to an 'implied contract' that allows RBOs to pay at severely
33 discounted rates. Why bother negotiating a contract with an indentured servant?

34 V. The Proposed Regulations will have an Adverse Impact on Emergency Care

35 A. Undermining Fair Payment Standards will Undermine Access to Emergency Care

36 After reviewing the DMHC's remarks in response to inquiries about emergency physician
37 complaints about underpayment of claims (**see attachment 6**), and based on recent discussions
38 with Department staff, it is clear to CAL/ACEP that the intent of this proposed regulation to
39 revise the reasonable value standard. Together with the with the other proposed balance billing
40 and IDRPs regulations, this will change the way emergency and on-call physician services in

1 California are financed. As we have stated, these changes would destroy any semblance of
2 timely and reasonable payment, would add huge overhead costs, and would completely destroy
3 our ability to continue in our group practice models. There would be no support for our care of
4 the poor and uninsured, or for the health and safety and security of the citizens of California. We
5 simply cannot afford to provide these services to the poor, and staff our EDs with qualified
6 emergency physicians and on-call specialists if health plans and their delegated payers are
7 allowed to walk away from their obligation to sustain the financial viability of the emergency
8 care safety net. As mentioned, Health Plans and RBOs constantly depend and rely on this same
9 safety net. Incredibly, it appears that these same health plans have convinced the DMHC to
10 presume that, despite the loss of some \$500 million a year in revenues to safety net providers,
11 these emergency physicians, on-call specialists, and hospital emergency departments would
12 somehow remain available and accessible to provide these services; and that patient access to
13 emergency care in California would be unaffected. No doubt, they feel safe in this presumption
14 knowing that when the Safety Net collapses, taxpayers will be forced to pick up the tab.

15 B. The Proposed Regulation Will Reduce the Availability of Qualified ER Physicians

16 CAL/ACEP recently surveyed 1800 emergency physicians in California, including residents in
17 training in emergency medicine, directors of emergency departments, and emergency department
18 staff physicians; in order to assess the potential impact of these regulations on patient access to
19 qualified emergency physician services. Based on this survey (see **Attachments 7, 8 and 9**), it
20 is apparent that these regulations could undermine staffing for many of California's emergency
21 departments. The survey assessed responses based on best-case, and worst-case scenarios. The
22 worst case scenario was predicated on the loss of an average of \$66,800 per year in income for
23 full time emergency physicians, based on the difference between payment at 110% of Medicare
24 rates (one of the safe harbor standards for initial payment suggested by the DMHC), and
25 payment at current rates from an extrapolation of average receipts on Knox-Keene claims from
26 several ER groups from around the State, both contracted and non-contracted (see **Attachment**
27 **10**). Thirty five percent of the physicians (635) responded to the survey, and of the currently
28 practicing emergency physicians, more than half indicated they would consider retiring early,
29 switching careers, or leaving California to practice elsewhere, in the worst case scenario. Thirty-
30 three of the fifty-four residents currently planning on remaining in California to practice
31 emergency medicine would also leave the State in this scenario. Even a very conservative
32 extrapolation of the results of this survey to the 3000+ emergency physicians in California
33 indicates such a dramatic loss of professional resources that the enactment of these regulations
34 would result in the closure of more than a third of all the EDs in California.

35 California has many excellent training programs in Emergency Medicine. Once considered a
36 'hotbed' of Emergency Medicine training and talent, the picture has changed remarkably in the
37 last 10 years. High numbers of uninsured and nonpaying patients coupled with low MediCal
38 reimbursement and heavy Managed care penetration has led to reimbursement rates that are
39 below the national average, while California's cost of living index, at 140 compared to the
40 national average of 100 (according to the ACCRA 2005 survey), is the third highest of 50 states.
41 The result is a net exodus of qualified emergency physicians and new Emergency Medicine
42 resident graduates leaving the State for better pay and a lower cost of living.

43

1 C. The Proposed Regulations Ignore the Documented Crisis in Emergency Care

2 The DMHC's bizarre conclusion that these regulations would not impact access to emergency
3 care in our State contradicts the analysis of the Institute of Medicine Report on the Future of
4 Emergency Services in the United States, and the analysis of access to care problems identified
5 in the American College of Emergency Physicians Report Card on Emergency Care. The IOM
6 report describes the increasing responsibilities of emergency departments in caring for patients
7 without medical insurance and for insured patients unable to access their physicians. Between
8 1993 and 2003, the number of visits to emergency departments increased from 90.3 million up to
9 nearly 114 million. At the same time, the number of hospitals in the United States decreased by
10 703, and the number of hospital beds dropped by 198,000. Emergency departments are forced to
11 practice "boarding," where hallways are lined with patients on gurneys while they receive care
12 and wait for an in-patient bed to become available. Only a fraction of federal funding for
13 emergency preparedness since 9/11 has been spent on medical preparedness. Emergency service
14 providers are a crucial part of the response to any disaster, yet they received only 4 percent of
15 \$3.38 billion distributed by the Homeland Security Department for emergency preparedness in
16 2002 and 2003 and only 5 percent of the funding from the Bioterrorism Hospital Preparedness
17 Program.

18 In the ACEP Emergency Medicine National Report Card, California ranked last in the nation
19 (51st after all states and the District of Columbia) for the number of emergency rooms per
20 million people. The closing of 67 emergency departments in California in the last 10 years has
21 markedly exacerbated this problem. This has led to longer waits, increased crowding and
22 ambulances being diverted to more distant hospitals when the closest ones can no longer accept
23 more patients.

24 California's nursing shortage is so severe that we were ranked 50 out of the 51 states and
25 Districts that were surveyed. Without enough nurses our system is crippled. It delays emergency
26 care and also delays admissions into the hospital. Many inpatient wards are closed throughout
27 California because there are not enough nurses to care for admitted patients. California ranked
28 46th out of 51 in staffed hospital beds. This has led to what we call 'boarding'. This term means
29 that admitted patients are kept in the ED for hours and even days, leaving fewer functioning ED
30 treatment areas to care for emergencies. This leads to GRIDLOCK in our Emergency
31 Departments.

32 ED waiting times and ambulance diversions have skyrocketed in recent years. A 2001 U.S.
33 GAO report found that 25 percent or more of hospitals throughout Southern California were on
34 ambulance diversion more than 10 percent of the time. In 2003, 9.7 million people went to a
35 California Emergency Room. This was almost 1 million more than 1994 visits. During the same
36 period of time, the number of hospitals operating emergency rooms declined from 402 to 357
37 and the total number of hospitals declined from 525 to 413. In 2005 there were only 64 trauma
38 centers, with 17 having closed over the past 20 years. In 2003, over-capacity emergency rooms
39 in California were "on diversion" for almost one-quarter million hours – a 16% increase over the
40 2002 level. A hospital on diversion is requesting that ambulances bypass its emergency room
41 and instead transport patients to other medical facilities. These delays can jeopardize patient
42 safety. In Los Angeles County, the public hospitals were on diversion an average of 63% of the
43 time. Since the implementation of mandated nurse staffing ratios in January 2004, despite an

1 undersupply of trained personnel, crowding and boarding pose a greater threat to the safety of
2 Californians seeking emergency care.

3 The system is woefully under-funded. A 2001 Kaiser Foundation study determined that
4 California ranked last in the country on spending per MediCal beneficiary. California spends less
5 than \$2500 per beneficiary per year as compared to the national average of over \$4,000. An
6 article in the March 24, 2004 edition of Health Affairs (Emergency Care In California: Robust
7 Capacity Or Busted Access? Californians should not expect their emergency care system to work
8 as it should, as long as so many people remain uninsured, by W. Wesley Fields, **Attachment 11**)
9 outlines the current state of California's emergency care crisis quite well.

10 Even since these proposed regulations were drafted, three major hospitals have announced
11 closure of their EDs due to downgrading and decertification. Daniel Freeman Medical Center in
12 Inglewood, Doctors Medical Center in San Pablo, and King Drew Medical Center in Los
13 Angeles have all announced closure or impending closure of their EDs, and the domino effect is
14 throwing surrounding hospitals and communities into crisis.

15 D. The Proposed Regulations Ignore the Existing Financial Crisis in Emergency Care

16 California has more than 7 million uninsured patients. According to a 2000 UCLA Center for
17 Health Policy Research study, three-quarters of California's legislative districts have higher
18 uninsured rates among the non-elderly (ages 0-64) than the national average of 17 percent.
19 Fewer employers are offering health insurance and not all poor patients qualify for the MediCal
20 program. The net result is that 20% of Californians are without health care benefits and these
21 patients have little option but to seek their healthcare through Emergency Departments. This
22 makes insurance more expensive for everyone, and undermines the financial viability of the
23 emergency care safety net.

