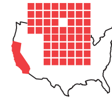

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1 Emilie Alvarez, Regulations Coordinator
2 Department of Managed Health Care
3 Office of Legal Services
4 980 9th Street, Suite 500
5 Sacramento, CA 95814

6 RE: Proposed Rulemaking Action Concerning Plan and Provider Claims Settlement; Control
7 #2007-1253

8 Dear Ms. Alvarez:

9 CAL/ACEP is hereby providing testimony on the proposed regulations related to the prohibition
10 of balance billing, the independent claims dispute resolution process, and the proposed change to
11 the Gould criteria. However, CAL/ACEP believes that the Department of Managed Health Care
12 (DMHC) lacks the authority to promulgate these regulations. Hence, this testimony is provided
13 under protest.

14 The California Chapter of the American College of Emergency Physicians (CAL/ACEP)
15 appreciates the opportunity to comment on the above-referenced rulemaking file, however, we
16 wish to make it clear that we reject the notion that the Department of Managed Health Care has
17 authority to promulgate these new regulations. CAL/ACEP represents more than 2000
18 emergency physicians in California. Emergency Physicians provide emergency services and
19 care to more than ten million Californians every year. We are obligated under the Emergency
20 Medical Treatment and Labor Act (EMTALA) and similar state laws, and by our commitment to
21 the health of our communities, to provide these services without regard to our patient's insurance
22 status or ability to pay. **These proposed regulations will have a profound impact on access to
23 emergency care services in California, on the financial viability of the emergency care
24 safety net, our patients, and our professional practices; and we are gravely concerned that
25 these regulations will have a disastrous effect on an already overburdened and under-
26 funded emergency care services system in our State.** The impact of this year's proposed
27 regulations is likely to be far more damaging then the regulations proposed last year by the
28 Department. It is indeed frustrating to note that it appears the Department failed to hear or heed
29 the thousands of pages of testimony presented last year, testimony which represented an
30 overwhelming outpouring of anger and resentment, and dire warnings as well as convincing data
31 and evidence from providers fearful of the adverse consequences of those regulations on access
32 to emergency care services and the welfare of our patients.

33 The Department's failure to respond in writing to last year's testimony, and to all but ignore
34 these concerns and warnings in redrafting the regulations for 2007, suggests that the Department
35 has not only failed to respond to this testimony, or given it any credence; but also that the
36 Department hopes that providers of emergency care will tire of the rule-making process, get
37 discouraged by the Department's deaf ear, and fail to react to the new set of regulations in as
38 effective and publicly visible manner as we did last year. CAL/ACEP can assure the DMHC
39 that, given the fact that the new regulations are even more disastrous that the originals, the
40 response of providers to these new regulations will likely be even more vociferous.

For the reasons described below, we urge your Department NOT to adopt these regulations, as these proposals violate the law and the rights of physicians, and would have significant and adverse impacts upon the health of the citizens of, and visitors to, our state. Our comments are set forth below.

I. Revisions to section 1300.71 commence at Page 3. Gould Criteria

A. There is No Authority for the Regulation

1. There Are No Valid Reasons to Modify the Gould Criteria

The Department of Managed Health Care lacks authority to expand the criteria in AB 1455 regulations used to determine that constitutes "reasonable" payment beyond that which the court carefully circumscribed in Gould v. W.C.A.B. No information beyond that listed by the Gould decision is reasonably relevant for the purposes of determining whether a non-contracted physician's billed charge for emergency services is reasonable. The DMHC has already recognized that the Medicare and Medi-Cal fee schedules are inappropriate guideposts to challenge the reasonableness of a physician's billed charge, and the other factors that the payers have proposed, such as accepted charges and average contract rates, are equally inappropriate and their consideration would be even more burdensome. Nonetheless, the DMHC has decided to use obtuse and deceptive language that, on first glance, seems to further restrict the criteria used to define reasonable payment, when in fact this language is actually permissive, expanding the criteria that originally make no mention of any consideration of Medicare or contracting rates or any other rate structure other than usual and customary charges.

Emergency physicians are bound by the principles of medical ethics not to charge or collect an excessive fee. They set their charges accordingly to reflect the reasonable value of their services, and they are entitled to be paid the amounts they have billed in the absence of a contract to accept a lower rate, and in the absence of any legal determination that these charges are excessive or unreasonable. The Gould Standard delineates general criteria under which providers and the courts can determine reasonable fees. Unfortunately, the DMHC appears to have abandoned the Gould Standard, despite its adoption in 2003 into AB 1455 regulations, after an exhaustive three-year rule-making process. As acknowledged by its own Director in legislative testimony, the Department has a less than stellar track record for enforcement of its own regulations. Instead, the Department has chosen to respond to anecdotal complaints from Risk Bearing Organizations of provider overcharges; and has failed to use existing mechanisms to deal with this issue, including referral to the courts or to the California Medical Board.

Now, the Department proposes to add to the existing Gould criteria two additional criteria to be used to define the reasonableness of a non-contracting provider's charges: Medicare reimbursement rates, and contracting rates. The DMHC apparently believes that by cloaking this expansion of the existing criteria in language that has the appearance of restricting consideration of Medicare and contracting rates as the **sole** basis for payment, the Department will have successfully hidden the true intent of this proposed change: to undermine the value of physician services and manipulate the market in order to reduce costs and maximize health plan profits. **Under this new revised definition, Health plans and RBOs would be allowed to submit Medicare and historic contract rates into a "reasonable rate" determination,**

whereas the existing regulations in no way permit the consideration of these factors in the determination of the reasonable value of a non-contracted provider's services. The existing criteria rely on usual and customary charges as the baseline standard for defining reasonable charges for these services, and the proposed expansion of the Gould criteria would likely undermine the value of these services, since Medicare and discounted contracting rates are substantially below usual and customary charges. This will only encourage payers to continue to take advantage of the EMTALA obligation of emergency care providers to provide care first, and beg for payment later; and discourage payers from negotiating for fair contract terms with these providers for their services.

Physicians voluntarily participate in Medicare, a government sponsored charity program for the elderly, as part of their professional commitment to their communities. In so doing, they gain the benefit of prompt payment and freedom from some administrative hassles, but are forced to accept rates far below the reasonable value of services. This government program isn't market based, and should never be included in any consideration of the reasonable value of commercial services, even as one of many factors used to create a payment methodology or fee schedule.

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

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

2. There Will Be Serious Consequences to Modifying the Gould Criteria

The California Association of Physician Groups (CAPG), an association of RBO payers, has suggested that the Gould criteria should be revised to additionally consider the "prevailing provider rates paid and accepted in the relevant geographic area", or in other words, the prevailing discounted rates for contracted services. California's emergency care safety net is already in crisis, with massive overcrowding, underpayment and continuing ED closures, which continue unabated since the prior regulations were proposed. In addition, our state suffers from a serious shortage of specialists to provide ED on-call backup. If the Department implements this revision, it would lead to substantially lower payments to emergency providers and on call physicians. In turn, these decreased payments would inevitably lead to a reduction in physician staffing in Emergency Departments (EDs), and the replacement of physicians with lower cost allied health professionals; and it would decimate our existing call panels. Together, these

impacts would cripple the provision of emergency care, increase ambulance diversion and waiting times, and cause irreparable harm to patients and to our emergency care infrastructure. There is no public benefit to the citizens of California for the DMHC to participate in this HMO sponsored scheme, and it would only lead to the destruction of our EMS safety net and the transfer of hundreds of millions of dollars from physicians to Health Plans and capitated medical groups.

B. The Alleged Justifications for these Regulations are False or Inadequate

1. The Department has not CLARIFIED the Gould Criteria

In its Initial Statement of Reasons, the Department claims that by the proposed regulations, it has clarified the criteria for determining the reasonable and customary value of health care services, in order to "achieve sensible and workable solutions to continuing…..claims settlement problems". There are no doubt innumerable problems with health care claims settlements, problems that are exacerbated by the fact that emergency care providers can not refuse to treat a health plan's enrollees even if the plan repeatedly fails to pay the provider appropriately or timely. The Department claims that the Gould criteria are insufficiently clear, and thus the Department is unable to rely on these criteria to fashion effective policy and standards that must be met by payers in making payments to non-contracted emergency care providers. In fact, the existing Gould criteria can readily be used as a guideline to establish an 'interim payment standard' for non-contracted provider claims. This is evidenced by the reliance of the DMHC on the Gould criteria, and specifically on the criteria that promotes usual and customary charges as the most well-defined and enumerated standard for determining reasonable value, in negotiating its consent agreement in an enforcement action against HealthNet for paying non-contracted providers inappropriately. The problem the Department has with the existing Gould criteria is NOT that they are unclear, but that they are predicated on the concept that usual and customary charges are the primary basis for determining reasonable value. Clearly, the Department now believes the Gould court has set too 'costly' a standard; and encouraged by payers, has declined to enforce existing regulations. The Department has also declined to enforce its own advisory response to Health Plans and RBOs, as delineated in the ICE Clarification Request Log, #CL 106, pg 34-35, 12/5/03: "Kevin Donohue (DMHC) discussed clarification with Keith Pugliese (ICE AB 1455 Team Co-lead) as follows: The DMHC's formal position is that, in the event that a payer pay a non-contracted provider claim an amount that is below billed charges and the non-contracted provider subsequently balance-bills then enrollee, then the payer is expected ensure that the enrollee is not in any way financially harmed or held responsible by considering one of the following three actions:

1) Try to negotiate with the non-contracted provider to agree to a rate that the provider would deem satisfactory;

2) Bring the non-contracted provider to court for a declaratory judgment action as to whether the payer's payment is unfair; or

3) Pay the claim in its entirety (i.e., "goodwill" payment). But the DMHC does not want the enrollee to pay the balance or face a collection agency."

If there is confusion and inconsistency in the application of the current regulations, as the Department claims, it is only because the Department has failed to consistently enforce these regulations, or take the necessary steps to translate these regulations into appropriate claims payment policy crafted to stabilize a failing safety net. Instead, the Department has chosen to water down these regulations through a 'clarification' that undermines the value of provider services and contracting rates. Thus, the Department has become complicit in the manipulation of the health care marketplace by the health care insurance industry

The Department claims that the proposed additions to the Gould criteria clarify these criteria. Normally, clarifying a set of criteria would result in limiting the way that the criteria are applied to achieve the objective, so that those applying the criteria would routinely come closer to the intent of the objective. For example, one could clarify the Gould criteria by establishing a uniform standard for usual and customary charges. CAL/ACEP has proposed to the DMHC that they use the charges submitted to the MediCal program to establish a database of the range of usual and customary charges of emergency care providers, and using this standard rather than allowing each and every health plan and payer to develop their own, unverified, unvalidated, and potentially manipulated data base of usual and customary charges. DHS staff has advised CAL/ACEP that such a database should be relatively easy to establish, since provider charges are already captured in the claims payment system. The changes to the Gould criteria proposed by the DMHC, on the other hand, do not clarify the existing criteria by limiting the way the criteria are applied; but instead expand the set of criteria to be considered so as to modify the conceptual underpinnings of the Gould standard. This is no clarification, it is a hijacking, and its veiled intent, market manipulation, is evidenced in the oblique language used, which appears to restrict that which it is really designed to permit.

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

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

CAL/ACEP is very concerned that the ICDR proposed in these regulations will quickly become overwhelmed with hundreds of thousands if not millions of payment disputes. Our suggestions for the safe harbor standard, if implemented, would reduce these by as much as 50% and were offered as part of a negotiation to design a workable ICDR process. Now, the Department has proposed an unworkable ICDR process and turned our good faith proposal into an unconscionable attempt to destroy the existing fair payment standard for non-contract services (i.e. the Gould Standard).

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

In response to historic complaints about inappropriate payment of claims by Health Plans, the California Legislature passed AB1455. This measure required the DMHC to develop and implement regulations for fast, fair, cost effective billing and claims payment, and was signed into law in 2000. The DMHC finally adopted these regulations in 2002, after an exhaustive review and comment period involving all stakeholders. One of the most important features in dispute was the non-contract fair payment standard. After an exhaustive review of legal precedent, the Department adopted the Gould criteria as the established legal standard. The current proposal to subvert this standard, first with attempted emergency regulations, then with last year's highly politicized and subsequently abandoned process, and again with this year's regulatory proposal, stands in stark contrast to the duly constituted review and adoption of the existing standard.