24 On call panels are deteriorating. Many physician specialists, that we rely on to provide
25 comprehensive care, are no longer willing to be on-call for our emergency departments. A 2002
26 California Senate Office of Research report on Growing Gaps in California's Emergency Room
27 Backup System (**See Attachment 12**) mandated by AB 2611 indicated that "problems with
28 access to emergency room on-call services in many specialties in many areas of the state are
29 adversely impacting the quality of patient care and forcing hospitals, physicians, patients and, in
30 some cases, medical groups and health plans to incur significant costs. **Problems with access to
31 on-call services are primarily the result of problems with reimbursement of physician
32 specialists who provide on-call services. Problems with lack of payment or underpayment
33 associated with on-call services extend to all payers – health plans, Medi-Cal, Medicare,
34 and safety net programs for the uninsured – and act cumulatively to reduce the willingness
35 of physicians to provide on-call services** (emphasis added). Specific problems affecting
36 payments for on-call services include: inadequate payments for on-call services for uninsured
37 patients under safety net programs, including local Emergency Services Funds, county indigent
38 health programs, the SB 855 disproportionate share hospital program, and the SB 1255
39 supplemental payment program, and problems with managed care contracting and payment
40 practices that affect the timing, level and certainty of reimbursement for on-call services to
41 insured patients. **These include: Medical group insolvencies and financial difficulties, lack
42 of contracts between health plans and sufficient numbers of physician specialists for on-call**

1 services, dissatisfaction of medical groups and their members with the terms of their
2 contracts with health plans, dissatisfaction on the part of non-contracting physicians with
3 the payment rates offered by health plans for on-call services, the use of inconsistent coding
4 and documentation standards by health plans, regulatory limits on reimbursement of on-
5 call services by Medi-Cal managed care plans, delays in adjudication of providers'
6 complaints about payments for on-call services by Medi-Cal managed care plans, and
7 inadequate Medi-Cal payment rates.” (emphasis added)

8 E. The Proposed Regulations Will Adversely Impact ER On-call Specialty Services

9 The Senate of Research Report recommended that “contracts between public and private health
10 plans and providers, and payments by health plans to physicians, should be sufficient to
11 reasonably ensure the availability of on-call physicians, ensure that payments by all payers for
12 on-call services are commensurate with the reasonable cost of providing the services, and avoid
13 practices that shift costs of on-call coverage to other entities, including hospitals, physicians, and
14 consumers.” Specific recommendations included: “**Establish in statute a presumptive**
15 **payment standard for payments by commercial health plans to non-contracting physicians**
16 **who provide emergency and on-call services. The standard would be the physician’s billed**
17 **charges, the physician’s usual charges, or a payment consistent with customary and**
18 **reasonable charges for the service for the geographic area based on published surveys or**
19 **databases as defined by DMHC** (emphasis added), and “provide that failure to follow the
20 standard on a repeated basis is grounds for a finding of an unfair payment pattern, improve
21 required disclosures in commercial and Medi-Cal managed care contracts with providers
22 concerning who is responsible for on-call services and the payment terms and conditions for on-
23 call services”, and “**prohibit commercial and Medi-Cal managed care plans from delegating**
24 **risk for ER and on-call services to medical groups or Independent Practice Associations**
25 **(IPAs) if DMHC or DHS finds them, or their contracting groups, to be in violation of**
26 **prompt payment provisions, including engaging in an unfair payment pattern.”** (emphasis
27 added)

28 Repetitively we have heard that on-call providers are not fairly reimbursed for these services by
29 either the health plans or by Medi-Cal, and that these patients are highly litigious. In Los Angeles
30 County this year for the first time the Maddy EMS Fund (which on average pays about 17% of
31 the provider’s fee for some uninsured patients) ran out of money after 9 months and emergency
32 care providers received no compensation from this Fund for their services for a 3 month period.
33 Without adequate reimbursement these specialists will not be willing to perform this service on a
34 moment’s notice 24 hours a day, 365 days a year.

35 F. The Consequences of these Proposed Regulations on State Financing Have Been 36 Ignored

37 These regulations undoubtedly will create more costs to both the state and local governments. By
38 reducing or eliminating the ability of emergency care providers to receive their usual, customary
39 and reasonable charges for non-contracted services, and thereby undermining contracting rates
40 with Knox-Keene payers for emergency care services; a deficit of perhaps \$500 million a year in
41 the funding that currently supports the provision of emergency care in California will revert back
42 to health plans in the form of additional, and undeserved profits. **It is foolish and imprudent to**

1 **assume that this deficit in funding will not impact patient access to emergency care, the**
2 **quality of the services rendered, or the health of California’s citizens; especially since the**
3 **emergency care safety net is already overwhelmed, under funded, and on the verge of**
4 **failure.** The State of California will have little choice but to replace this deficit out of general
5 fund revenues, through expanded MediCal reimbursement rates, increased contributions to
6 County EMS Funds, and expanded financial support for our financially strapped hospitals. This
7 regulation will also increase a county’s financial obligation under Welfare & Institutions Code
8 §17000, because Counties will also have to find a way to expand support for emergency care
9 services for MIA patients. **Thus far, the DMHC has refused to acknowledge the financial**
10 **consequences of these regulations on limited State financial resources, and appears to be**
11 **oblivious to its responsibilities to protect consumers at-large, and not just the enrollees of**
12 **health plans.**

13 All recent assessments of the state of emergency care in the Nation and California conclude that
14 the emergency care safety net is on the verge of financial collapse due to under-funding and an
15 ever increasing patient care burden. The first and hardest hit will be the EDs in our poorest
16 communities. We have already lost 67 EDs in the last 10 years: how many more can we afford
17 to lose? The question here should not be: ‘Can the DMHC justify using some obscure and
18 tortuous rationale for modifying the current regulations, and manipulating the market in this
19 way? The question ought to be: ‘Can we LIVE with the consequences?’ If you are a patient
20 riding a gurney in the back of an ambulance looking for an open ED bed, a qualified emergency
21 physician and good specialty backup; the answer might be an unfortunate ‘NO’.

22 IV. Conclusion

23 For the reasons mentioned above, it would be inappropriate for the DMHC to modify the Gould
24 criteria in these regulations as suggested by CAPG. The courts, in developing the Gould criteria,
25 established that the reasonable value of a non-contracted provider’s services are generally related
26 to the prevailing charges of similar non-contracted providers in the community. This does not
27 mean that prevailing charges are ‘determinative’. Final determination of this value depends on
28 the application of the other Gould criteria as appropriate. Modifying these criteria as requested
29 by CAPG would completely subvert the our current and duly constituted fair payment standard,
30 and contaminate the prevailing charge concept with historically low government and contract
31 rates. In our view, this would result in huge illegal taking and would destroy our practices,
32 devastate our emergency care system and harm our patients.

33 We urge the rejection of this proposed regulation in the strongest possible terms.

34 Thank you for your consideration of these comments.

35

36 Sincerely,

37

38

39 R. Myles Riner, MD, FACEP

40 President, CAL/ACEP

41

42 cc: California Medical Association

Attachment 1

February 21, 2003

VIA FAX AND U.S. MAIL

Joel Schaer, OIG Regulations Officer
Office of the Inspector General
Department of Health and Human Services
ATTN: OIG-71-N, Room 5246
Cohen Building
330 Independence Avenue SW
Washington, D.C. 20201

Re: OIG-71-9 (Solicitation of New Safe Harbors and Special Fraud Alerts)

Dear Mr. Schaer:

The California Medical Association (CMA) greatly appreciates the opportunity to provide the Office of the Inspector General (OIG) with its input regarding abusive credentialing practices which are occurring in the health care industry. In its solicitation published in the Federal Register, Volume 67, No. 236, the OIG made it clear that it is showing special sensitivity to problems that physicians and other health care providers are encountering today, given the current competitive health care environment. CMA believes that the OIG can play an important role in protecting against unfair and illegal activities, promoting not only the quality of care provided to Medicare beneficiaries, but also the public at large. CMA agrees with the concerns raised by the American Medical Association, and would like to bring an additional consideration to your attention.

SUMMARY OF PROBLEM

As is evident by its October 21, 1991 Financial Management Advisory Report (MAR) on financial arrangements between hospitals and hospital-based physicians, the OIG has long been concerned about practices between these parties that may violate the Medicare and Medicaid anti-kickback statute. At that time, the OIG was particularly concerned about contracts requiring hospital-based physicians to split portions of their income with hospitals through a variety of mechanisms, such as payments for endowment funds, capital improvements, the purchase of radiology equipment, etc. The OIG pointed to a number of problems created by illegal kickbacks between hospital-based physicians and hospitals, including the fact that hospitals could award exclusive contracts to these physicians based on improper financial considerations instead of traditional considerations centering on the professional qualifications of the physician. The 1991 MAR has provided considerable guidance to the hospital industry and CMA believes that the practices so strongly condemned by the OIG in its MAR have largely abated. However, based on reports from our physician members, CMA is extremely concerned about an equally, if not more pernicious activity.

Specifically, CMA is concerned about the severe adverse consequences of coercive contracting as it relates to managed care plans and hospital-based physicians. CMA has received numerous

reports of hospitals and/or hospitals and their contracting managed care plans coercing hospital-based and other physicians into signing unfair managed care contracts as a condition of obtaining medical staff privileges. If the hospital-based physicians do not have an exclusive contract with the hospital, the hospital may exert pressure on the physicians by threatening to bring other physicians in, perhaps on an exclusive basis. If the physicians do have an exclusive agreement with the hospital, the physicians are nonetheless particularly vulnerable to coercion because their contracts with the hospital can often be cancelled for no cause and/or on short notice. These physicians frequently have no outside source of income to fall back on. In either case, this type of coercion, whether direct or indirect, significantly affects both physician professional decision-making and medical staff accountability, threatening quality of care, defeating patient choice, and jeopardizing the goals of the Medicare program.