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

During the process used to establish these regulations, many of the arguments put forward by CAPG to support modification of the Gould criteria and include prevailing contracting rates in determining the value of the non-contracted provider's service were the very arguments that were rejected by the Department in 2002. Presumably, revision of the existing regulation is in response to the urgings of health plans and their capitated providers that the criteria needed to be opened up to account for such contentious, legally irrelevant, and injurious considerations such as contracted rates, rates paid by governmental programs (and thus subject to budgetary constraints), and rates physicians may accepted under coercion by hospitals. Significantly, these changes were requested during the initial AB 1455 rulemaking period and specifically were rejected by the Department on the grounds that it lacked statutory authority to accept them. As the Department responded in the Third Comment Period to the AB 1455 regulations, ending April 30, 2003, in its response to Comment No. 43: "The criteria set forth in this section accurately reflect current CA case law relating to non-contracted services. Therefore, these criteria must be considered when properly adjudicating a claim. **The Department has declined to unilaterally add any factors that were not enunciated in the Gould decision because it lacks the authority to create new contract principles**. (Emphasis added.) When the final regulations were adopted, the Department indicated that "No alternative considered by the Department would be more effective in carrying out the purpose of the proposed regulation,

1 would be as effective and less burdensome to affected private persons, or would lessen any
2 adverse impact on small businesses."

3 4. Discounted Contracting Rates do Not Reflect the Full Value of Contracted
4 Services

5 If the intent of the proposed regulation is to ensure that non-contracted providers receive the
6 reasonable value of their services, there is one very obvious flaw in CAPG's argument that
7 'prevailing contract rates' should serve as one of the criteria for establishing the reasonable value
8 of these services. Even if one were to accept CAPG's quantum meruit theory on the reasonable
9 value of a service, which CAL/ACEP specifically rejects, it should be obvious that **the value of**
10 **a contracting provider's service (to the patient or the payer) is not equivalent to the**
11 **discounted rate the contracting provider agrees to accept as payment in full. The true**
12 **value of a contracting provider's services is equal to the contract rate paid and accepted**
13 **PLUS the monetary value of the consideration exchanged for accepting a discounted**
14 **payment**. This consideration can take many forms, including exclusivity of referrals, volume of
15 referrals, expedited payment, and/or other considerations that have real value to the provider.
16 CAPG would have the Department ignore the value of these considerations that the contracted
17 provider receives, and allow the payers and IDRP adjudicators to take into consideration a
18 discounted contract rate as a full measure of the value of his service. In fact, the full value of a
19 contracted provider's service is most closely approximated by considering the usual and
20 customary fees charged by the provider, and other similar providers, when they provide the same
21 services, (i.e. services that are NOT covered by a contract). Any consideration of prevailing
22 contract payments, even if they are not the **sole** basis for payment or for the reasonableness of a
23 provider's charges, ignores the value received by the provider in exchange for accepting the
24 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 5. 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

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

6. An ICDR Cannot be Relied Upon to Establish a Reasonable Rate Standard

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

C. CAPG's Request to Modify the Gould Criteria are Based on False Assertions

1. The Gould Criteria are Not Restricted to Workers Compensation Payments

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

2. For Non-contracted ER Providers, Quantum Meruit Means Usual and Customary Charges

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

unconstitutional." The basic premise of the Gould court, and the courts that cite the Gould criteria, is that a significant majority of provider's charges ARE reasonable. Contracted payment rates cannot be used as a benchmark because in some cases they represent whatever the payer chooses to pay the provider, and in some instances the rate is based upon coercion. Lastly, the contracted payment rate is based upon a discounted rate for large volumes or expedited payments. Non-contracted providers do not reap any of these benefits.

3. Commercial Insurers Must Support a Safety Net for All Patients

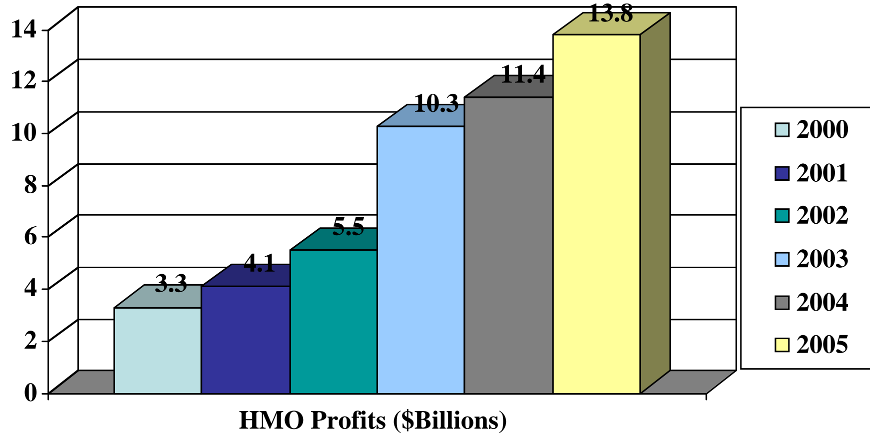
Regarding Page 5, and Reasonable Value: CAPG alleges that "Quantum Meruit claims measure the value of services to the recipient rather than the cost to the provider and therefore the plaintiffs' alleged lost profits and costs are not recoverable." CAPG further argues that the value of the emergency physician's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

4. CAPG's Request is an Attempt to Maximize Profits, not Protect Patients

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

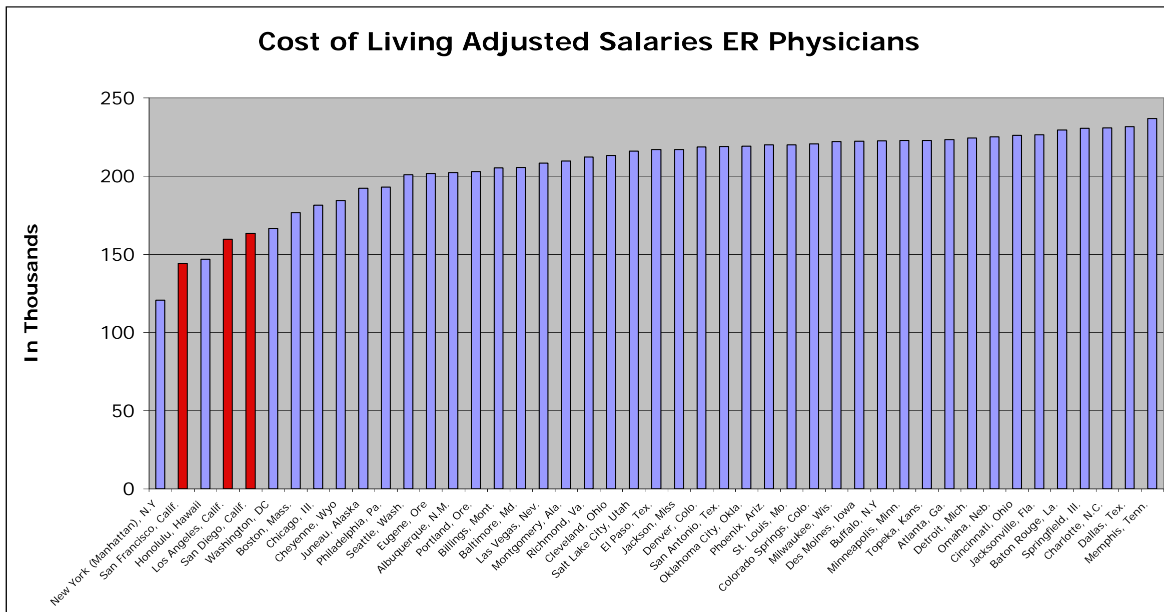
Street or spending on outrageous CEO compensation (**See below**); while in California emergency physician incomes (in red) are well below the national average when adjusted for the average cost of living (**see below**). Changing the fair payment regulations will only hasten the degradation of one of 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 5. The Courts Have Rejected Medicare Rates as a Surrogate for Reasonable Value

2 The Courts have likewise rejected the inclusion of Medicare or MediCal rates into the Gould
3 criteria as surrogates for the reasonable value of a non-contracted provider's services, as
4 suggested by CAPG. The recent decision in the Bell and Prospect case demonstrates that the
5 courts 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 by enabling a
33 linkage of the commercial health insurance market to government payers operating on a deficit
34 budget, or to historically exploitative managed care payers imposing deeply discounted contract
35 rates, cannot be justified. The impact on access to emergency care would be too dear a price to
36 pay. The effort to amend the AB 1455 regulations in this way is bad public policy with
37 potentially disastrous consequences, not simply a minor tweak to an existing carefully defined
38 and well established standard.

39 6. CAPG's Allegations of Excessive Charges are Unsupported

40 Regarding Page 9: The CAPG Survey: CAPG purports to have conducted a survey in late 2004
41 revealing a 'stark and dramatic contrast' between contracted and non-contracted emergency
42 physician charges'. As the Department is well aware, CAL/ACEP also conducted a survey and

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

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

40 CAPG has said that non-contracted emergency physicians take advantage of their 'exclusive
41 contracts' with hospitals to charge exorbitant fees to our patients, who have little choice but to
42 use our services. CAL/ACEP acknowledges the possibility that there may be outlier physicians
43 who overcharge, but where is the validated and independently derived data that proves this
44 charge of exploitation? And how can the DMHC reasonably consider such flawed data to justify

its position that the Gould criteria should be abandoned or modified, and that most emergency care providers' charges are excessive?

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

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

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

8. Paying Usual and Customary Rates to Non-contracting Providers Promotes Fair Contracting

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

D. Summary

Sensing the opportunity to preserve the status quo of emergency services underpayment; i.e. enable continued payment of non-contracted provider claims at discounted contracting rates (per statement in 'CAPG Update', Volume 8, Number 6, September 2006), CAPG requested that the DMHC amend the AB 1455 regulations, and dilute the Gould Standard to include consideration of historic rates (i.e. –historic contract rates). Each side presented data on its charge and payment experience, and CAL/ACEP, while acknowledging that there might be some outlier overcharging, provided voluminous data to show that its members' charges were consistent with the usual and customary rates of all providers for non-contracted services, including rates charged by CAPG physicians. Despite this, and absent any evidence for its opinion, DMHC took the position that enforcement of the existing Gould Standard would raise payment levels and discourage direct contracting; and again siding with the payers, has expanded the Gould criteria to include consideration of Medicare rates and contracting rates in the determination of the reasonable value of the non-contracted provider's services. The impact of these proposed changes will seriously undermine the value of these services, to the detriment of patient access to emergency care and qualified emergency care providers.

II. Revisions to section 1300.71 commence at Page 4. 'Expedited Payment'

A. The Department's Proposed Expedited Payment Process is an Invitation to Underpay Every Claims

The Department has proposed that Plans and RBOs make an 'expedited payment' based on 150% of the Medicare rate for any contested emergency care provider claim. Based on a recent survey of emergency physician claims for non-contracted services to HMO patients, the average charge was approximately equivalent to 260% of the Medicare rate. Thus, the Department's 'expedited' payment represents about 58% of the average emergency physician's charge. CAL/ACEP knows of no emergency physician groups in the State whose fee schedule is at or below this payment rate, thus this 'expedited payment' is below even the 10th percentile of usual and customary charges, and close to 100% of provider's claims would likely be underpaid with this mechanism. The proposed regulations even allow the payer to use the IDRP to demand that the arbiter approve payments BELOW the 'expedited payment' rate. In addition, the Department's expedited payment standard allows payers to down-code and bundle coded services at will prior to applying the expedited payment standard to determine payment, which could easily result in expedited payments at 25% or less of the provider's charges. Thus, the

Department would allow payers to make severely discounted payments on each and every claim submitted by a non-contracted emergency care provider. The Department has not included in the proposed regulations any automatic built-in deterrents to such abusive payment practices, no penalties for repeatedly disputing every claim even if the payer loses every single dispute, no 'loser-pays' disincentive to filing frivolous disputes, and no dispute limitation standards that would cause the Department to automatically consider enforcement actions for a pattern of inappropriate claims underpayment through excessive use of the dispute mechanism. **At the very least, payers that pay a claim at the 'expedited payment' rate should be required to pay the claim as coded by the provider**. The only defense that provider's would have to fend off this abusive and financially devastating payment practice would be to file complaints against the payers for a pattern of inappropriate claims payment, and the Departments abysmal record of failure to enforce this AB 1455 fair payment regulations has been well documented in Legislative hearings. In fact, this disinclination of the Department to appropriately enforce its own regulations led the CMA and CAL/.ACEP to sponsor AB 1155 Huffman in 2007 to mandate that the Department take effective enforcement actions to deter just such behavior by Plans and RBOs. The DMHC has opposed this bill, because it limits the Department's enforcement discretion, which from CAL/ACEP's perspective, it overuses. In addition, the Department has repeatedly indicated to CAL/ACEP that it has no direct authority over RBOs, and thus is unable to directly address an RBO's failure to comply with AB 1455 regulations. By allowing, even facilitating, the routine and gross underpayment of emergency care provider's claims, the DMHC's proposed regulations will encourage Health Plans and RBOs to down-code and dispute the charges of every claim submitted by a non-contracting provider, forcing providers to either accept these underpayments, or flood the IDRP with hundreds of thousands, if not millions, of underpaid claims, rendering the IDRP totally useless and ineffectual, and allowing the payers to pocket hundreds of millions of dollars in ill-gotten profits.

B. Impact of the 'Expedited Payment' Rate on Contracting

Current commercial plan contracting rates for emergency care providers, and in particular, emergency physicians, are predicated on several factors: 1) how much emergency physicians are currently able to collect on non-contracted claims; 2) pressure, or coercion, from our hospitals to contract and the impact of plan or RBO market share on hospital revenues; 3) the economic value of the considerations exchanged for the discount in the contracted rate (such as volume referrals, good relations with our hospitals and HMO colleagues, reduced billing and collection hassles, prompt payment, agreements regarding down-coding and bundling, etc); 4) the prevailing market for emergency physician contracted services; and 5) competition between emergency physician groups and hospitals for insured patients. The first consideration is the most important factor sustaining fair contracting rates. The DMHC's proposed regulations prohibiting balance billing and allowing payers to grossly underpay nearly every non-contracted ER physician claim is nothing less than an assault on the providers' ability to negotiate fair contracting rates. CAL/ACEP has provided to the DMHC, on numerous occasions, data that substantiates our expressed concern that setting an expedited payment rate for non-contracted services at 150% of the Medicare rate undermines the vast majority of existing contracts between HMOs and RBOs and emergency physician groups. For one large ER physician group that has over 300 contracts with health plans and RBOs, more than 85% of the ED visits covered under contract are paid at contracted rates that exceed 150% of Medicare. [Those under the 150% rate are typically the result of 'take it or lose your staffing contract with the hospital' coercive

demands attributable to leverage applied by plan or RBO on the hospital, despite rarely enforced state law intended to prohibit this practice]. Why would any plan or RBO continue to contract at 220% of Medicare, or at 90% of charges, or even at 160% of Medicare rates, if they could obtain the same services for their enrollees from the same provider at the expedited rate of 150% of Medicare? An overwhelmed IDRP with no penalties for frivolous disputing is certainly not likely to be a deterrent. Despite assurances from the DMHC that it wants to encourage contracting between the payers and emergency care providers, it is clear the true intention of the Department is to use their regulatory authority, either in collusion with the health insurance industry or in total ignorance of the health care marketplace, and with no concern about the impact on patient access to emergency care, to undermine contracting rates for emergency care services.

C. DMHC's 'Expedited Payment' is Not Really Expedited

The proposed regulations would require the payer to send the 'expedited payment' to the provider within 30 or 45 days, but existing regulations (Health and Safety Code 1371 et seq), already require the reimbursement of a complete claim, or the uncontested portion of a complete claim, within this same time period. Even when a payer currently contests the coding of a claim, or believes the provider's charges are excessive; the payer is obliged to send some payment, based on their recalculation of the 'correct' or 'usual and customary payment' to the provider within the required payment period. Thus, there is nothing in the proposed modification to the regulations that actually expedites payment in any way over the current regulations; and the term is apparently being applied in the hope that it makes these proposed regulations appear balanced by offering a benefit to providers that does not currently exist. This is nothing more than false advertising by the Department.

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

1. The Regulations will Transfer Millions of Dollars from Providers to Plans

The DMHC's proposed regulations will devastate the Emergency Care Safety Net economically, by transferring millions of dollars in revenues to health plans and RBOs. In the worst case scenario, where the IDRP is so overwhelmed with disputed underpaid claims that it is ineffective in securing fair payment for any but a small number of claims and providers, where all emergency physician claims are paid at the 'expedited rate' rather than at the provider's reasonable and customary charge, and where down-coding and bundling of claims is rampant and unmitigated, and where contracting rates are equally undermined by the regulations; emergency physicians would stand to lose upwards of $150 a claim, times 2.5 million DMHC regulated claims a year, or close to $375 million dollars a year. A study conducted by CAL/ACEP of current collections from non-contracted HMO claims which reviewed data from over 83,000 claims during the last half of 2006 revealed the following information, which was shared with the Governor's office and members of the State Legislature:

Non-contracted HMO ER Physician Claims Collections

Total Visits	83,695
Total Charges	$30,232,936

Average Total Charge	$361
Total Net Payment	$25,201,941
Average Net Payment	$301
Total Insurance Payment	$21,942,291
Average Insurance Payment	$262
Total Patient Payment	$3,259,650
Average Patient Payment	$39
Collection Ratio	83.4%

Based on CAL/ACEP's survey (above) of non-contracted HMO collections, the average HMO claim for a non-contracted emergency physician is about $360, and the average total collection is about $300, and the Medicare allowable rate for the average HMO claim is about $115 (not all CPT codes are paid by Medicare, thus the discrepancy in ratios between charges and payments as related to Medicare). The DMHC's new proposed regulations would set an interim payment standard at 150% of Medicare. This standard would result in an average collection of $173 for a $360 claim, which would amount to a loss of something like $127 per claim over current collections, equating to a transfer of $170 million dollars from ER physicians to health plans, for non-contracted services. This does not include any losses for down-coding and bundling, or the additional cost of participating in the IDRP for all the disputed underpaid claims. On top of this, an interim payment standard of 150% of Medicare rates is substantially BELOW the rates for probably 3/4ths of all claims covered under contract with HMOs, thus resetting the bar for ALL contracted rates for emergency physicians' services even below this standard. This would generate an equally devastating transfer of revenue back to the plans. The combined result could easily be a total loss of $300 million dollars in ER physician revenues in CA, per year, and this study did not even include the PPO patients covered under the Knox-Keene act and these proposed regulations, which would easily add another $75 million in losses to the equation. **This is equivalent to firing one-third of all ER physicians working in this State, or the closure of 100 Emergency Departments.**

In light of the above consequences, which we have demonstrated repeatedly to the Department**, it is laughable for the DMHC to claim, in its Notice of Rulemaking Action, that it is not aware of any cost impacts that a private business would necessarily incur as a result of these regulations, or that they will not result in the elimination of jobs, or that there would be no significant statewide adverse economic impacts directly affecting businesses in California.** The practice of emergency medicine is both a profession and a business, often a 'small business'; it can not be sustained on good will alone.

The Regulations clearly would have an adverse impact on small businesses in California

In response to inquiries about the impact of the proposed regulations on small businesses, the answers given by the Department were misleading and false. The Department stated that

1 independent physician groups are not small businesses. That proposition is debatable, but
2 bedside the point, since capitated medical groups would receive a financial windfall if the
3 regulations are enacted. Most emergency physician staffing groups are clearly small businesses.
4 There are over fifty emergency staffing groups in the state that staff only one or two emergency
5 departments and have twenty or less physicians, usually in a limited partnership. No reasonable
6 person could argue that most emergency staffing groups are not small businesses. Radiology
7 groups, anesthesiology groups, and pathology groups are also small businesses. Call panel
8 specialists also belong to individual or small group practices in most cases.

9 It is also clear that the regulations if enacted would cause severe economic harm to these small
10 businesses. Nevertheless, the Department provided the following false answers:

11 Significant statewide adverse economic impact directly affecting businesses, including the
12 ability of California businesses to compete with businesses in other states: **None**
13 Costs to private persons or businesses directly affected**: The Department is not aware of
14 any cost impacts that a representative private person or business would necessarily
15 incur in reasonable compliance with the proposed action.**
16
17 The Department is not aware of any cost impacts that a "private person or business would
18 necessarily incur"? If the Department would refer to the written and oral testimony that was
19 given in 2006, it would be well aware of the cost impacts on emergency physician incomes and
20 on the financial viability of emergency groups. **Unfortunately, the Department has failed to
21 respond in any way to the thousands of pages of written and oral testimony provided on the
22 regulations the Department submitted last year.** The Department is also well aware of the
23 adverse economic impact that such regulations would have on other hospital-based physician
24 groups which are clearly small businesses.

25 If the Department asserts that it is not "aware" of adverse cost impacts, then it is asserting or
26 admitting a rather inexcusable lack of awareness. Voluminous testimony given in 2006 has
27 certainly made the Department aware that these regulations would reduce the income of hospital
28 based physicians. Transfer of money from small physician-owned businesses to health plans and
29 capitated medical groups would make it very hard to recruit or retain physicians and ameliorate
30 the already critical shortages of human capital staffing the emergency safety net in California.

31 The impact on on-call specialty physician services would of course be equally devastating, and
32 probably more immediate. There just wouldn't be any on-call physicians available. Emergency
33 physicians will flee to other states. Wait times will increase dramatically, ambulance and
34 paramedic diversions will increase, morbidity and mortality will increase, and ERs will close.
35 The losses to hospitals, which are also affected directly by these regulations, could mount into
36 the BILLIONS.

37 It is true that this worse case scenario is likely to be mitigated to an extent by recovery of some
38 underpayments (due to inappropriate down-coding and underpayment at the 'expedited rate')
39 through the IDRP. It is also true that not all plans and RBOs will underpay every claim, and that
40 not all contract rates will be reduced or contracts terminated as a result of the implementation of
41 the new regulations. Nonetheless, even if emergency physicians only experience one-third of the
42 losses in the worse case scenario; the result would devastate emergency care services, and patient

access to emergency care, throughout the State. This would be most acutely evident in the EDs providing services to MediCal patients, the elderly, and the medically indigent; as these EDs are most dependent on revenues derived from the limited number of commercial patients they do treat to sustain their staffing and resources for the treatment of the under and uninsured. **State leadership, and the DMHC, will be blamed for transferring $375 million in revenues from ER physicians, probably a like amount from on-call physicians, and perhaps billions of dollars from hospitals, to HMOs, and for the health care consequences above.**

2. Undermining Fair Payment Standards will Undermine Access to Emergency Care

After reviewing the DMHC's remarks in response to inquiries about emergency physician complaints about underpayment of claims (**see attachment 6),** and based on previous discussions with Department staff, it is clear to CAL/ACEP that the intent of this proposed regulation is to revise the reasonable value standard. Together with the other proposed balance billing and IDRP regulations, this will change the way emergency and on-call physician services in California are financed. As we have stated, these changes would destroy any semblance of timely and reasonable payment, would add huge overhead costs, and would completely destroy our ability to continue in our group practice models. There would be no support for our care of the poor and uninsured, or for the health and safety and security of the citizens of California. We simply cannot afford to provide these services to the poor, and staff our EDs with qualified emergency physicians and on-call specialists if health plans and their delegated payers are allowed to walk away from their obligation to sustain the financial viability of the emergency care safety net. As mentioned, Health Plans and RBOs constantly depend and rely on this same safety net. Incredibly, it appears that these same health plans have convinced the DMHC to presume that, despite the loss of some $500 million to $1 billion a year in revenues to safety net providers, these emergency physicians, on-call specialists, and hospital emergency departments would somehow remain available and accessible to provide these services; and that patient access to emergency care in California would be unaffected. No doubt, they feel safe in this presumption knowing that when the Safety Net collapses, taxpayers will be forced to pick up the tab.

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

When the DMHC first proposed regulations prohibiting balance billing, CAL/ACEP surveyed 1800 emergency physicians in California, including residents in training in emergency medicine, directors of emergency departments, and emergency department staff physicians; in order to assess the potential impact of these regulations on patient access to qualified emergency physician services. Based on this survey (**see Attachments 7, 8 and 9**), it was apparent that these regulations could undermine staffing for many of California's emergency departments. The survey assessed responses based on best-case, and worst-case scenarios. The worst case scenario was predicated on the loss of an average of $66,800 per year in income for full time emergency physicians, based on the difference between payment at 110% of Medicare rates (one of the safe harbor standards for initial payment suggested at the time by the DMHC), and payment at current rates from an extrapolation of average receipts on Knox-Keene claims from several ER groups from around the State, both contracted and non-contracted (**see Attachment**

1 **10)**. Thirty five percent of the physicians (635) responded to the survey, and of the currently
2 practicing emergency physicians, more than half indicated they would consider retiring early,
3 switching careers, or leaving California to practice elsewhere, in the worst case scenario. Thirty-
4 three of the fifty-four residents currently planning on remaining in California to practice
5 emergency medicine would also leave the State in this scenario. Even a very conservative
6 extrapolation of the results of this survey to the 3000+ emergency physicians in California
7 indicates such a dramatic loss of professional resources that the enactment of these regulations
8 would result in the closure of more than a third of all the EDs in California.