PROPOSED SOLUTION

CMA believes that there is a clear need for the OIG to issue a direct statement to the hospital and managed care industry that it is illegal to threaten, directly or indirectly, hospital-based or other medical staff providers with the loss of their medical staff contracts/privileges in order to get these physicians to accept managed care contracts which they otherwise would have rejected. Further, CMA believes that the OIG, either through regulations, or through its legislative efforts, should provide broad whistleblower protection to physicians and other health care providers so they are able to come to the OIG freely, without fear of retaliation, and report directly to the OIG those and other suspect and coercive arrangements they have been presented with. With broad anti-retaliation and confidentiality protections, health care providers will be in a better position to express their concerns and provide more concrete examples of abusive practices so that the OIG can fulfill its mission of protecting the Medicare program.

BACKGROUND

A. Medical Staff Privileges Are Vitrally Important To A Physician's Ability To Practice Medicine As Well As To The Provision of Quality Of Care Provided Throughout The Hospital Generally

Membership on a medical staff affords important advantages on both an individual and on a societal level. First, staff privileges are a prerequisite for a physician or other health care provider to admit patients to a hospital and provide health care services there. See *Illinois Association v. Falk* (N.D. Ill. 1986) 638 F.Supp. 876, 877 (only persons on the medical staff may admit patients, order medical treatment, and vote on hospital policies); see also *Capp v. Rank* (1990) 51 Cal.3d 1 (a hospital that admits clinical psychologists to its staff may permit such psychologists to take primary responsibility for the admission, diagnosis and treatment and discharge of their patients); see also Joint Commission on Hospital Accreditation Standards (2002) M.S. 6 ("Individuals who admit patients are granted specific privileges to do so."); M.S. 6.5.1 (management of a patient's general medical condition is the responsibility of a qualified physician member of the medical staff). See also 22 C.C.R. §70703 (each physician member of the medical staff is morally, ethically, and legally vested with primary responsibility for the medical treatment of every patient that the physician admits). Under these circumstances, physicians must have privileges to be able to provide their patients services at the hospital. Without privileges, neither physicians nor their patients that wish to remain within their physicians' care have access to the hospital. Further, patients who are unwilling or unable to travel to a hospital where their physician retains his or her privileges, will be forced to find another physician. The impact will be particularly severe when the hospital is the only one in the

area, or when, due to the existence of various Medicaid, Medicare, HMO or PPO contracts, it is the only hospital in the area in which the patient can afford to receive care.

Because of the importance of the privileging decisions on a physician's ability to care for patients at a hospital, and thus pursue his/her profession, it is well settled under California law that, before an organization which affects important economic interests of its members (such as a hospital) may exclude a member, the exclusion must be based on substantive rationality, following fair procedures. See, e.g., *Anton v. Board of Directors of San Antonio Community Hospital* (1977) 19 Cal.3d 802, 140 Cal.Rptr. 442; *Ascherman v. St. Francis Memorial Hospital* (1975) 45 Cal.App.3d 509, 119 Cal.Rptr. 507; *Miller v. Eisenhower Medical Center* (1980) 27 Cal.3d 514, 166 Cal.Rptr. 826; *Volpicelli v. Jared Sydney Torrance Memorial Hospital* (1980) 109 Cal.App.3d 242, 167 Cal.Rptr. 610. See also *Pinsker v. Pacific Coast Society of Orthopedists (Pinsker I)* (1969) 1 Cal.3d 160; *Pinsker v. Pacific Coast Society of Orthodontists (Pinsker II)* (1974) 12 Cal.3d 531, and *Ezekial v. Winkley* (1977) 20 Cal.3d 267.

Further, federal law recognizes that given the importance of the credentialing process to a physician's livelihood, it must be done fairly. The federal Health Care Quality Improvement Act¹ ("HCQIA") provides a significant immunity for the "professional review bodies" of certain health care entities, and to specified persons involved in the peer review/credentialing process.² The HCQIA immunity operates to protect the entity and persons performing peer review/credentialing from liability for money damages arising out of a peer review action, *but only if* the peer review action complies with four "fairness standards" enumerated in the HCQIA. Generally speaking, compliance with these standards requires that the review action be taken "in the reasonable belief that [it] was in the furtherance of quality health care."³

Failure to meet the HCQIA standards for peer review does not per se constitute a violation of the law. HCQIA simply provides that the federal immunity for peer review activities does not apply if the "reasonableness" standards are not met. Because the HCQIA immunity may be the only immunity available in federal court cases arising out of peer review activities, however, loss of the immunity for failure to conduct peer review in conformity with the four HCQIA "fairness standards" can run the risk of significant liability exposure. Nonetheless, HCQIA and the cases interpreting it underscore the fact that medical staff privileging decisions carry significant professional and economic ramifications and thus must be done fairly and for proper purposes. See *Bryan v. James E. Holmes Regional Medical Center* (11th Cir. 1994) 33 F.3d 1318, 1333; *Austin v. McNamara* (9th Cir. 1992) 979 F.2d 728, 734. See also *Islami v. Covenant Medical Center* (N.D. Iowa 1992) 822 F.Supp. 1361 (participants in professional review action not entitled to immunity as matter of law because plaintiff presented sufficient evidence for a jury to conclude review participants did not provide plaintiff with fair and adequate process); *Brown v. Presbyterian Healthcare Services* (10th Cir. 1996) 101 F.3d 1324 (peer review panel's review of only two of physician's charts prior to revocation of privileges provides sufficient evidence reasonable jury would find, by preponderance of evidence, that peer review action was not taken

¹42 U.S.C. §§11101 *et seq.*

²42 U.S.C. §11111(a)(1). The HCQIA also requires peer review bodies to make reports to the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank.

³*Patrick v. Burget* (1988) 486 U.S. 94, 105 n. 8, 100 L.Ed.2d 83.

after “reasonable efforts to obtain the facts of the matter” under the HCQIA fairness standard no. 2).

Second, medical staff membership gives the physician an important voice in the operation of a hospital. According to federal Medicare law, each hospital must have an organized self-governing medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. See 42 C.F.R. §482.12. See also Joint Commission Standards, M.S. 1 through M.S. 6. To ensure that patients receive competent care, the law and public policy recognize that only those with appropriate medical or scientific knowledge and training have the ability to establish standards of care and to measure a practice by those standards. Thus, the medical staff is accountable to the governing body for the quality of care provided to patients. See also 22 C.C.R. §70703.

To that end, medical staffs, composed of individual health care practitioners, are vested with a number of important responsibilities for quality patient care, including, but not limited to, establishment of patient care standards and establishment and enforcement of criteria and standards for medical staff membership. Under these circumstances, an individual’s medical staff membership through an organized self-governing medical staff provides a physician with a vehicle to improve quality of care in the operation of a hospital which transcend the individual’s interest in providing care to his or her patients.

B. Credentialing Decisions Must Not Be Predicated Solely On Economic Decisions

An organized self-governing medical staff’s credentialing process determines competency of an individual physician to obtain medical staff privileges. See 42 C.F.R. §482.12(a)(3) (medical staffs must ensure the criteria for selection are individual character, competence, training, experience, and judgment). Through this professional evaluation of medical staff applicants and re-applicants, credentials, licensure, training and other certification is verified and the outcomes of ongoing review of clinical performance and professional competence are evaluated. The medical staff plays a key role in the credentialing process to ensure that physicians on the staff are competent and capable of rendering quality care. Neither the law nor public policy condone credentialing decisions based solely on economic considerations.

To protect the integrity of the credentialing and peer review process and to assure high quality patient care, decisions to grant or terminate clinical privileges should not be based on economic considerations that do not legitimately relate to a professional’s competence. When economic criteria, such as whether a physician has entered into a managed care contract advantageous to a hospital’s bottom line, take the place of a valid basis for granting privileges, such as the licensure, education and expertise of an individual physician, both patient welfare and physician rights are compromised.

Granting privileges on the basis of whether a physician has entered into a particular managed care contract constitutes “economic credentialing.” CMA defines “economic credentialing” as the use of economic criteria, unrelated to quality assurance, to determine a physician’s qualification for the granting or renewal of medical staff membership or privileges.⁴ Economic credentialing is used to enhance a hospital’s profitability by seeking to grant membership to physicians whose practices increase hospital profits and in the traditional sense, include a broad range of specific criteria, such as the physician’s average length of stay, number of ICU days, number of tests ordered, etc. At issue here is a newer, more subtle form of economic

⁴A true and correct copy of CMA’s policy statement on economic credentialing and exclusive contracts is attached hereto as Exhibit “A.”

credentialing—credentialing only those physicians who enter into contracts with managed care plans that may financially benefit the hospital, through increased patient numbers and/or reimbursement. This activity is illegal under California law and, as discussed below, constitutes a violation of the federal anti-kickback law.

Because of the detrimental effect of economic credentialing on patients, the use of standards having no demonstrable nexus to the ability to provide quality care has been ruled unreasonable by California courts.⁵ In the absence of affecting the quality of care physicians provide their patients in the hospital, the use of strictly economic criteria to exclude a physician or group of physicians from a hospital can be challenged as arbitrary and irrational.⁶

Hospitals which grant or deny clinical privileges on economic grounds may jeopardize their Medi-Cal (Medicaid) funding status, due to the statutory requirement that “(a) hospital contracting with the Medi-Cal program . . . shall not deny medical staff membership or clinical privileges for reasons other than a physician’s individual qualifications as determined by professional and ethical criteria, uniformly applied to all medical staff applicants and members.”⁷ In addition, credentialing on the basis of a provider’s contract with a managed care plan may even risk loss of a hospital’s license. Health & Safety Code §1322 provides:

A hospital which contracts with an insurer, non-profit hospital service plan, or health care service plan shall not determine or condition medical staff membership or clinical privileges upon the basis of a physician’s and surgeon’s or podiatrist’s participation or non-participation in a contract with that insurer, hospital service plan, or health care service plan.