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

17 4. The Proposed Regulations Ignore the Documented Crisis in Emergency Care

18 The DMHC's bizarre conclusion that these regulations would not impact access to emergency
19 care in our State contradicts the analysis of the Institute of Medicine Report on the Future of
20 Emergency Services in the United States, and the analysis of access to care problems identified
21 in the American College of Emergency Physicians Report Card on Emergency Care. The IOM
22 report describes the increasing responsibilities of emergency departments in caring for patients
23 without medical insurance and for insured patients unable to access their physicians. Between
24 1993 and 2003, the number of visits to emergency departments increased from 90.3 million up to
25 nearly 114 million. At the same time, the number of hospitals in the United States decreased by
26 703, and the number of hospital beds dropped by 198,000. Emergency departments are forced to
27 practice "boarding," where hallways are lined with patients on gurneys while they receive care
28 and wait for an in-patient bed to become available. The government has spent only a fraction of
29 federal funding for emergency preparedness since 9/11 on medical preparedness. Emergency
30 service providers are a crucial part of the response to any disaster, yet they received only 4
31 percent of $3.38 billion distributed by the Homeland Security Department for emergency
32 preparedness in 2002 and 2003 and only 5 percent of the funding from the Bio-terrorism
33 Hospital Preparedness Program.

34 In the ACEP Emergency Medicine National Report Card, California ranked last in the nation
35 (51st after all states and the District of Columbia) for the number of emergency rooms per
36 million people. The closing of 67 emergency departments in California in the last 10 years has
37 markedly exacerbated this problem. This has lead to longer waits, increased crowding and
38 ambulances being diverted to more distant hospitals when the closest ones can no longer accept
39 more patients.

40 California's nursing shortage is so severe that we were ranked 50 out of the 51 states and
41 Districts that were surveyed. Without enough nurses our system is crippled. It delays emergency
42 care and also delays admissions into the hospital. Many inpatient wards are closed throughout

1 California because there are not enough nurses to care for admitted patients. California ranked
2 46th out of 51 in staffed hospital beds. This has lead to what we call ‘boarding’. This term means
3 that admitted patients are kept in the ED for hours and even days, leaving fewer functioning ED
4 treatment areas to care for emergencies. This leads to GRIDLOCK in our Emergency
5 Departments.

6 ED waiting times and ambulance diversions have skyrocketed in recent years. A 2001 U.S.
7 GAO report found that 25 percent or more of hospitals throughout Southern California were on
8 ambulance diversion more than 10 percent of the time. In 2003, 9.7 million people went to a
9 California Emergency Room. This was almost 1 million more than 1994 visits. During the same
10 period of time, the number of hospitals operating emergency rooms declined from 402 to 357
11 and the total number of hospitals declined from 525 to 413. In 2005 there were only 64 trauma
12 centers, with 17 having closed over the past 20 years. In 2003, over-capacity emergency rooms
13 in California were “on diversion” for almost one-quarter million hours – a 16% increase over the
14 2002 level. A hospital on diversion is requesting that ambulances bypass its emergency room
15 and instead transport patients to other medical facilities. These delays can jeopardize patient
16 safety. In Los Angeles County, the public hospitals were on diversion an average of 63% of the
17 time. Since the implementation of mandated nurse staffing ratios in January 2004, despite an
18 undersupply of trained personnel, crowding and boarding pose a greater threat to the safety of
19 Californians seeking emergency care.

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

27 Even since the initial proposed regulations were drafted, at least five major hospitals have
28 announced closure of their EDs due to downgrading and decertification, including Daniel
29 Freeman Medical Center in Inglewood, Doctors Medical Center in San Pablo, and King Drew
30 Medical Center in Los Angeles. These hospitals have all announced closure or impending
31 closure of their EDs, and the domino effect is throwing surrounding hospitals and communities
32 into crisis.

33 5. The Proposed Regulations Ignore the Existing Financial Crisis in Emergency
34 Care

35 California has more than 6 million uninsured patients. According to a 2000 UCLA Center for
36 Health Policy Research study, three-quarters of California's legislative districts have higher
37 uninsured rates among the non-elderly (ages 0-64) than the national average of 17 percent.
38 Fewer employers are offering health insurance and not all poor patients qualify for the MediCal
39 program. The net result is that 20% of Californians are without health care benefits and these
40 patients have little option but to seek their healthcare through Emergency Departments. This
41 makes insurance more expensive for everyone, and undermines the financial viability of the
42 emergency care safety net.

On call panels are deteriorating. Many physician specialists, that we rely on to provide comprehensive care, are no longer willing to be on-call for our emergency departments. A 2002 California Senate Office of Research report on Growing Gaps in California's Emergency Room Backup System (**See Attachment 12)** mandated by AB 2611 indicated that "problems with access to emergency room on-call services in many specialties in many areas of the state are adversely impacting the quality of patient care and forcing hospitals, physicians, patients and, in some cases, medical groups and health plans to incur significant costs. **Problems with access to on-call services are primarily the result of problems with reimbursement of physician specialists who provide on-call services. Problems with lack of payment or underpayment associated with on-call services extend to all payers – health plans, Medi-Cal, Medicare, and safety net programs for the uninsured – and act cumulatively to reduce the willingness of physicians to provide on-call services** (emphasis added). Specific problems affecting payments for on-call services include: inadequate payments for on-call services for uninsured patients under safety net programs, including local Emergency Services Funds, county indigent health programs, the SB 855 disproportionate share hospital program, and the SB 1255 supplemental payment program, and problems with managed care contracting and payment practices that affect the timing, level and certainty of reimbursement for on-call services to insured patients. **These include: Medical group insolvencies and financial difficulties, lack of contracts between health plans and sufficient numbers of physician specialists for on-call services, dissatisfaction of medical groups and their members with the terms of their contracts with health plans, dissatisfaction on the part of non-contracting physicians with the payment rates offered by health plans for on-call services, the use of inconsistent coding and documentation standards by health plans, regulatory limits on reimbursement of on-call services by Medi-Cal managed care plans, delays in adjudication of providers' complaints about payments for on-call services by Medi-Cal managed care plans, and inadequate Medi-Cal payment rates."** (emphasis added)

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

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

1 **prompt payment provisions, including engaging in an unfair payment pattern.”** (emphasis
2 added)

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

10 7. The Consequences of these Proposed Regulations on State Financing Have
11 Been Ignored

12 These regulations undoubtedly will create more costs to both the state and local governments. By
13 reducing or eliminating the ability of emergency care providers to receive their usual, customary
14 and reasonable charges for non-contracted services, and thereby undermining contracting rates
15 with Knox-Keene payers for emergency care services; a deficit of perhaps $500 million a year in
16 the funding that currently supports the provision of emergency care in California will revert back
17 to health plans in the form of additional, and undeserved profits. **It is foolish and imprudent to
18 assume that this deficit in funding will not impact patient access to emergency care, the
19 quality of the services rendered, or the health of California’s citizens; especially since the
20 emergency care safety net is already overwhelmed, under funded, and on the verge of
21 failure**. The State of California will have little choice but to replace this deficit out of general
22 fund revenues, through expanded MediCal reimbursement rates, increased contributions to
23 County EMS Funds, and expanded financial support for our financially strapped hospitals. This
24 regulation will also increase a county’s financial obligation under Welfare & Institutions Code
25 §17000, because Counties will also have to find a way to expand support for emergency care
26 services for MIA patients. **Thus far, the DMHC has refused to acknowledge the financial
27 consequences of these regulations on limited State financial resources, and appears to be
28 oblivious to its responsibilities to protect consumers at-large, and not just the enrollees of
29 health plans.**

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

39 E. Summary

40 For the reasons mentioned above, it would be inappropriate for the DMHC to establish an
41 ‘expedited payment’ policy which encourages payers to underpay every claim, and undermines

nearly every current contract between insurers and emergency care providers. The courts, in developing the Gould criteria, established that the reasonable value of a non-contracted provider's services are generally related to the prevailing charges of similar non-contracted providers in the community. This does not mean that prevailing charges are 'determinative'. Final determination of this value depends on the application of the other Gould criteria as appropriate. Modifying these criteria as requested by CAPG, and adopting the 'expedited payment' standard at 150% of Medicare rates, would completely subvert our current and duly constituted fair payment standard, and contaminate the prevailing charge concept with historically low government and contract rates. In our view, this would result in huge illegal taking and would destroy our practices, devastate our emergency care system, and harm our patients.

III. Revisions to section 1300.71.38 commence at Page 26. The IDRP

A. The Proposed Dispute Resolution Process is Unlawful, Untested and Ill-defined, and Unworkable

We believe that the proposed regulations are unnecessary and unlawful. In addition, we intend to show that the proposed ICDR process would be unworkable and would likely result in serious harm to California's emergency services system, and hence to our patients. We feel strongly that the decision to promulgate an ICDR is more properly left to the legislature and that major policy decisions of this nature should not be decided by the DMHC or delegated to a private organization. Critical provisions such as funding, fees, standards for the appointment of the arbitrator, etc., will greatly determine whether this process is fast, fair and cost effective, as mandated by the Governor's executive order and required by law (see Wilkinson v. Madera Community Hospital (1983) 144 Cal.App.3d 436, and clarity); and the proposal lacks the detail and clarity necessary to assure the medical community that it will work appropriately. Specifically, the proposal for the IDRP does not address the procedures required to access the process, the documentation required from participants, the standards that would be applied to disputes over coding and bundling (such as the AMA CPT coding rules that providers have consistently demanded be used), the qualifications of those adjudicating the disputed claims, the costs for participation, the mechanisms for restitution, the timelines for responding to notices of dispute, the mechanics of the deliberation (baseball arbitration is one approach that CAL/ACEP recommended), limitations if any on use of attorneys, limitations on length of arguments submitted, requirements for reporting of the results of dispute proceedings, the required qualifications of the IDRO selected by the Department, and a host of other key considerations that vitally affect the notion of fair, fast, and cost-effective. For example, as to fairness, there is nothing in the regulations prohibiting the Department from selecting an IDRO that has multiple financial, consulting, or contractual relationships with the Plans and RBOs likely to be involved in these disputes.

1 B. The Proposed IDRP Process Must be Used to Adjudicate Only a those Claims that are
2 Reasonably Contested

3 Another major problem with the ICDR proposal is that it cannot be relied upon to achieve fair
4 payment for large numbers of claims, and thus cannot substitute for the enforcement of policies
5 that result in the proper payment of most claims with the first payment. Under our Constitution,
6 providers have a right to charge and collect for their services, and patients and plans have a right
7 to contest in the courts whether the charges were reasonable. EMTALA requires that these
8 services be provided regardless of the patient's ability to pay; however, this does not give the
9 state the right to exploit this mandate and impose a billing prohibition without the assurance that
10 it has developed both a "fast, fair and cost-effective alternative" (per Governor
11 Schwarzenegger's Executive Order) for the dispute of reasonably contested claims, and an initial
12 payment standard that results in proper payment of the vast majority of claims. CAL/ACEP has
13 repeatedly indicated that it is willing to participate in an ICDR provided that it is not relied upon
14 as a substitute for the initial payment of the vast majority of emergency care provider claims at
15 the full reasonable value of the services rendered. Our belief is that most emergency care
16 provider charges are reasonable, and thus should be paid in full with the initial payment. The
17 Department apparently believes that ALL emergency care provider charges are excessive: why
18 else promote an 'expedited payment' that is lower than every provider's charge?

19 C. The Proposed Process Would Be Cumbersome, Overwhelmed, and Unworkable

20 In order to demonstrate why the proposed process won't work and would devastate our
21 emergency care system we offer the following analysis. Based on our experience, there are at
22 least five different types of payment disputes, which occur singly and in combination; including:

23 - a) Payment for a service at rates below the provider's usual and customary charge
24 - b) Down-coding of the provider's charged service, usually applied to the evaluation
25 and management service level
26 - c) Bundling of two or more separately billed services under a single coded service
27 - d) Denial of payment for a coded service, or denial of coverage as an emergency
28 - e) Delay of payment
29 -

30 Unfortunately, the payer's explanation of benefits which usually accompanies the payment to the
31 provider often does not specify exactly why the claim was paid at less than the provider's charge.
32 The payer often neither specifies how the paid rate was determined, which service was down-
33 coded to what level and why the service was down-coded, why services were bundled, nor which
34 coding rule was used to justify bundling or denial of payment for a service. Often, more than
35 one of these four means to justify underpayment is applied to a single claim, or several claims
36 are paid under one EOB, and the reasons for underpayment of the entire set of claims is
37 unspecified on a claim by claim basis. This is particularly true for RBO paid claims, as RBOs
38 are not directly regulated by the DMHC and HMOs often fail to provide oversight of their
39 subcontractors' claims adjudication practices. Thus, for arbitration to be effective in the
40 resolution of these disputes; the payer's EOB MUST specify exactly and specifically why each
41 and every coded service in the claim was reduced, bundled, underpaid, or denied. In particular,
42 down-coding of claims is difficult to address: coding of an E+M service involves documentation
43 in the medical record, and providers are obligated to ensure that their documentation supports the

level of service coded, according to published AMA CPT coding rules. Unfortunately, payers do not necessarily adhere to these rules, and rely only on the final diagnosis reported on the CMS 1500 form, rather than the documentation in the medical record, to make a payment or down-coding determination. This is inappropriate because some less serious diagnoses can only be determined by excluding the more serious possibilities with often rigorous and thorough evaluations.

In CAL/ACEP's experience, when a particular fee schedule is agreed upon in contract, or is required as an initial payment standard to be considered compliant with AB 1455 minimum claim payment regulations (as in the recent HealthNet consent agreement); payers resort to more aggressive use of down coding, bundling, and denial of payment as a means of reducing payments to emergency care providers and enhancing their profits. HealthNet, for example, relied on aggressive bundling for ECG and X-ray interpretation charges following the HealthNet enforcement action on payment rates, until a subsequent complaint to the DMHC required HealthNet to begin paying emergency physicians for these services. This is why many emergency physicians, especially when coerced into contracting with a networked payer by their hospital administrator, try to insist on case rate contracting, by which every claim is paid at an agreed upon averaged rate regardless of the service provided, so as to eliminate disputes over down coding, bundling or denial of payment. Thus, even if the DMHC were to impose significant penalties on payers for patterns of inappropriate claims payment, which seems unlikely; any dispute resolution or arbitration program is likely to be overwhelmed with hundreds of thousands of coding-disputed claims, requiring the careful evaluation of medical records and coding of these claims by trained coding experts. If, as proposed in these regulations, the 'expedited' initial payment of the claim is substantially below the usual and customary charge of almost all emergency care providers, and in addition the payer is allowed to down-code and bundle claims prior to making this 'expedited payment'; the need for providers to contest nearly every claim will overwhelm the IDRP and make fair payment of most claims an impossibility.

E. The Proposed Process Would Be Unaffordable For Emergency Physicians

CAL/ACEP members estimate that processing each disputed claim through the proposed ICDR process would cost the provider approximately $20-25 per claim, or perhaps 30% less, if similar types of disputes could successfully be batched or consolidated. Based on our member's experience, the average claim underpayment for emergency physicians is about $80. Our current coding, billing and overhead costs are approximately $15 for each Health Plan or RBO appeal, regardless of the size of the claim. If balance billing is prohibited, it is likely that at least three quarters of a million Knox-Keene regulated emergency physician claims a year will be underpaid and subject to dispute. With 50 different plans, (including MediCal Managed Care Plans), 250 separate RBOs, and 160 emergency physician groups, it will likely be necessary for emergency physician groups in California to engage in tens of thousands of separate disputes, even if it is possible to consolidate two or even three months worth of claims into a single dispute. The picture gets even worse if the proposed 'expedited payment standard' in the regulations is enacted. This then is the perfect foil for large and wealthy Health Plans and RBOs to use their vastly superior resources to drown emergency care providers with paperwork and drive us out of business defending our claims and pleading for reasonable payment, or force us into accepting unreasonable contracts.

An analysis of one large ER physician group's experience with the dispute of underpaid claims with Knox-Keene regulated plans and their delegated payers reveals many potential problems with the DMHC's proposed ICDR. In 2005, California Emergency Physicians Medical Group (CEP) disputed over 87,000 underpaid claims, and negotiated settlement agreements on another 50,000 misspaid (mostly underpaid) claims. More than 35,000 of the disputes were subject to the Knox-Keene fair payment regulations, involving more than 200 plans, medical groups, and IPAs. What the table below (culled from attachment 4) demonstrates is that some payers often respond to disputes with additional payment, and others rarely do. (**see table below)** For the latter, it is often a waste of time and effort to have to dispute the underpayment first with the payer. About the only significant improvement the DMHC made to the first attempt to enact these regulations in 2006, which now appear in these new proposed regulations for 2007, is that providers would now have the discretion to go directly to the independent dispute process, and not have to suffer the substantial cost and redundancy in the DMHC's 'chase payment twice, dispute, and hope for payment later' proposal.

Using the payer's internal dispute process is as often as not a waste of time and effort

Percent of time dispute resulted in any pmt ↘

KAISER PERMANENTE	2004	1,668	$152,939	1,172	$0	2,840	$152,939	58.7 %
	2005	3,524	$276,362	1,955	$0	5,479	$276,362	64.3 %
	2006	1,286	$94,887	1,187	$0	2,473	$94,887	52.0 %
	Total	6,478	$524,188	4,314	$0	10,792	524,188	60.0 %
DESERT MED GRP /OASIS IPA	2004	280	$40,540	924	$0	1,204	$40,540	23.3 %
	2005	935	$151,530	2,811	$0	3,746	$151,530	25.0 %
	2006	291	$50,770	1,217	$0	1,508	$50,770	19.3 %
	Total	1,506	$242,840	4,952	$0	6,458	242,840	23.3 %
HILL PHYSICIANS	2004	1,243	$103,450	443	$0	1,686	$103,450	73.7 %
	2005	2,852	$240,474	628	$0	3,480	$240,474	82.0 %
	2006	282	$24,826	162	$0	444	$24,826	63.5 %
	Total	4.377	$368.750	1.233	$0	5.610	368.750	78.0 %
ANCHOR MEDICAL GRP	2004	67	$2,142	61	$0	128	$2,142	52.3 %
	2005	52	$2,779	144	$0	196	$2,779	26.5 %
	2006	9	$262	54	$0	63	$262	14.3 %
	Total	128	$5,184	259	$0	387	5,184	33.1 %
REDLANDS CMNTY HOSP	2004	21	$2,101	171	$0	192	$2,101	10.9 %
	2005	23	$2,238	103	$0	126	$2,238	18.3 %
	2006	9	$1,129	53	$0	62	$1,129	14.5 %
	Total	53	$5,467	327	$0	380	5,467	13.9 %

A more recent analysis of claims disputed in January 2006 reveals that a total of 25,814 Knox-Keene related commercial claims (this number excluded Medicare Managed Care and MediCal Managed Care claims, and an additional 500 or so that were not separately codified as subject to Knox-Keene) were billed in that month. Of these 25,000+ claims, 2981 were disputed (746 are still open claims as of September, 2006). Although most of these claims were non-contracted,

quite a few were disputes of contracted claims. For these disputed claims, the average percent of full charges (non-contracted) or allowable charges (per terms of the contract) that were in dispute was 38%. Only 52.4% of this disputed claims received any additional payment, and the average disputed amount paid was 46.2%. Thus, although some plans and RBOs did respond appropriately with additional payment as a result of CEP accessing the payers' internal dispute process, something like two thirds made only a partial or no payment. This additional payment averaged $58 of the $140 in average disputed amounts.

In a full year, CEP would file more than 35,000 Knox-Keene related disputes, and since the claims data from this ER billing company set represents about 17% of all of California's ED patients, this would mean that more than 210,000 non-contracted commercial Knox-Keene related emergency physician claims could potentially be disputed in California. Actually, because of its wide geographic coverage in California, CEP has a very active contracting program with health plans and RBOs in the state, resulting in a far higher percentage of contracted claims than most ER groups. A more accurate prediction would be closer to 270 – 300,000 non-contracted ER physician claims disputes per year.

CEP also settled a substantial number of contracted Knox-Keene related incorrectly paid (usually underpaid) claims with contracted plans and RBOs (contracting is no guarantee of payment at the contracted rate), thus making it likely that some 400,000 Knox-Keene emergency physician claims per year are currently being underpaid, and certainly even more would potentially be disputed in the IDRP under the proposed regulations. The DMHC has been fully informed on multiple occasions in writing and with full documentation about the extensive experience detailed above that CEP and other emergency care providers have had with the submission of tens of thousands of underpaid claims to payers' internal dispute programs, yet in the Rulemaking Action (page 4), the Department has the nerve to claim that emergency care providers "generally ignore the processes available to them for submitting claims to, and obtaining payment from, health plans, and to resolve disputes regarding claims payment and claims settlement".

Even if two to three months of claims disputes can be consolidated with each payer by each emergency physician group; this means that the ICDR would have to resolve more than 100,000 consolidated claims disputes per year for emergency physician services alone. This projection doesn't even address the impact of disputes with a myriad of other emergency care provider on-call specialists, or the impact of hospital facility fee disputes. There are probably ten times as many other specialty physicians and physician groups providing emergency care in California, with probably an equal number of underpaid claims, thus increasing the number of potential consolidated dispute referrals to the ICDR program to 200,000 per year. How the DMHC can possibly expect an ICDR to be able to resolve this many disputes is unimaginable. An effective ICDR in California is nothing more than wishful thinking at this point, unless the Department changes course and implements an initial claims payment standard that results in the payment of most emergency care providers' claims at their usual, customary and reasonable charge. This is clearly not the DMHC's intent.

F. The Proposed ICDR Fails to Address Contracted Claims Disputes

There are currently more than 10,000,000 emergency department visits in California every year, and the numbers continue to grow. Of these, approximately 1,600,000 are HMO insured enrollee visits, 2,500,000 are Knox-Keene regulated insured visits (this and all other numbers in this review are based on extrapolation from a much smaller database, and may be off by as much as 30%). Approximately half of the emergency physician claims for HMO insured patients are covered by contracts between the provider and the HMO or the HMO's subcontracted, delegated payer (RBO). A significant percentage of these contracted claims are paid at the contract rate. When the contracted provider considers these claims to be paid inappropriately, either because the claim was not paid according to the terms of the contract, or because the payer down-coded the services billed, or bundled services together under one code, or denied payment of certain services; the payer must generally dispute the payment using the payer's internal dispute mechanism. Alternatively, the provider can sue the Plan or RBO for breach of contract, or complain to the DMHC if there is a pattern of inappropriate claims payment. However, it is clear that the DMHC will not address disputes between contracted providers with the IDRP, or has jurisdiction to take direct enforcement action for patterns of inappropriate claims payment against RBOs. An independent dispute resolution mechanism, short of lawsuits in the court, is needed for individual or bundled claims that the contracted provider feels are inappropriately paid; since payers often fail to overturn initial determinations on claims payment.

G. The Cost of Disputing Small Claims is Prohibitive

Offering emergency care providers a dispute resolution process which imposes even more costs will not help them to obtain fair and prompt payment, particularly when it is tied to a system that will encourage health plans to challenge even more of their bills. This is particularly true given the relatively small dollar value of each claim and dispute for emergency physicians. Disputing these underpayments in the independent dispute process is likely to add more than 60 days to the provider's days in accounts receivables for these claims, and easily double the cost of billing and collections for these claims (the typical cost prior to dispute is about 12% of collections for emergency physician claims). The Arbitration Mediation & Conciliation Center believes that the cost of paying for arbiters to adjudicate these disputes would be about 20% of the disputed amount. In addition, the added cost to the provider for the clerical work to participate in these disputes, preparing the files, medical record copies, and other documentation required for the disputes, developing the arguments in support of the provider's position, and carrying the open accounts receivable through the two tiered dispute process is estimated, based on feedback from several emergency physician billing companies, to be another $15-25 per claim. **Thus, the cost of seeking fair payment for a $120 dispute, even if the cost of the arbitrator were split between the provider and the payer, would amount to an investment of $45 in the hope of collecting up to $120 in additional reimbursement on an emergency physician's underpaid claim**. Clearly, this alone would make participation in this process financially untenable for emergency physicians, and some sort of state subsidy for this process would be needed to ensure a fair and cost-effective mechanism. **The DMHC, however, failed not only to specify in the regulations how the costs of the ICDR process would be distributed and borne, but also indicated that the process would require no additional funding from the State.**

The DMHC staff has also proposed that, to reduce the cost of dispute resolution, claims disputes should be bundled and arbitrated together as much as possible. This might be possible if a particular payer consistently denies payment for a particular code or consistently bundles two

particular codes together. Unfortunately, it will be difficult if not impossible to bundle claims involving more than a single disputed issue, and claims involving more than one reason for underpayment. Furthermore, some emergency physicians receive payment from more than fifty different HMOs and RBOs, often as few as five or ten a month from any particular payer, involving payers throughout the State. Thus, bundling disputes will require either substantial delay to accumulate claims from a particular payer over a particular disputed issue, or will require delay to accumulate bundled disputes for each disputed issue for each payer; and result in ever growing accounts receivables that must be carried by these providers. Most likely, emergency physicians will simply throw up their hands trying to manage the dispute resolution process and chalk up the underpayment of most of these claims as bad debt. Of course, this will only encourage payers to even more aggressively underpay these claims, in a calculated effort to reduce their overall payments. In summary, despite the contention of the DMHC staff, arbitrated dispute resolution for emergency physician HMO covered claims is likely to be expensive, inefficient, overburdened and ineffective in resolving the issue of claims underpayment.