Thus, California law categorically condemns instances where hospitals attempt to coerce physicians into contracting with managed care organizations.

Further, medical staffs that permit economic considerations to enter credentialing and disciplinary deliberations may be sacrificing the legal protections granting them immunity for

⁵*Miller v. Eisenhower Med. Ctr.* (1980) 27 Cal.3d 614, 166 Cal.Rptr. 826.

⁶*See Bergeron v. Desert Hospital* (1990) 221 Cal.App.3d 146, 270 Cal.Rptr. 397. In *Bergeron*, the court ruled that physicians have a “property” interest in being on the emergency room call roster and that, therefore, a physician may not have his or her participation on that roster suspended or otherwise restricted except pursuant to the procedures set forth in the medical staff bylaws. This case severely limits the ability of the hospital to unilaterally sanction individual physicians for economic reasons. *Also see Anton v. San Antonio Comm. Hosp.* (1977) 19 Cal.3d 802, 823, 140 Cal.Rptr. 442, in which the California Supreme Court, found: “The essential nature of a qualified physician’s right to use the facilities of a hospital is a property interest which directly relates to the pursuit of livelihood.”

⁷Welfare & Institutions Code §14087.28.

peer review activities under California's peer review immunity statutes, Civil Code §43.7,⁸ Evidence Code §1157,⁹ and Civil Code §43.8.¹⁰

Finally, the federal Health Care Quality Improvement Act adamantly prohibits the application of its immunity provisions for peer review for any consideration other than “conduct [that] affects or could affect adversely the health or welfare of a patient.”¹¹ Peer review based on, or primarily based on, any matter that does not relate to the competence or professional conduct of the physician does not qualify for the federal immunity. (42 U.S.C. §11151(9)(E).)

LEGAL DISCUSSION

A. Medical Staff Privileges Constitute Remuneration For The Purposes Of The Federal Medicare And Medicaid Kickback Laws

As discussed above, medical staff privileges constitute “remuneration” for the purposes of the federal kickback laws. While this is true for physicians generally, it is particularly true in the context of hospital-based physicians. Typically, hospitals select only one group of such physicians to provide services at a given facility, and these physicians receive all of their referrals for services to be provided at the hospital from that facility. Hence, by selecting a group of hospital-based physicians that will be the recipients of the hospital’s business, the hospital indirectly controls all the referrals to those physicians. The OIG has recognized this in its MAR discussed above, as well as in its Advisory Opinion 97-5 (stating “Hospitals are in a position to influence the flow of radiology work performed at the hospital because the hospital controls to whom radiologic interpretations are referred).

42 U.S.C. §1320a-7b(b)(1)-(2) prohibits any type of “remuneration” in return for referrals, whether “directly or indirectly, overtly or covertly, in cash or in kind.” The meaning of the term “remuneration” has been broadly interpreted to encompass almost anything of value.

⁸Civil Code §43.7. The basic immunity granted to the process of evaluating medical staff members and applicants is a protection granted “any member of any peer review committee whose purpose is to review the quality of medical, dental, dietetic, chiropractic, optometric, acupuncture or veterinary services rendered...for any act or proceeding undertaken or performed in reviewing the quality” of those services as long as the committee, professional society or hospital board members act without malice, make a reasonable effort to obtain the facts of the matter in which the action is taken, and acts in the belief that the action taken was reasonable given the facts obtained.

⁹Evidence Code §1157. The prohibition on discovery and compelled testimony regarding medical staff records and proceedings pertains only to those committees having “the responsibility of evaluation and improvement of the quality of care rendered in the hospital...”

¹⁰Civil Code §43.8. Communications provided to such committees are protected to the extent that they are “intended to aid in the evaluations of the quality, fitness, character...of a practitioner....”

¹¹42 U.S.C. §11151(9).

As originally enacted, this provision prohibited only those arrangements that involved either a kickback or a bribe. However, in 1977 the statute was expanded to prohibit not only direct kickbacks and bribes, but any remuneration paid or received in return for referrals.

United States v. Greber (3d Cir. 1985) 760 F.2d 68 is one of the seminal cases addressing the meaning of remuneration. There, a cardiologist appealed his criminal conviction under the anti-kickback statute. Dr. Greber owned a company that provided diagnostic services to other physicians' patients. He billed Medicare directly and forwarded an "interpretation fee" to the referring physician for consultation for services in reporting test results to the patients. In defense of his anti-kickback prosecution, Dr. Greber contended that compensating a physician for services actually rendered could not violate the statute. The court disagreed, noting that even if the physician performs some services for the money received, there was an unnecessary drain on the Medicare system and that the statute was aimed at the inducement factor. According to the court:

"The text refers to any remuneration." That includes not only sums for which no actual service was performed, but also those amounts for which some professional time was expended. "Remunerates" is defined as "to pay an equivalent for service." *Webster 3rd New International Dictionary*, (1996).

By including such items as kickbacks and bribes, the statute expands "remuneration" to cover situations where no services were performed. That a particular payment was a remuneration (which implies that a service was rendered) rather than a kickback, does not foreclose the possibility that a violation nevertheless could exist. (*Id.* at 71-72.)

The Ninth Circuit has adopted the *Greber* court's interpretation. See *United States v. Katz* (9th Cir. 1989) 871 F.2d 102.

Your office has followed the trend of the courts to interpret the term "remuneration" broadly to encompass virtually anything that benefits or could benefit either party to the transaction. Thus, for example, consistent with *Greber* and *Katz*, the OIG in Advisory Opinion 97-5 concluded that even the mere opportunity to invest in a radiology center jointly owned by a physician group and a hospital could, in certain circumstances, constitute illegal remuneration if offered in exchange for past or future referrals. More recently, the OIG Special Advisory Bulletin on offering gifts and other inducements to beneficiaries (August 2002) recognizes that the terms "remuneration" has been interpreted broadly to include anything of value, and implicitly recognizes that "any good or service has a monetary value."

From the physicians' perspective, the granting of privileges itself constitutes "remuneration" since these privileges can provide the only vehicle for these physicians to access their patients and, in the case of hospital-based physicians, are also the referral source for the patients themselves. Further, the fact that hospitals demand that physicians enter into discounted arrangements with managed care organizations so that the hospitals themselves can maintain a financial relationship with the managed care organizations similarly constitutes "remuneration" for which no safe harbor protection is available. Put another way, in return for referring patients to the hospital-based physicians, the hospital forces physicians to enter into discounted arrangements with managed care organizations that, in turn, enhance the hospital's profitability. To be sure, physicians do not enter into managed care arrangements on an arms-length basis, as a competitive market simply does not exist in California and many other states. Given the fact that approximately five health plans control nearly 90% of California's health plan market, and three plans now represent 67% of all patients, HMOs wield enormous bargaining power, leaving

physicians unable to negotiate reimbursement rates essential to provide the medically necessary care promised to enrollees by their health plans and the law. See Bodenheimer, M.D., *California's Beleaguered Physician Groups—Will They Survive?* (April 6, 2000) 32 N.Eng.J.Med. 1064. See also Robinson, *Physician Organization in California: Crisis and Opportunity* (July/August 2001) Health Affairs 81, 85, stating “Low payments, expressed most clearly in dismal per member per month capitation rates, are the proximate cause of the difficulties inflicting medical groups and IPAs in California.”

However, even with these low rates, physicians typically have no choice but to contract with health plans. Indeed, a San Francisco Superior Court judge, in an order filed on August 22, 2001, recognized the anticompetitive conditions for physicians, at least so far as Blue Cross of California is concerned, emphasizing the practical reality that physicians cannot say no:

Physicians who wish to survive economically in California participate as providers in Blue Cross' Prudent Buyer [Health] Plan (PBP), one of the fastest and largest growing preferred provider organizations in California . . .

See Order granting Plaintiff's Motion for Class Certification in *Anesthesia Care Associates Medical Group, et al. v. Blue Cross of California* (San Francisco Superior Court No. 986677). Under these circumstances, hospitals further coercing physicians into entering inadequate managed care arrangements diminishes whatever bargaining power physicians may have, and limits access of choice of medical care to the extent those physicians have the ability to say no.¹² Finally, the goals of the Medicare program will be seriously defeated if this activity is allowed to continue. To the extent that qualified and competent physicians do not enter into these contracts and hence lose the ability to maintain staff privileges, the credentialing decision would have been based on improper financial considerations as opposed to the professional qualifications as required by federal Medicare law. Medicare beneficiaries will be denied access and freedom of choice to see those very providers that might be most suitable for them. Medical staffs will lose accountability for ensuring the provision of quality of care. Individual physicians will lose their voice to advocate for improved patient care.

Further, access and quality may be compromised given the implication of other laws designed to assure independent physician medical judgment making and free competition. For example, if a hospital is entitled to base privileging determinations on pure economics, state corporate practice of medicine bars, such as California Business & Professions Code §2400, which are designed to protect physician decision-making, are interfered with to the extent the hospital is allowed to control or set the hospital-based physician fees with the managed care organizations. Finally, antitrust issues, which are equally focused on access and quality, may be implicated if a hospital and a health plan attempt to force physicians to join affiliated managed care plans. See *U.S. v. Health Care Partners, Inc.* DOJ Civ.No. 395-CVO1945 RWC (consent decree prohibiting

¹²And indeed, according to an independent 2001-2002 study commissioned by the California Health Care Foundation and conducted by researchers at the U.C.S.F. Center for Health Care Professions, California physicians are increasingly dropping out of managed care plans, with only 58% of private care physicians accepting new patients with HMO coverage. See *California Physicians 2002: Practice and Perceptions* (Dec. 2002) California Workforce Initiative. The study goes on to note that the rate of physician participation and private HMO plans is approaching the historically low rate of physician participation in Medi-Cal—the state's insurance plan for low income Californians.

hospital from exercising control over staff privileges for the purpose of reducing competition in managed care); see also *HealthAmerica Penn. Inc. et al. v. Susquehanna Health System* (M.D. Pa 2001) 142 F.Supp.2d 496 (a health care system offering physician hospital services would engage in an illegal tying arrangement by refusing to enter into hospital contract with insurance and managed care companies unless companies agreed to enter into contract for physician services with the system at super competitive prices).

Finally, the OIG should note that prohibiting the activity in question would not result in unreasonable costs to the system. To the extent physicians freely choose not to contract with a particular managed care organization, they would still be limited to the Medicare/Medicaid allowed amount for beneficiaries, and in the commercial context, to a "reasonable" fee. Cf *Gould v. WCAB* (1992) 4 Cal.App.4th 1059.

In sum, we are extremely concerned about the possible implications any time any player in the health care system uses economic considerations as a basis for granting privileges. Such as basis is improper as a matter of quality care, but raises in addition serious fraud and abuse considerations when it is coupled with coercive contracting tactics designed to force unwilling physicians into disadvantageous contracting arrangements.

Thank you again for your consideration of our comments.

Sincerely,

Catherine I. Hanson
Vice President and General Counsel
California Medical Association

CIH/plm

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Attachment 2

Coercive Contracting and Managed Care– Impact on Hospitals and Hospital Based Physicians Myles Riner, MD

The following outlines several adverse consequences of coercive contracting as it relates to managed care plans and hospital based physician practices. Coercive contracting takes many forms in hospital based physician practices, including forced participation in contracts with managed care plans, requirements to treat hospital employees for free, failure to pay fair market value for administrative and other services provided by the physician to the hospital, and other arrangements that put unfair and illegal restraints on independent contract - hospital based physician reimbursement. This outline focuses on the first practice, which involves hospital administrators who insist that contracted hospital based physician groups sign contracts with preferred managed care plans and IPAs or risk losing the group's exclusive contract to provide physician services at the hospital.

Hospital based physicians are particularly vulnerable to coercion in these situations because their contracts with the hospital can be cancelled for no cause on short notice, because these physicians frequently have no outside source of income to fall back on; and because frequently certain members of the medical staff of the hospital affiliated with the plan are willing participants in this coercion and stand to benefit financially from the coerced discounting arrangement. However, there are a number of serious drawbacks and consequences that can arise as a result of coercive contracting in this setting.

1. Anti-Kickback Statute Violations

The practice is likely to be a violation of anti-kickback statutes. In return for securing an exclusive contract to provide services at the hospital (and thus access to the hospital's patients), the hospital demands that the hospital based physician group provide services to a preferred Plan or IPA's patients at rates that are well below free market value. The hospital in turn is granted access to patients enrolled in the Plan or IPA, or receives some other form of preferential relationship with the Plan or IPA, which benefits economically from the coerced contracting arrangement. Though a bit convoluted, this arrangement meets the criteria for an illegal 'kickback for patient referral' activity. Potential penalties for any and all parties engaging in such activities include, but are not limited, exclusion from Medicare and Medicaid, loss of medical license, hefty fines, and imprisonment. Contracts for physician services that can not be negotiated in good faith because of coercion are per se more likely to involve violations of the statute. The following legal opinion was provided by Richard Kinney of Circuit, McKellogg, Kinney and Ross:

Stark II prohibits kickbacks for referring patients for designated health services which include in-patient services in the hospital. There is a Stark II proposed rule and a Stark Advisory Opinion Rule. Under these rules, the hospital is treated as referring patients to the hospital-based physicians in that the hospital arranges for the care of patients. Some comments about Stark II include:

a. Remuneration for purposes of Stark II means ". . . any payment, discount, forgiveness of debt, or other benefit that may directly or indirectly, overtly or covertly, in cash or in kind, . . ." The Health Care Financing Administration (HCFA) notes that discounts will be considered remuneration and will not meet the applicable exception unless the discount meets a fair market value standard. Consequently, unusually low discounts imposed upon physicians may be treated as a kickback benefiting the hospital. If the Hospital receives global capitation for both physician and Hospital services and then keeps a larger than justified portion of the total capitation payment for itself, or requires the hospital based physician to accept specific payment rates under a payer contract where the payer plan is affiliated with the hospital, it sounds and smells like an illegal kickback from the hospital based physician to the Hospital for the privilege of holding the emergency department contract. HCFA will require that a discount be an arm's-length transaction (i.e. determined in good faith) and offered to all similarly situated individuals, regardless of whether they make referrals to the Hospital, and that the discount not reflect the volume or value of any referrals. Further, under related rules, any discount in physician fees below a fair market discount must be passed on to Medicare or insurers. Remuneration includes payments from a physician to an entity like a hospital regardless of who profits or gains and regardless of whether any party receives a net benefit.

b. Various exceptions to the rules require that compensation paid under a contractual arrangement be consistent with fair market value. The proposed rules basically define market value of services rendered as the price paid as a result of bona fide bargaining between well-informed parties to the agreement. So the fair market price to be paid for emergency physician services would be the price generally prevailing in the market place in the particular geography of a contract. This definition appears to encompass discounts, as long as the discounts were the result of bona fide bargaining between well-informed parties and are generally available in the market place to similarly situated purchases. On the other hand, HCFA indicates the discounts can be a form of remuneration that restricts a physician's ability to refer for designated health services under the Stark law. The proposed rules also indicate that for a discount to be considered "fair market value" and, therefore, not a financial relationship under the Stark law, the discount must be passed along to the Medicare program or to the insurers.

2. Violation of the Corporate Practice of Medicine Bar

Coercive contracting may be a violation of the bar against the Corporate Practice of Medicine. Again per Mr. Kinney:

With limited exceptions for certain facilities, hospitals or other lay entities cannot practice medicine under California's corporate practice of medicine statutes. California Business & Professions Code § 650 and §2400. These rules are being actively addressed in various pending California cases. To avoid running afoul of the corporate practice of medicine bar, physician contracts with hospitals should not give the Hospital or lay entity direct or indirect rights to influence medical decisions and related aspects of the physician practices. Such control may indicate a disguised employment relationship in

violation of the law. Violations are misdemeanors and can result in loss of physician licensure. Both the physician and the Hospital are subject to the laws.

A hospital that contracts with third-party payers for physicians' services therefore is being directly paid for providing medical services is in fact practicing medicine in violation of Business & Professions Code §2400. So the physician contract with Hospital must not authorize the hospital to control physicians' fees and to enter into contracts with payers on the physician's behalf. A limited exception under California Health & Safety Code §32129 not applicable in the instant situation does permit a hospital district to set fees for professional services. A 1972 attorney general opinion concluded that an agreement between a medical director of an electroencephalography department and a hospital constituted the unlawful practice of medicine where among other provisions the physician neither set his own fees nor had any control over the receipt and collection of his fees.

Hospitals are increasingly encouraging medical staff members to join hospital ventures such as independent practice associations (IPAs), physician hospital organizations (PHOs) and management service organizations (MSOs) to improve the hospital's contracting ability and market share. Hospitals apply both subtle and not so subtle pressure on medical staff members to join hospital arrangements. Some physicians have been denied hospital-based contractual arrangements because they will not sign on managed care plans with which the hospital is affiliated. According to California Health and Safety Code Section 1322, medical staff exclusion by the hospital for this reason is illegal. This law reads:

A hospital which contracts with an insurer, nonprofit hospital service plan, or health care service plan shall not determine or condition medical staff membership or clinical privileges upon the basis of a physician's . . . participation or nonparticipation in a contract with that [plan].

3. Violation of Medical Staff Bylaws

Coercive contracting practices may violate the hospital's Medical Staff Bylaws. CMA's Model Medical Staff bylaws incorporate a provision similar to California Health and Safety Code Section 1322 by stating that:

Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or nonparticipation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts [a] hospital.

4. Service Contract Violations

Coercive contracting likely violates the contract between the hospital and the hospital based physician group.

All contracts under California law contain an implied covenant of good faith and fair dealing. Assuming that the Health and Safety Code section above does not flatly prohibit

the hospital's conduct, if the hospital threatens to terminate or not to renew the hospital-based contract because the group will not join a certain plan, this may not meet the "good faith" requirement. While a contract is in effect, each party must act in good faith in carrying the contract. This requires cooperating with the other party and honest behavior in creating and settling disputes. A contracting party may not engage in conduct with frustrates the other party's rights to the benefits of the contract. (R Kinney)

5. Anti-trust Violations

Coercive contracting may involve violations of Antitrust Laws. Per Mr. Kinney:

Antitrust issues may be implicated if a hospital and a health plan or IPA are affiliated, and the hospital is attempting to force physicians to join the affiliated managed care plans, particularly if the hospital is located in a rural area. For example, the Department of Justice entered into a consent decree with a hospital having a monopoly in in-patient care. The consent decree prohibited the hospital from exercising control over staff privileges for the purpose of reducing competition and managed care. See U.S. v. Healthcare Partners, Inc. Civ. No. 395-CV01945 RWC. The complaint was that the hospital abused its monopoly position in inpatient services to unlawfully maintain its priority and gain an unreasonable advantage in markets for outpatient services.