H. The Rational Alternative

Enforcement of an initial payment standard based on the Gould criteria in AB 1455 does have a significant advantage. If emergency physician claims were paid at the lesser of the provider's charge or the 75th percentile of emergency physician charges, and arbitration reserved for disputing charges in the upper 25th percentile, many fewer claims would end up in dispute resolution and the process could focus on what is more likely to be truly excessive charges. However, in disputes over claims coding, or involving a combination of a coding or bundling dispute and a reasonable value dispute, baseball style arbitration may not be adequate to achieve a fair adjudication of the claim. CAL/ACEP has proposed, on several occasions, approaches to using an IDRP to adjudicate claims that relies on clear standards, carefully detailed procedural steps, limitations on advocacy to promote cost-effectiveness, processes such as baseball arbitration, and disincentives to frivolous disputes such as 'loser pays', which in the aggregate describe workable approaches to claims dispute resolution that focus on a narrow selection of disputed claims coding, charges, and payments, and thus are not likely to be overwhelmed to the point of utter failure. At least two states (Colorado and New Jersey) have adopted an alternative approach to the elimination of balance billing: requiring the plans to pay the claim in full, eliminating any unpaid balance, and allowing these plans to sue the provider in court or in a claims dispute process if the provider's charges were felt to be excessive. This was also proposed to the DMHC. The Department has consistently ignored these recommendations.

I. Summary

The Department's proposal for an independent claims dispute resolution process is ill-defined in the regulations, is likely to be overwhelmed with disputed underpaid claims, would probably be inefficient and expensive for providers, and will fail to ensure the proper payment of most non-contracted emergency care provider claims. Its only utility will be to serve as a smokescreen for the illegal and damaging transfer of hundreds of millions of dollars from providers to health insurance plans.

IV. Adoption of section 1300.71.39 commences at Page 28 Unfair Billing Regulation

A. No Authority for the Regulation

In the recent Prospect v Saint John's and Northridge Medical Group appellate decision, the Court held for the defendants that balance billing was not prohibited under law, and payment for emergency services at Medicare rates did not meet the standard for usual and customary reimbursement. This case is now under review by the California Supreme Court at the request of the DMHC

The DMHC has no authority in the Knox-Keene Act, or anywhere else in California law, to adopt regulations prohibiting non-contracting physicians from obtaining payment for their services. The Legislature only granted the DMHC jurisdiction to issue regulations regulating its own licensees – health plans, not individuals that have no contract or other connection with a health plan. Given their EMTALA obligations under the law, emergency physicians often have no knowledge of whether a patient to whom they have provided emergency services has any health insurance, let alone whether they happen to be covered by a Knox-Keene plan. The Legislature has clearly not authorized DMHC to act in this area. In fact, the statute the DMHC relies upon for "authority" in issuing this proposal, Health & Safety Code §1371.39, expressly requires the DMHC to go to the Legislature with its recommendations with respect to "unfair billing practices." Had the Legislature intended for the Department to directly regulate physicians' billing practices, it would have expressly granted this authority rather than directing the department to refer this issue back for Legislative consideration.

In its Notice of Rulemaking Action for these regulations, the Department cites Section 1371.39(b)(1) and other sections established in AB 1455 authorizing the Department to define 'unjustified billing patterns' as justification for the Department using these regulations to prohibit balance billing by non-contracted emergency care providers and hospitals. However, the Department conveniently failed to note or cite the two related parts of this Section that were also adopted with AB 1455:

1371.39(b)(2) 'The department shall convene appropriate state agencies to make recommendations by July 1, 2001, to the Legislature and the Governor for the purpose of developing a system for responding to unfair billing patterns as defined in this section. This section shall include a process by which information is made available to the public regarding actions taken against providers for unfair billing patterns and the activities that were the basis for the action.'

1371.39(c) ' On or before December 31, 2001, the department shall report to the Legislature and the Governor information regarding the development of the definition of "unfair billing pattern" as used in this section. This report shall include, but not be limited to, a description of the process used and a list of the parties involved in the department's development of this definition as well as recommendations for statutory adoption.

The Department has never fulfilled either of these obligatory statutory elements of the process for establishing the definition of unfair billing patterns or the system for responding with actions

against providers for unfair billing patterns. Furthermore, the reference to recommendations for statutory adoption in 1371.39(c) clearly indicates that it was the Legislature's expectation that these definitions of unfair billing patterns and related enforcement processes all would require Legislative approval and adoption, which has never happened. In fact, the Legislature has had two opportunities in the last two years to adopt Legislation specifically prohibiting balance billing by non-contracted emergency care providers, and in both instances the Legislature has decisively turned away from this opportunity, in the latest instance declining even to give this legislation a hearing in committee, an unusual and rather definitive rejection. The fact that the Department deliberately declined to mention in its Rulemaking Action these restrictions on the authority of the DMHC to assert regulatory jurisdiction over unfair billing patterns by providers without Legislative approval strongly suggests that the Department prefers to ignore these restrictions, or fears that these restrictions invalidate their authority to enact these regulations as written. If the Department truly believed that these restrictions do not really apply to the act of defining balance billing as an unfair billing pattern; the Department would certainly have acknowledged the obligatory and restrictive language in statute; and explained in the Notice why this language did not apply to the proposed prohibition of balance billing or impact the Department's authority to adopt this language in regulation.

B. Inconsistency with Knox-Keene Act

Further, the proposed regulations concerning "unfair billing practices" are wholly inconsistent with California law. The Knox-Keene Act is replete with references to allowing non-contracting physicians to bill enrollees for the reasonable value of their services. See, for example, Health & Safety Code §1363 (enrollees should be informed of financial liability); 28 C.C.R. §1300.63 (in event the health plan fails to pay for the non-contracting provider's service, the member may be liable to the non-contracting provider for the cost of the service); Health & Safety Code §§1373.95 and 1373.96 (non-contracted physicians do not need to accept health plan rates); Health & Safety Code §§1374.34 and 1262.8 (recognizing right of non-contracted emergency care providers to seek reimbursement from enrollees). These statutes recognize a non-contracted physician's common law right to seek reimbursement from the person who directly benefited from the physician's services, and are fully consistent with the most recent, citable California court decision on this issue. See Bell v. Blue Cross of California (2005) 131 Cal.App.4th 211, 31 Cal.Rptr.3d 688. Indeed, the Bell decision recognized the constitutional infirmity of the type of regulation the DMHC proposes, that is, by proposing to allow the health plans to unilaterally set rates, health plans would be empowered to pay at confiscatory levels in violation of the Constitution.

C. Failure to Regulate Underpayment as the Root Cause of Balance Billing

In its Notice of Rulemaking Action, the Department claims that: "When a health plan adjudicates a health care provider's claim to adjust for the provider's inappropriate unbundling of claims or up-coding of services, unfair billing patterns as defined in Section 1371.39, the amount the plan pays to the provider is correspondingly reduced. This subjects the enrollee to the provider's balance billing activities for the difference between the amount the provider billed and the amount reimbursed by the plan." This statement clearly reveals the Department's biased perspective on balance billing: the statement could just as easily have said: "When a health plan adjusts the provider's claim by inappropriately bundling or down-coding the services listed in the

1 claim, unfair payment practices as defined in Section 1371.37, the amount the plan pays to the
2 provider is correspondingly reduced. This subjects the enrollee to the provider's balance billing
3 activities for the difference between the amount the provider billed and the amount reimbursed
4 by the plan." In courts across the country, it is the Plans, not providers, which have been
5 admonished and fined millions of dollars for the systematic practice of inappropriate bundling
6 and down-coding claims. At the very least, the Department should have acknowledged that there
7 are two sides to this issue, and crafted their regulations accordingly. It is this very bias which
8 has resulted in proposed regulations that reflect this slanted approach: regulations that are
9 fashioned to protect consumers from balance bills (a good think except for the impact on access
10 to care) and plan and RBO profits (an unnecessary thing) at the expense of providers (with a
11 disastrous consequence).

12 A 2002 California Senate Office of Research report on Growing Gaps in California's
13 Emergency Room Backup System (**See Attachment 12**) recommended that: "Health plan
14 enrollees and health care consumers should be better protected from the impacts of contracting
15 and payment disputes between health plans and physicians related to on-call services and from
16 being required to pay out-of-pocket for services that are covered by their health plans, by
17 providing that **a payment practice that indirectly harms a health plan enrollee by causing**
18 **the enrollee to pay amounts in excess of applicable co-payments, deductibles, or**
19 **coinsurance for ER and on-call services that are covered by their health plan constitutes an**
20 **unfair payment pattern and is subject to the remedies under the prompt payment statute**.
21 An example would be a plan that follows a practice of paying discounted fees to non-contracting
22 providers for on-call services, with the result that the providers bill their patients and the patients
23 pay the remainder of the fees. **Note that the SOR correctly recommended that balance billing**
24 **be considered a consequence of "unfair payment patterns", not unfair billing.** The DMHC
25 has failed to heed this recommendation, and instead of addressing balance billing as a by-product
26 of claims underpayment, it is exceeding its authority by attempting to regulate physician billing
27 without Legislative review or approval.

28 D. Regulatory Double Standard

29 Of note, the California Association of Physician Groups (CAPG), an organization of capitated
30 medical groups that subcontracts for insurance risk from Health Plans, has been the leading
31 advocate of these proposed regulations. It is particularly frustrating for emergency care
32 providers to have a prohibition imposed on non-contracted emergency care billing practices,
33 when it is a well known fact that the physicians who are affiliated with CAPG's medical groups
34 and IPAs exercise these same rights to seek payment of the balance of a bill from the patient
35 when they provide services that are not covered under contract with a patient's health care plan,
36 and the plan underpays the claim. The DMHC claims (Rulemaking Action page 3) that 'the
37 most significant and frequent balance billing problems occur in the context of emergency care,
38 yet the Department has never reported any data on the incidence of balance billing, and really
39 has no information to back up this claim. The rationale for this selective enforcement by the
40 DMHC appears to be that patients seeking emergency care have no choice in where they go for
41 care, and that they expect the physicians at networked hospitals to be contracted as a part of their
42 network. These are legitimate considerations, but they should be addressed directly, as indicated
43 below, rather than by placing one-sided restrictions on good faith providers.

A related question regarding regulatory double standards is: why should Blue Cross and Blue Shield PPOs be allowed to benefit from the prohibition against balance billing simply because these are Knox-Keene plans? These two plans are not sold to enrollees with the same expectations of coverage as HMO products. These regulations could give these two PPO plans a distinct and unfair advantage in the PPO marketplace.

Emergency physicians have experienced a long and difficult history of underpayment, delayed payment and non-payment by Health Plans and Capitated Medical Groups. As the result of inaction on the part of DMHC in this area over which it has undisputed jurisdiction, CAL/ACEP members have been forced to pursue costly and time consuming resolution via litigation; and, ten years after its formation, the DMHC is only now attempting to address the issue of provider payment grievances under the auspices of its current Director. From its inception, the DMHC has had a consumer driven mission; however, the culture of the Department has been highly influenced by payers, with many staff members at the highest levels obtaining employment with these payers after leaving the Department. Over the long term, CAL/ACEP has no reason to believe that this culture will change, despite the best intentions of the current Director to address these problems.

E. Fundamental Requirement for Patient Participation in Market Based Health Insurance Relationships

The DMHC has asked if it is absolutely necessary to 'keep patients in the middle of these disputes' for provider's to be paid reasonably. The answer is that we have a 'third party payer' system in Knox-Keene. This means that there are three parties involved in payment and coverage related transactions: the patient, the provider and the insurer. There are times when the patient, and only the patient, is able to provide information necessary to make an appropriate determination of the reasonable value of the service provided. The non-contracting physician's only 'contract' is with the patient, and the patient in turn has the contract with the insurer. Sometimes, only the patient knows what the insurer has agreed to insure and pay for. Sometimes, only the patient can confirm why they felt they needed emergency care. Sometimes, only the patient can confirm that the care billed for was actually provided, or required. An involved consumer is essential if the DMHC is to be able to manage its regulatory function effectively. Most importantly, emergency care providers are frequently not informed that a patient is covered by a health insurance plan, and does not receive this information until the patient or a relative or conservator receives a bill from the provider and responds with coverage information. **The DMHC's proposed regulations do not grant any exceptions to the prohibition against billing the insured patient (except for copays and the like), even if the provider has no way of knowing that the patient is covered by insurance, or whether the insurance plan is subject to these regulations.** The Department's ignorance of standard billing procedures and claims payment hurdles is evident throughout these proposed regulations; and a blanket prohibition against patient's receiving bills for covered services is but one example.