Both federal and California laws generally outlaw agreements which restrain trade or competition. One form of unlawful agreement is a "tying arrangement," which the United States Supreme Court described as the seller's exploitation of its control over one product to force the buyer into the purchase of another product, . . . that the buyer either did not want at all or might have preferred to purchase elsewhere on different terms. When such "forcing" is present, competition on the merits in the market for the tyded product is restrained and the Sherman Act is violated. A common example in health care law is where a physician who is a member of a PPO plan must also be a member of the related HMO plan. Tying arrangements have been held to have no pro-competitive purpose and, accordingly, are not tolerated by the courts. A physician's participation in a particular health plan should be voluntary and not due to any economic coercion. For example, physicians may not wish to enter into a contract with an HMO. Physicians may be concerned that the plan does not have adequate safeguards to insure that it does not deny or delay medically necessary services. Some plans offer capitation rates so low the physicians do not believe they can provide quality patient care for the offered rates. A tying arrangement may exist here where the seller of services (the hospital based physician group) is coerced to join a particular association (a health plan) as a condition of retaining the contract relationship with the Hospital. Price fixing has, for a long time, been a major antitrust issue that affects the formation of IPAs and other agents or parties that wish to negotiate contracts with third-party payers for physician services. This, in addition to the corporate practice reasons, is another reason why hospital based physician contracts traditionally require the physician group to separately contract payers also doing business with the hospital. This also explains why the group's contract with the hospital requires the group to negotiate with payers in good faith, at prevailing rates in the geography or some similar approach, versus the hospital imposing certain payer contract terms on the group.

6. Unintended Market Consequences

In communities where managed care plans have a high market penetration, hospital based physicians that provide services to a significant number of uninsured or under-insured patients have little ability to cost shift this burden to the insured population. EMT-ALA provisions require that hospital based (and on-call) specialists provide this care regardless of the patient's ability to pay or insurance status. When hospital based physicians are forced to provide even greater discounts to managed care plans and IPAs than might be expected in a fair market environment, the ultimate result is often an intolerable reduction in revenue that undermines the ability of the physician group to recruit and retain qualified physicians to staff the contract. These groups must compete for qualified physicians with other communities and states where the market penetration of managed care is smaller and fees for physicians' services have not been eroded. The end result of coercive contracting is a destabilization of the hospital based physician group, and ultimately a decrease in the quality of care provided to the hospital's patients.

7. Unintended Consequences for the Hospital

As hospital based physician groups fall under the sword of coercive contracting, the managed care Plan or IPA may be encouraged to extract even greater concessions from the hospital, to engage the hospital in other arrangements of questionable merit, to demand similar heavily discounted services from physicians whose practices are performed primarily in the hospital (trauma surgeons, interventional cardiologists, intensivists, etc), and to gain unfair and noncompetitive advantage over other Plans or IPAs that do not have as much clout with the hospital administrator. Managed care plans that exercise this kind of market control lower the reimbursement bar for not only key members of the medical staff who bring in much of the hospital's revenue, but for the hospital itself.

CAPG's Bogus Survey of ER Physician Charges

No independent or objective third party auditor

participation from 13 medical groups out 400 (less than 3% participation

states "claims data covering approximately 1million commercial lives were collected and analyzed, detailed information on 35,600 claims: but reported only on 4, 324 claims

report made on the "ten most frequently performed services in the emergency department."

3 of CAPG's 10 most common emergency department codes (Echo of Heart, Left Heart Catherization, and In Patient Consultation) are not services performed in the ED at all.

Data manipulation to support their erroneous conclusions?

Attachment 4 (CAL/ACEP survey compared to Ingenix Database)

Comparing ER physician charges to other physician charges

	Ingenix survey	CAL/ACEP survey
Code 12001	Surg Repair Wound	
50th percentile	\$255	\$183
75th percentile	\$282	\$260
95th percentile	\$327	\$318
Code 12052	Layer Closure Wound	
50th percentile	\$379	\$359
75th percentile	\$443	\$441
95th percentile	\$584	\$557
Code 24640	Treat Elbow Dislocation	
50th percentile	\$249	\$271
75th percentile	\$317	\$272
95th percentile	\$477	\$311
Code 29105	Apply Long Arm Splint	
50th percentile	\$99	\$122
75th percentile	\$143	\$140
95th percentile	\$207	\$193

	Ingenix survey	CAL/ACEP survey
Code 12001	Surg Repair Wound	
50th percentile	\$255	\$183
75th percentile	\$282	\$260
95th percentile	\$327	\$318
Code 12052	Layer Closure Wound	
50th percentile	\$379	\$359
75th percentile	\$443	\$441
95th percentile	\$584	\$557
Code 24640	Treat Elbow Dislocation	
50th percentile	\$249	\$271
75th percentile	\$317	\$272
95th percentile	\$477	\$311
Code 29105	Apply Long Arm Splint	
50th percentile	\$99	\$122
75th percentile	\$143	\$140
95th percentile	\$207	\$193

Attachment 5 (CAL/ACEP Compared to Ingenix Database)

DESCRIPTION	CODES	Comparison of CAL ACEP survey to 50% of Ingenix	Comparison of CAL ACEP survey to 75% of Ingenix
EMERGENCY PHYSICIAN SERVICE	99281	84%	83%
EMERGENCY PHYSICIAN SERVICE	99282	92%	92%
EMERGENCY PHYSICIAN SERVICE	99283	103%	101%
EMERGENCY PHYSICIAN SERVICE	99284	109%	105%
EMERGENCY PHYSICIAN SERVICE	99285	107%	102%
CRITICAL CARE	99291	137%	116%
I & D ABSCESS/CYST	10060	155%	241%
I & D ABSCESS/CYST	10061	106%	100%
SURGICAL REPAIR WOUND	12001	99%	111%
SURGICAL REPAIR WOUND	12002	99%	113%
SURGICAL REPAIR WOUND	12004	98%	107%
SURGICAL REPAIR WOUND	12011	88%	104%
SURGICAL REPAIR WOUND	12013	99%	102%
LAYER CLOSURE WOUND	12052	100%	100%
TREATMENT OF BURN	16020	98%	97%
TREAT ELBOW DISLOCATION	24640	104%	87%
TREAT DISTAL RADIAL FRACTURE	25600	86%	80%
TREAT METACARPAL FRACTURE	26600	91%	77%
TREAT FINGER FRACTURE	26720	99%	81%
TREAT METATARSAL FRACTURE	28470	113%	91%
TREAT TOE FRACTURE	28510	119%	121%
APPLY LONG ARM SPLINT	29105	105%	99%
APPLY FOREARM SPLINT	29125	90%	89%
APPLY FINGER SPLINT	29130	88%	95%
APPLY LOWER LEG SPLINT	29515	100%	95%
CONTROL NOSEBLEED	30901	103%	102%
CONTROL NOSEBLEED	30903	98%	98%
TRACHEAL INTUBATION	31500	96%	92%
BLOOD TRANSFUSION	36430	93%	88%
INSERT IV CATHETER	36489		
LUMBAR PUNCTURE	62270	82%	80%
NERVE BLOCK	64450	56%	48%
INTERPRET X-RAY SKULL	70250	85%	101%
INTERPRET X-RAY CHEST	71010	83%	93%
INTERPRET X-RAY CLAVICLE	73000	72%	94%
INTERPRET X-RAY ANKLE	73600	88%	81%
INTERPRET X-RAY ABDOMEN	74000	82%	83%
INTERPRET X-RAY ABDOMINAL SERIES	74022	90%	125%
IV INFUSION THERAPY	90780	94%	91%
N/GASTRIC ASP LAVAGE	91105*	360%	348%
CPR	92950	130%	120%
ECG INTERPRETATION	93010	154%	123%
ECG RHYTHM INTERPRETATION	93042	103%	104%
EVALUATE BRONCHOSPASM	94060	142%	146%
NONINVASIVE PULSE OXIMETRY	94760	69%	94%
NIGHT SERVICE	99052	56%	61%
SUNDAY/HOLIDAY SERVICE	99054	56%	61%
CONSCIOUS SEDATION	99141	127%	123%
CONSULTATION	99252	85%	97%
CONSULTATION	99253	102%	111%
CRITICAL CARE ADD'L 30 MIN. Services between 10P-8am (24 Hr. Facility) Vaginal Delivery (only)	99292	129%	116%

red = lower than black = higher than

* probably miscoded by responders to Ingenix as simple NG tube insertion, whereas in ED this is NG lavage for overdose

Attachment 6

Received: 20 Jul 2006 20:10:37

From: "Donohue, Kevin" <kdonohue@dmhc.ca.gov>

To: <mwagoner@calacep.org>, <iedwards@emergentmed.com>

Cc: "Myles Riner, M.D." <mriner@inreach.com>,
"Ehnes, Cindy" <CEhnes@dmhc.ca.gov>,
"Bechtold, Steven" <sbechtold@dmhc.ca.gov>,
"Dobberteen, Amy" <ADobberteen@dmhc.ca.gov>

Hi Irv:

Here is an update on your inquiry:

1. Health Net non payments of EKG and X-ray interps. In April of this year Mr. Bechtold informed me that our case had been completed and that our argument was correct and that he would forward his report and recommendation to his superiors for a final decision. We have heard nothing.

The Department's enforcement division has made a preliminary determination that HN's payment policies are NOT consistent with CMS' payment guidelines. HN has indicated that its payment policies result in better payments to the provider than would be received from CMS. We have questioned this representation and have provided HN an opportunity to demonstrate that its payment policies are consistent with other recognized national standards. We are also in discussion with HN to change its payment policies to conform to CMS payment policies on a going forward basis. We anticipate that HN will respond by the end of July. At that point, a decision will be made whether the issue can be resolved through voluntary action or whether a formal complaint will be issued.

2. Blue Shield. You, Andy Selesnick and I had a conference call about the date that payments would be retroactive and you stated that a fine was in order although the amount had not been determined. Since that time we have heard nothing and I believe we last spoke of this over 60 days ago.

The Department is in active enforcement mode with BS. As you are aware, the Department has required and confirmed that BS has implemented corrective action so emergency service providers are being reimbursed directly by the plan. BS has already retroactively paid affected ER claims for services back to February. The Department is in the middle of settlement discussion with BS concerning this issue. We anticipate a resolution within the next 30 days. In view of the sensitive nature of these discussions, I cannot provide any greater detail without jeopardizing the Department's position.

3. Blue Cross low payments. I believe we filed this complaint in February with compelling proof that Blue Cross paid a mere fraction of all other health plans. As I recall you were waiting for their response and we have never heard any updates on this matter.

Staff has reviewed the information that you sent comparing BC payments to Kaiser's reimbursement levels for non-contracted provider services. Since you have been actively participating in the "Reasonable & Customary" executive meetings and the meetings to establish an IDR process, you are aware of the continuing struggle to determine a satisfactory way to calculate the reasonable and customary value of non-contracted services that results in fair payment to the providers but does not disrupt California's health care delivery system. When we review the documentation you provided, BCC payments were not so dissimilar to Kaiser's reimbursement to allow us to conclude that BCC's reimbursements result in a "demonstrable and unfair payment pattern." If we compare the BCC payments to Medicare or the plan's average contract rates, the reimbursements appear to exceed 110% of those two figures. We were also able to determine that non-contracted provider charges often exceed 250% of Medicare well above typical contract rates. Until we are able to secure more stakeholder consensus on the appropriate weighing of the Gould factors or establish an IDR process to make specific payment determination, it would be very difficult to successfully establish in court that the plan has violated the Knox-Keene Act. As you are aware two recent California appellate courts confirm that both the health plan and the providers have standing to resolve their claims payment in a court of law. This is an avenue we encourage all parties to use to address these payment issues.

To date, we have hesitated to totally close out provider complaints relating to the reasonable and

customary value of non-contracted provider claims, hoping that we could achieve a break through for more specificity for implementing the Gould criteria that could potentially result in the re-adjudication of at least a portion of these disputed claims. Unfortunately, stakeholder consensus has alluded all of our diligent efforts.

4. I believe CEP and Myles also filed a complaint about a Group in Northern CA. I do not believe that any response has been received on this matter either.
Payment Unexecuted contracted not 110% Medicare studying this issues

We are still studying this issue, but we have determined that while the medical group did elect to reimburse CEP at the unexecuted contract rate, that rate was in excess of the payments it would have made CEP under its reasonable and customary methodology. As such, the provider was in a better position that if the medical group paid under it currently filed methodology. As discussed above, the specificity for the payment methodology of non-contracted providers is not sufficiently clear to allow the Department to successfully challenge a payment methodology as resulting in a "demonstrable and unfair payment pattern" where the medical groups payment results in the payment of non-contracted provider claims in excess of 110% of the payer's average contract rates and 110% of current Medicare reimbursement rates.

I understand your concern that you have not heard frequently enough from the PCU unit on the status of current claims. But as you will recall, the Department just recently receive authorization to hire additional personnel to staff the PCU unit. We are in the process of interviewing and hiring staff. Once we are fully staffed, the Unit will implement a practice to send a short status/update to the provider approximately every 45 days. I am hopefully we can implement this additional service for providers by September 1, 2006.

If you have any other questions, please feel free to give me a call.

Kevin F. Donohue

Kevin F. Donohue
Deputy Director
Department of Managed Health Care
Office of the Director
980 9th Street, Ste. 500
Sacramento, CA 95814
Phone: 916-445-9753
Fax: 916-322-2533

Attachment 7

ED Director Survey
 Response Status: Completes
 Filter: No filter applied
 Sep 01, 2006 03:05 PM PST

An executive order by the governor directs the Department of Managed Health Care (DMHC) to change the way that emergency physicians, and possibly on-call physicians and hospitals, bill for services to health plans. The CAL/ACEP executive committee calculates that this change might lead to a shift of \$200 million dollars from emergency physicians to health plans; and that the impact on each EM physician in the state could be as much as \$60 thousand dollars or more per year in lost income. This would be the worst-case scenario. In the best-case scenario, the result would likely be at least some restraint on the future market for emergency physician services in California. Faced with these possible impacts, how would this affect your professional plans?

Indicate THE statement that BEST reflects your inclinations, for the worst-case, and the best-case scenarios.

1. Worst case scenario:

I would strongly consider leaving California to practice in another state with higher reimbursement and lower housing costs.	50	33%
I would strongly consider switching careers to another field of medicine.	10	7%
I would strongly consider retirement from medicine altogether within the next 24 months.	33	22%
I would support efforts at my Emergency Department to cut hours of physician coverage in order to prevent significant cuts in our income, even if these service cuts would increase patient waiting times, aggravate hospital overcrowding, increase ambulance diversion and negatively impact patient satisfaction	38	25%
I would likely continue to practice emergency medicine in California regardless.	21	14%
Total	152	100%

2. Best Case Scenario

I would consider leaving California to practice in another state with higher reimbursement and lower housing costs.	19	13%
I would consider switching careers to another field of medicine.	14	9%
I would consider retirement from medicine altogether within the next 24 months	10	7%
I would support efforts at my Emergency Department to cut hours of physician coverage in order to prevent significant cuts in our income, even if these service cuts would increase patient waiting times, aggravate hospital overcrowding, increase ambulance diversion and negatively impact patient satisfaction	47	31%
I would likely continue to practice emergency medicine in California regardless.	61	40%
Total	151	100%

Attachment 8

ED Staff Physician Survey
 Response Status: Completes
 Filter: No filter applied
 Sep 01, 2006 03:00 PM PST

An executive order by the governor directs the Department of Managed Health Care (DMHC) to change the way that emergency physicians, and possibly on-call physicians and hospitals, bill for services to health plans. The CAL/ACEP executive committee calculates that this change might lead to a shift of \$200 million dollars from emergency physicians to health plans; and that the impact on each EM physician in the state could be as much as \$60 thousand dollars or more per year in lost income. This would be the worst-case scenario. In the best-case scenario, the result would likely be at least some restraint on the future market for emergency physician services in California. Faced with these possible impacts, how would this affect your professional plans?

Indicate THE statement that BEST reflects your inclinations, for the worst-case, and the best-case scenarios.

1. Worst case scenario:

I would strongly consider leaving California to practice in another state with higher reimbursement and lower housing costs.	242	60%
I would strongly consider switching careers to another field of medicine.	35	9%
I would strongly consider retirement from medicine altogether within the next 24 months.	70	17%
I would likely continue to practice emergency medicine in California regardless.	55	14%
Total	402	100%

2. Best Case Scenario

I would consider leaving California to practice in another state with higher reimbursement and lower housing costs.	116	29%
I would consider switching careers to another field of medicine.	41	10%
I would consider retirement from medicine altogether within the next 24 months	47	12%
I would likely continue to practice emergency medicine in California regardless.	197	49%
Total	401	100%

Attachment 9

Emergency Medicine Resident Survey
 Response Status: Completes
 Filter: No filter applied
 Sep 01, 2006 03:03 PM PST

Note: Open ended responses are not displayed in Excel exports.

1. Select the statement that best applies to you:		
I am planning to stay in California to practice emergency medicine and would certainly stay in California if I can find a good position.	54	66%
consider moving to another state to practice emergency medicine if I identify a good employment opportunity out of state.	24	29%
I am planning on leaving California and looking hard for out of state opportunities.	4	5%
Total	82	100%

2. An executive order by the Governor directs the Department of Managed Health Care (DMHC) to change the way that emergency physicians, and possibly on-call physicians and hospitals, bill for services to health plans. The CAL/ACEP executive committee calculates that this change might lead to a shift of \$200 million dollars from emergency physicians to health plans, depending on how this works out; and that the impact on each EM physician in the state could be as much as \$60 thousand dollars or more per year in lost income. If this were to be the impact of this change, how would this affect your professional plans? Select the statement that best applies to you:		
A decrease in potential income would not change my mind. I still plan to focus my efforts on finding a position in California.	21	26%
A further drop in emergency physician incomes in California will definitely change the equation for me and greatly increase the likelihood that I will leave the state to practice.	58	71%
I am planning on leaving California and looking hard for out of state opportunities.	3	4%
Total	82	100%

Attachment 10

**Calculation of Potential Financial Impact of DMHC Regulations on
Emergency Physician Income**

**Average per claim ER physician revenue for contracted
and non-contracted Knox-Keene related claims*:** **\$260**
times 1.6 million claims per year = \$280 x 1.6 M = **\$416 M**

**Estimated per claim ER physician revenue for contracted
And non-contracted Knox-Keene related claim
based on 110% of Medicare rates**** **\$132**
times 1.6 million claims per year = \$132 x 1.6 M = **\$211 M**

Estimated revenue loss to emergency physicians per year; **\$205 M**
Estimated percentage of revenue retained as income: **75%**
(covers billing, malpractice, and overhead)

Estimated number of FTE ER physicians in California **2300**
Estimated income loss per emergency physician
(\$205 M x .75) / 2300 = **\$66,800**

* based on survey of several ER physician billers

** based on CAL/ACEP fee survey and Medicare fee schedule
and average charge of \$350

From The Field

Emergency Care In California: Robust Capacity Or Busted Access?