However, it should be possible to minimize the need to involve patients in the resolution of these disputes over fair payment and reasonable charge. In the ideal world, these instances would be fairly uncommon, and this could be accomplished by adopting a set of preconditions that should already have been established under existing law, including: 1) honoring and enforcing the existing Gould usual and customary charge paradigm with an initial claims payment standard

that resulted in most claims being paid fairly and in full; (2) responsible AB 1455 enforcement to ensure that payers meet the fair and timely payment regulations; (3) effective Knox-Keene enforcement so that Health Plans would be required to develop adequate provider networks that reduce their reliance on non-contracted ER On-call specialists; and (4) focused mechanisms to address those few providers who may, in fact, overcharge. Unfortunately, the DMHC appears to have abandoned the Gould standard, despite its adoption in 2003 after an exhaustive three-year rule-making process. And, as acknowledged by the Director in legislative testimony, the Department has a less than stellar track record for enforcement of its own regulations. Instead, the Department appears to have become so distracted with RBO complaints of, and an unfounded presumption of, wide spread overcharging that it has failed to use existing mechanisms to deal with this issue, such as referral to the courts or to the California Medical Board. Even if all of these mechanisms were working the way they should, however, there would still be instances where the patient would have to play a role in the payment process - they are, after all, one of the three parties in our 'third party payer' system, and they should never be blinded from these transactions.

The right of non-contracted providers to bill the unpaid balance of the claim to the patient (which is in dispute), the complaints of balance billed patients, and the spotty enforcement of AB 1455 fair claims payment by the DMHC, are the only reasons that HMOs and RBOs pay us at all; since these payers recognize that EMTALA requires emergency physicians to provide their services to everyone regardless of payment. If balance billing is prohibited, and if the DMHC fails to pursue enforcement of AB 1455 for HMOs and RBOs; the percentage of claims underpaid, and more significantly the amount of underpayment, will accelerate, and contracting rates will plummet. Although balance billing makes up a small fraction of emergency physician revenue, our right to seek payment of our usual and customary fees as non-contracting physicians is a linchpin in our ability to negotiate reasonable contract rates, and thus protects not only providers, but also consumers, who must rely on a viable emergency care safety net. The Department in its Rulemaking Action (page 4) likens balance billing to the unfair leveraging of innocent enrollees by providers seeking excessive payments. This one-sided analysis reveals the Department's blindness to the obverse consideration: that the underpayment of claims by health plans, thereby passing the responsibility for the unpaid portion of the claim on the enrollee even as the plans discourage patients from paying these balance bills, is the health plan's way of leveraging the patient's misdirected anger at providers to force these providers to accept lower contracting rates. Patients recognize the intrinsic value of the emergency services that they receive, whereas insurers only view these services as overhead; and they have little market incentive to negotiate reasonable contract rates with us, with the exception of their desire to placate their enrollees.

F. Existing Restraints on Emergency Physician Charges

CAPG and the DMHC often refer to 'exclusive contracts' emergency physicians have with their hospitals, and have alleged that these physicians exploit these exclusive arrangements to resist contracting with plans or RBOs and to demand excessive contracting terms. In fact, under California law, emergency physician staffing arrangements with hospitals are NOT considered exclusive staffing arrangements because any physician may treat a patient in the ER at the patient's request, including assigned capitated physicians. In addition, emergency and other hospital-based physicians have frequently experienced coercion and threats to their staffing

contracts and contractually-linked medical staff privileges from hospital administrators when they attempt to negotiate fair and reasonable contract rates with hospital-sponsored capitated medical groups and other networked payers. This practice, known as "coercive contracting", functions as a reverse kickback so hospitals can obtain more plan referrals; and even though technically prohibited under federal and state law (Health & Safety Code section 1322), is nevertheless so prevalent that it is actually written into many ER staffing contracts. Health & Safety Code section 1322 prohibits hospitals from conditioning medical staff membership or clinical privileges upon the physician's participation in a contract with an insurer, hospital service plan or health care service plan. Furthermore, the vast majority of hospitals stipulate the requirement for emergency physician groups to submit any changes in their fee schedule for hospital review and approval, (90 % of 52 hospitals in a recent emergency physician survey). These market and non-market forces already restrain emergency physician charges and undermine fair payment for these essential services. The proposed regulations would exacerbate the existing inequities by forcing these providers to look only to the Health Plans and RBOs for payment; and would only add additional coercive pressure to contract at deeply discounted rates.

G. Alternatives to Proposed Unfair Billing Practices Regulation

1. Requiring Adequate Provider Networks

Finally, there is no need for regulation of this sort. As we have already stated, the DMHC has a number of powers within its scope of authority to address what it sees as the problem—patients being placed in the "middle" of billing disputes. Health plans are getting more and more aggressive in their contracting practices, making it more and more difficult for physicians to contract with them. Despite the fact that enrollees are increasingly having significant problems finding contracted specialist and primary care physicians who are willing and able to treat them, the DMHC has not taken a single enforcement action to ensure that health plans have adequate networks of physicians to assure access to care, as required under Health & Safety Code §1367.

2. Adopt the 'Pay the Bill, and Dispute the Charge' Approach

The DMHC also has the authority to adopt a regulation codifying a recommendation it made to health plans and RBOs in December 2003 stating that they should keep patients out of the middle of payment disputes: by either (1) paying the full charge, (2) negotiating the rate, or (3) paying the bill charged and then instituting litigation against the provider to the extent they believe that charge is unreasonable (**see Dec 10, 2003 minutes of ICE AB 1455 Team, Attachment 13**). This approach would, if implemented by the plans and their delegated payers, immediately result in the elimination of all claims sent to patients for the balance of a bill which otherwise might be underpaid by their health plan. This approach would also level the playing field for both the payer and the provider, encourage the parties to bill and pay fairly at the outset, and avoid punishing the vast majority of emergency care providers in this state whose charging and billing practices are reasonable and appropriate. In fact, CAL/ACEP has recommended just such a regulatory approach to the DMHC on several occasions in the past, and also incorporated this concept in a recent proposal to the Department supporting the use of an ICDR process as a less expensive substitute for litigation to resolve the question of excessive charges. In fact, the New Jersey Department of Insurance recently fined Aetna $9 million for failing to hold their enrollees harmless for the underpaid portion of their non-contracted emergency care provider's full charge,

and required Aetna to pay the provider's full charge in all future such claims. **(see Attachment 14)** The State of Colorado takes a similar approach to the issue of balance billing, by requiring payment of non-contracted provider's claims in full. The DMHC's. only response has been to express concern that this approach would result in unrestrained fee increases by emergency care providers, ignoring the impact of the constraints listed in paragraph F above.

3. Create a Trial ICDR Program as a Voluntary Alternative to Balance Billing

For nearly two years, CAL/ACEP participated in meetings with the DMHC and other stakeholders to try to develop proposals that would resolve the issues of claims underpayment without putting patients in the middle of these disputes. CAL/ACEP was the first of the stakeholders to submit a compromise proposal to the Department, and has since submitted multiple iterations and variations of these proposals in an attempt to achieve consensus within this working group. All of these proposals were predicated on the implementation of an independent claims dispute resolution process that was initially a voluntary trial program. This would have eliminated the need for regulations to establish the ICDR, but payers insisted providers accept mandatory participation in an unproven process rather than a trial program. The latest version of these proposals would actually have addressed the occasional physician that over-charges and eliminated the need for balance billing of any patients without the need for a regulation imposing restrictions on physician billing practices (**see Attachment 15).** The DMHC has never indicated why the Department rejected these proposals, and instead insists on imposing an untried and untested ICDR on providers through these regulations.

4. Replace Exploitation of the EMTALA Mandate with Fair Market Contracting for Emergency Services

The DMHC could also enforce the 'adequate networks' provisions of the Knox Keene Act to include contracts with emergency and on-call physicians. Requiring plans and their subcontracting medical groups to contract with hospital based providers at hospitals where the plan or RBO has a network relationship would substantially reduce the situations where patients may be caught in the middle of disputes over fair payment; and would have the additional effect of improving the coordination of emergency care under the managed care model. (footnote to SOR Report). The Department has repeatedly indicated that it favors more managed care contracting for emergency services; however, the DMHC has never taken action against plans or RBOs with inadequate network coverage for emergency services, and it's policies and inactions reinforce the view that the emergency care system can be taken for granted despite these 'adequate network' requirements in law. This lack of enforcement is interpreted as tacit approval for Health Plans and RBOs to rely on the EMTALA obligation of emergency and on-call physicians, rather than having to negotiate fair market contracts for these services.

5. Actively Enforce Fair Payment Regulations. Reducing Claims Underpayment

The DMHC could also reduce the initial underpayment of claims by taking a more active approach to enforcement of AB 1455 fair payment regulations, thus reducing the instances where the payers underpay claims, leading to hundreds of thousands of disputed underpayments each year for emergency physicians alone. Last year, under the direction of current Director, the DMHC took its first and only enforcement action for claims underpayments to emergency care

1 providers. It this action, HealthNet, a large HMO, was fined $250,000 after underpaying
2 emergency care providers by more than $7 million. Health Net had to repay at least the
3 provider's fee or an amount equal to the 50th percentile of a usual and customary survey of fees
4 (Ingenix Medicode database), however the repayment period was limited to only 9 months out of
5 a multi-year damage period, and providers had to resubmit claims to receive this additional
6 payment. As a result of the consent agreement negotiated between the DMHC and HealthNet,
7 only $670,000 of this $7 million was paid back to providers. Hence, HealthNet was allowed to
8 keep more that $6 Million of its ill-gotten gains: hardly an effective deterrent. The injured
9 providers had no opportunity to participate in developing this consent agreement.

10 The Director of the DMHC acknowledged, in testimony to the Senate Budget Committee, that in
11 prior years the Department had simply discarded stacks of provider complaints about plan
12 underpayments without even reviewing them, let alone taking enforcement actions.
13 Subsequently, a highly placed DMHC official told us that the Department's reluctance to levy
14 substantive fines for Health Plan violations was based on the concern that these costs would be
15 passed through in the form of higher premiums and decreased affordability for consumers. In
16 our view, this lack of enforcement rewards continued violations of the law; whereas effective
17 enforcement promotes a level playing field in the market place. CAL/ACEP pointed out that
18 health plans that are compliant with the law will be rewarded with more enrollees and companies
19 that violate the law can either get by on a smaller profit margin or lose market share as a
20 consequence of their irresponsible behavior; but the Department continues to be a reluctant
21 enforcer of fair payment regulations.

22 In addition, CAL/ACEP has referred a variety of additional payment complaints to the DMHC,
23 including; (1) Blue Shield's PPO's longstanding Policy of paying patients instead of providers
24 for non-contract emergency services, (violation of H & S Code 1371.4), (2) Inappropriate down-
25 coding and bundling of separate services and procedures (the basis for a recently successful
26 federal class action suit against numerous HMO's), (3) Claims denials for 'not an emergency'
27 (also a violation of H & S Code 1371.4), and (4) Systematic delays, denials and underpayments
28 by RBOs. In the Blue Shield case, the DMHC fined the PPO $200,000 (being used to promulgate
29 the proposed ICDR) and again imposed a limited scope repayment period.

30 The Department has also expressed concern that enforcement of the Gould criteria in AB 1455,
31 as with the HealthNet consent agreement, would discourage providers from contracting with
32 plans by raising payments to non-contracted providers, when in fact the Department has no
33 evidence or even an indication that this would be the case. As we have stated, payment of non-
34 contracted emergency care providers at the lesser of the provider's charge or the 50th or 75th
35 percentile of usual and customary charges would result in full payment of between 40% and 60%
36 of these claims (unless the payers began to resort to even more aggressive down-coding and
37 denial of payment). If Kaiser can pay this way, why can't the remaining plans and RBOs? On
38 average, it has taken eight to ten months for the DMHC to take any action at all on complaints
39 submitted to the Department by CAL/ACEP members, even when the Department acknowledges
40 that the payers have violated the laws and regulations the Department is supposed to enforce.
41 CAL/ACEP provided information to the Department demonstrating that many RBOs and Plans
42 respond to disputed underpayments very rarely compared to their peers (**see Attachment 16,**
43 **presentation to FSSB, 2005**), yet the Department has failed to audit these payers even as the
44 Department insists that providers continue to submit these disputes for adjudication. The

1 Department's dismal record of enforcement **(see attachment 17 – an email from M. Riner,**
2 **MD**) is a major contributor to the continued underpayment of emergency care provider claims,
3 and the disputes that ensue.