Californians should not expect their emergency care system to work as it should, as long as so many people remain uninsured.

by W. Wesley Fields

ABSTRACT: Licensed emergency department (ED) capacity is a static measure that is inadequate to evaluate a system that the public and policymakers expect to respond dynamically to individual patients in a timely manner. Government mandates on hospital-based providers, undersupply of trained and willing personnel, and private market imperatives all curtail the functional capacity of the emergency care system. Although most Californians still live within a few miles of the closest hospital, many ambulance patients are diverted much further because of ED crowding. Many ambulatory patients are delayed so long in waiting rooms that they return home without ever being seen.

Where licensed emergency department (ED) bed capacity predictive of the industry's ability to meet the needs of Californians for acute care, the analysis of Glenn Melnick and colleagues would be cause for celebration.¹ Unfortunately, static measures are inadequate to evaluate a system that both the public and policymakers expect to respond dynamically to individual patients who need immediate access to a vast array of resources in every corner of the state at any given moment. Multiple trends not addressed by the authors suggest that the system is far from robust and, without resolution of inherent conflicts between regulators, providers, and payers, destined to collapse no later than California's next large-scale demand for "surge capacity" following a natural or man-made disaster.

Crowding factor. The U.S. General Accounting Office (GAO) provided an analysis in 2003 of ED crowding, a more dynamic measure of functional system capacity.² The GAO report affirmed that crowding is a multifactorial problem that reached historic levels in the new millennium, and it found that the single most

common variable linked to capacity was the growing problem of “boarding” patients who were already screened and stabilized by emergency staff until inpatient beds were available.

When EDs saturate because of patients waiting for beds and nurses to become available on

Attachment 12

Stretched Thin

Growing Gaps in California’s Emergency Room Backup System

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Section I: Defining the Scope of the Issue

Extent of the On-Call Coverage Problem in California

Historically hospitals have had few problems ensuring backup coverage for their emergency departments. Physician specialists provided on-call services as a way of building their practices, and hospitals either required physicians to be available on call as a condition of hospital privileges or relied on voluntary participation in call panels.

Today, physician specialists are either in short supply or are eliminating or reducing their participation in ER call panels. They do this by forgoing hospital privileges, restricting their scope of practice, resigning from medical groups that accept on-call coverage responsibility, or simply refusing to sign up for ER call rosters.

As recently as 1998, more than half of all hospitals in California were relying on mandatory call requirements. According to some estimates, that percentage may now be closer to one-third.¹³ In addition, even where mandatory call requirements exist, hospitals reportedly have difficulty enforcing them. According to EMTALA experts in Los Angeles County, in some cases hospitals do not even bother to call physicians who are designated as being on call before transferring patients to other hospitals because they assume the physicians won't respond, particularly for uninsured patients. In some cases, these transfers result in citations against the transferring hospitals.¹⁴

In a 1998 survey, 18 percent of hospital administrators, emergency department directors, and medical staff chiefs ranked lack of on-call physician backup as a

¹³ "On Call But Not Replying: Physician Specialists Increasingly Refuse to Drop What They Are Doing to Care for Strangers in Emergency Rooms," Los Angeles Times, December 29, 2001.

¹⁴ Mindel Spiegel, M.D., DHS hospital licensing consultant, personal communication, July 2001.

very serious problem for their emergency departments and 42 percent indicated it was a somewhat serious problem.¹⁵

Sixty-eight percent of hospital administrators rated the on-call coverage problem as very serious or somewhat serious compared to 63 percent of medical staff chiefs and 49 percent of emergency department directors.

Generally, community hospitals with basic emergency departments reported the greatest problems, particularly those serving high numbers of uninsured and Medi-Cal patients. Teaching hospitals, county hospitals, and community hospitals with standby emergency departments generally report somewhat fewer problems.¹⁶

A high percentage of hospitals also report difficulty in transferring patients to other hospitals when they don't have the specialists to see them. For example, according to a 2001 survey, 67.1 percent of ER physicians report that they encounter problems transferring patients to higher-level-of-care hospitals, mostly due to the lack of accepting physician specialists (48.9 percent) and lack of nursing capacity at receiving hospitals.¹⁷

According to the 1998 survey, the leading reasons for the problems with on-call coverage are:

- ◆ Physicians do not equate hospital privileges with a duty to assist their hospital in fulfilling its public service responsibilities.
- ◆ Lack of adequate payment, or no payment for such services under managed care.
- ◆ Physicians resent not being paid for ER call, especially when they compare their incomes with the profits and salaries of corporate executives.
- ◆ Physicians' goals and outlooks in general have changed: in years past physicians were willing to make sacrifices to serve in emergency departments as a way of building their practices. With managed care penetration at current levels, such service is not as relevant to practice growth.

¹⁵ "Potential Solutions to the Lack of Physician Back-up in Hospital Emergency Departments," *op. cit.*

¹⁶ *Ibid.*

¹⁷ UC-Irvine Medical Center Division of Emergency Medicine, unpublished survey results, 2001.

According to the survey, specialties facing the greatest gaps in ER care include neurosurgery; neurology; ear, nose, and throat specialists; thoracic and vascular surgery; and psychiatry.¹⁸ According to a more recent survey, the seven specialties in which the greatest proportion of ERs report trouble with specialty response are plastic surgery (37.5 percent), ENT (35.9 percent), dentistry (34.9 percent), psychiatry (35.6 percent), neurosurgery (22.9 percent), ophthalmology (18.4 percent), and orthopedics (18.0 percent).¹⁹

Nearly 64 percent of emergency physicians responding to the more recent survey indicated that a lack of patient insurance had a negative effect on the willingness of on-call physicians to provide care for at least a quarter of their patients and over 80 percent reported that problems with insurance status did impair the willingness of specialists to provide follow-up care at least to some degree.

Impact of On-Call Coverage Problem

Problems with on-call coverage contribute to delays in care and significant unreimbursed costs to hospitals and patients, and are a growing source of EMTALA violations by hospitals and physicians. In some cases, according to emergency room physicians, delays in backup coverage contribute to poor patient outcomes, including patient deaths.

Delays in Care

According to some estimates, lack of available on-call services accounts for one-third of the transfers of patients from one hospital to another.²⁰ According to many ER physicians, the bulk of these transferred patients could have been treated at the hospital of origin had adequate on-call coverage been available.

AB 2611 working group members cited deaths and numerous other examples of adverse outcomes associated with breakdowns in the provision of on-call services.

Costs to Hospitals and Patients

¹⁸ “Potential Solutions to the Lack of Physician Back-up in Hospital Emergency Departments,” op. cit.

¹⁹ UC-Irvine Medical Center, op. cit.

²⁰ “On-Call but not Responding,” op cit.

According to the 1998 survey, a significant percentage of hospitals must pay physicians to provide on-call coverage under various arrangements. According to the survey, 38 percent of hospitals contract for on-call services, 22 percent provide daily stipends to specialists, 22 percent provide compensation for some portion of the uncompensated care rendered by on-call physicians, 11 percent provide insurance coverage for on-call physicians, and 8 percent contract with designated physicians (referred to as hospitalists) to provide backup ER coverage.²¹

According to a more recent survey, the percentage of hospitals that pay particular types of specialists for on-call availability or services varies by specialty. According to the survey, the percentage of hospitals paying for neurosurgery (29.7 percent) and orthopedics (29 percent) were the highest, followed by ENT (17.9 percent), plastic surgery (11 percent), and ophthalmology (10.3 percent).²²

According to the 1998 survey, payment of stipends by hospitals is by specialty and generally ranges from \$100 to \$1,000 per day, with trauma surgeons, neurosurgeons, and obstetricians at the higher end. More recently, stipends as high as \$1,900 per day and even as high as \$2,500 have been cited.²³ In total, stipends cost California hospitals an estimated \$200 million annually.²⁴ For the most part, these payments are not directly reimbursed to hospitals by third-party payers, although they may be reimbursed to some extent through the overall negotiated rates with health plans.

²¹ “Potential Solutions to the Lack of Physician Back-up in Hospital Emergency Departments,” op. cit.

²² UC-Irvine Medical Center, Division of Emergency Medicine, op cit.

²³ “On Call But Not Responding,” op cit.; “Contract Dispute Between Palomar Medical Center, Surgeons Prompts Trauma Center Closure,” California Healthline, January 8, 2002.

²⁴ Loren Johnson, MD; Todd Taylor, MD; Roneet Lev, MD, “The Emergency Department On-Call Backup Crisis: Finding Remedies for a Serious Public Health Problem,” Annals of Emergency Medicine, May 2002, Vol. 37, No. 5.