4 6. Directly Regulate RBO Claims Payment

5 The DMHC has also acknowledged that it does not have the authority to directly regulate RBOs,
6 or directly enforce compliance with AB 1455 prompt and fair payment regulations by RBOs,;
7 but that the Department would have to utilize its regulatory authority over health plans to ensure
8 compliance by the plans' subcontractors. CAL/ACEP members have submitted at least two
9 complaints to the DMHC about the underpayment of claims by RBOs. In one instance, after 8
10 months of investigation, the DMHC indicated that "Because Inland Healthcare Group's payment
11 methodology did not appear to take into consideration all of the 6 enumerated factors (in the
12 Gould criteria), the Department instructed the medical group's contracting health plans to further
13 investigate Inland's payment methodology. If the medical group's contracting health plans can
14 not verify that Inland has considered the 6 enumerated factors, they are required to instruct the
15 medical group to revise its payment methodology and then to re-adjudicate the disputed claim."
16 Thus, the Department is acknowledging not only that it can only enforce RBO compliance
17 indirectly through its oversight of health plans; but that it must depend on these plans to
18 investigate complaints about their own subcontractors' failure to comply, and rely on the plans to
19 report this failure even though the plans might ultimately be financially responsible for the
20 correction of these underpayments. This bizarre and ineffective form of indirect regulation
21 completely undermines provider confidence in any DMHC managed independent claims dispute
22 resolution process, and **begs the question of how the DMHC can possibly justify regulating**
23 **physician billing practices when it acknowledges no authority to directly regulate medical**
24 **group claims payment practices?** In fact, in its amicus brief to the court in the Bell vs. Blue
25 Cross case, the DMHC stated that: "the Knox-Keene Act does not authorize the Department to
26 set specific reimbursement levels <u>or to exercise jurisdiction over providers</u> by adjudicating
27 individual payment disputes that arise between providers and health plans. Should the
28 Department attempt to adjudicate such claims, its decision would not be binding upon the
29 individual providers nor upon the health plans that contest the Department's authority to set
30 reimbursement rates." Bell vs Blue Cross of California, 131 Cal.App. 4th at 217-218.
31
32
33 7. Modify Emergency Care Risk Delegation

34 The DMHC could also address many of the issues that discourage hospital-based providers from
35 contracting with payers. One of the major problems emergency care providers have with
36 California's delegated model is that it allows subcontracting IPAs and Medical Groups (RBOs)
37 to pay the claims of non-contracting providers within an inconsistently defined 'geographic
38 network area'. This means that ER providers must seek reimbursement from payers even when
39 the provider and RBO have no reason to entertain a contracting relationship, and even in many
40 cases where the RBO actively discourages its enrollees from using the hospital where the
41 provider works. CAL/ACEP has on many occasions recommended to the Department that the
42 RBO's network be defined by contractual relationships, and not geographic boundaries. CAPG
43 and the Department have expressed concern that this would undermine the incentives inherent in
44 the delegated model that encourage RBOs to offer less expensive alternatives to ER care to their

enrollees. In response, CAL/ACEP has suggested that payment for emergency care services not be delegated to RBOs, and that alternative incentive programs such as risk pools be used by health plans to encourage RBOs to minimize the use of ER services by RBO assigned enrollees. We believe that the existing system creates more incentives for RBOs to manage payment instead of managing care. CAL/ACEP has also suggested that the Department focus on assisting RBOs and plans that have difficulty contracting with hospital based and emergency care providers who work in networked hospitals, by developing an arbitration process to help resolve impasses related to reasonable contracting rates and terms.

CAPG has resisted de-delegation, indicating that when plans take back the responsibility for paying for emergency care provider claims, the plans take too large a bite out of the cap payments made to the RBOs. This strongly suggests that this book of business, rather than being a financial drain on RBOs because of excessive provider charges; is actually a profit center for RBOs because of their ability to underpay these providers without risk of DMHC enforcement of fair payment regulations. The DMHC recently asked if RBOs should be required to meet the same safe harbor payment standard for the payment of non-contracted emergency care provider claims as the health plans. The answer is that RBOs should not be delegated the responsibility to pay the claims of these non-contracted providers in the first place.

Other major advantages of de-delegating payment for emergency care services is that it would limit the number of payers that non-contracting providers would have to submit claims to, and dispute underpayments with. For example, one ER physician group that treats about 15% of the ER patients in California has had to dispute some 60,000 underpaid claims a year with over 300 different payers, each with their own unique rules, procedures, and contacts for the dispute process. Over 200 of these payers averaged less than 50 claims, and 10 disputed claims, per year; which makes it all but impossible to consolidate most of these disputes. This is one reason why this group employs more than 270 FTEs to bill and collect for less than 800 FTE providers. CAPG and the Department have thus far rejected these suggestions for improved contracting and partial or full de-delegation of emergency care provider claims payment.

H. Summary

CAL/ACEP has proposed a variety of reasonable alternatives to help the Department buffer patients from claims disputes, - alternatives that would be well within the scope of the Department's jurisdiction, and much more effective and less harmful than the proposed regulations. Throughout this controversy, the DMHC has taken an increasingly hard line against emergency care providers in the name of consumer protection, and even tried to impose the current draft regulations as emergency regulations that were subsequently withdrawn. This supports our contention that the attempt to impose these regulations is inherently unfair and unnecessary; and that instead, the Department should simply do its duty and uphold the law.

VI. Conclusion

The Department of Managed Health Care's proposals to prohibit non-contract balance billing, promulgate an mandatory, untested Independent Dispute Resolution Process, and dilute the Gould Standard for usual and customary payment for emergency services are unlawful,

unnecessary and unworkable. In many ways the issue of balance billing is a problem of the department's own making because of its historic failure to enforce existing fair-payment laws and regulations.

If the standards used by an arbitrator are compromised by a revision of the Gould criteria, or the arbitrators give credence to the quantum meruit arguments proposed by CAPG, or the process is so expensive or complicated that few providers are willing to access it, or the DMHC's so-called 'expedited payments' are so low that payers feel compelled to take advantage of this window of opportunity to underpay every non-contracted provider's claim; then ultimately the ICDR will become a smoke screen for the manipulation of the market for emergency care services by health plans and delegated payers. These regulations do not just impact emergency physicians: they also impact other hospital based physician specialists who provide EMTALA obligated services, and the hospitals our communities depend upon, and these regulations will simply further drive away our on-call specialists, who are the most tenuous link in this chain of survival, and who can easily "vote with their feet", and force even more of our safety net hospitals to close.

California's emergency departments are already operating at critical capacity. Sixty-seven have closed in the last ten years, and three more, Daniel Freeman Medical Center (Inglewood), Doctors Medical Center (San Pablo), and King Drew (Los Angeles), have just announced closure, financial insolvency, or loss of accreditation. The proposed regulations would exacerbate this situation and result in immeasurable harm to patients and to our emergency care infrastructure. Considering these risks, we recommend in the strongest possible terms that your department withdraw these proposals in deference to duly constituted legislative resolution.

We appreciate your consideration of our comments.

Sincerely,

Michael Solomon, MD, FACEP
President, CAL/ACEP

R. Myles Riner, MD, FACEP
Immediate Past President, CAL/ACEP

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 Vitally 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 Act[1] ("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 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

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[1]42 U.S.C. §§11101 *et seq*.
[2]42 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.

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 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

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[4]A true and correct copy of CMA's policy statement on economic credentialing and exclusive contracts is attached hereto as Exhibit "A."

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

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 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).)

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[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."

[7]Welfare & Institutions Code §14087.28.

[8]Civil 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.

[9]Evidence 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.…"

[10]Civil 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.…

[11]42 U.S.C. §11151(9).

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.

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 force 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

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[12]And 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.

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 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

Macintosh HD:Users:mylesrin:Documents: working docs: DMHC/Regs: Gov's EO / regs Bal Bill: CACEP testimony regs:CACEP testmny dmhc regs 07.doc

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.

Attachment 3

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
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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.	99292	129%	116%
Services between 10P-8am (24 Hr. Facility)			
Vaginal Delivery (only)			

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 review 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 IDRP 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 "demonsratable 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 IDRP process to make specific payment determination, it would be very difficult to successful 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 have encourage all parties to use to address these payment issues.

To date, we have hesitaated 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: (covers billing, malpractice, and overhead)	**75%**
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

Attachment 11

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.

Were 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 inpatient units, hospitals increasingly close to new ambulance arrivals seeking emergency care, and waiting rooms fill up with patients waiting for a bed—or even a chair—to become available in the ED. In 2001 the GAO found that 25 percent or more of hospitals throughout Southern California were on ambulance diversion more than 10 percent of the time. Since the implementation of mandated nurse staffing ratios in January 2004, despite an undersupply of trained personnel, crowding and boarding pose a greater threat to the safety of Californians seeking emergency care.[3]

The GAO found that crowding was more likely to occur in metropolitan areas than rural areas. Not surprisingly, crowding was more prevalent in areas with rapid population growth and most severe in areas with lower household income.[4] Melnick and colleagues may be correct in stating that ED beds per capita are stable statewide; a more rigorous analysis of data by metropolitan statistical areas (MSAs) is likely to reveal that hospitals are only adding ED capacity in suburban markets with higher household income where an adequate return on investment is expected. In urban areas the picture is very different. In Los Angeles, where two million residents lack health insurance, federal courts recently blocked the county government's plan to reduce inpatient capacity at the downtown county facility by a mere 100 licensed beds because it posed an unacceptable loss of access to acute hospital care for the medically indigent.[5]

Not a private voluntary market. Melnick and colleagues based their analysis on the assumption that the system can be understood as a private voluntary market. That is only true for the small fraction of California hospitals that operate on a for-profit basis. The recent announcement that Tenet, the largest for-profit hospital corporation in the state, will sell or close nineteen facilities—eighteen in Los Angeles and Orange Counties—is frank evidence that acute hospital services in California are a failing marketplace.[6] For the vast majority of hospitals that continue to operate on a nonprofit basis, ED operation is not voluntary but a requirement of tax-exempt status. Whether an open door to their own community helps or hurts the financial viability of hospitals depends a great deal on the demographics of their own service area. The hospital and real estate industries have three things in common: location, location, and location.

Nonemergency admissions more lucrative. Market forces affect ED capacity very differently than Melnick and colleagues suppose. The GAO concluded that twenty-one of the twenty-two most common medical conditions for which Medicare beneficiaries are admitted on an emergency basis are not accretive for the hospitals providing the care.[7] Meanwhile, office-based specialists are free agents who can choose which hospital to refer most insured patients for elective admission for more lucrative procedures. Struggling hospitals are sorely tempted

to balance their books by giving priority to nonemergency admissions that will contribute more per case to the hospital bottom line, while ED patients in need of inpatient beds wait for hours or even days. The authors note that most Californians still live within a few miles of the closest hospital: Given current waiting times in EDs, many urban patients return home without ever being seen.[8]

Impact of managed care. Melnick and colleagues imply that the advent of managed care has had no deleterious effect on the emergency care system. Most stakeholders in the emergency care system would vehemently disagree. Access to emergency services has been protected under federal law (the Emergency Medical Treatment and Active Labor Act, or EMTALA) since 1986; managed care plan members are as well protected as the medically indigent. Providers are allowed to seek payment only after emergency conditions have been stabilized, including costly hospitalizations for life-threatening illnesses and injuries for more than six million Californians without health care coverage. The gap between licensed and functional capacity can be traced to this disconnect between our health insurance and health care delivery systems.

In the same period that Melnick and colleagues studied, the health insurance industry has shifted to a business model that refutes the obligations of private sponsors for anything more than "market rates" for the costs of services to their own covered populations. Legal counsel for the state's Department of Managed Health Care has opined that providers without managed care contracts are not entitled to collect their usual fees from managed care patients, which include the costs of uncompensated care to the medically indigent, and should be compelled to accept the heavily discounted rates that plans and their delegates pay contracted providers in exchange for large volumes of referrals. Nor can the handful of for-profit health plans that dominate the California private market claim that their members' ED use is inappropriate. ED visits in California stand at twenty-seven per hundred people per year—fully ten visits less per hundred than the U.S. average.[9]

Costs of uncompensated care. The costs of uncompensated care to Americans without health insurance were recently estimated at $35 billion for 2001.[10] Not surprisingly, 92 percent of all hospitalizations by the uninsured are the result of an ED visit.[11] California's share of this burden on hospital-based providers can be reasonably placed on the order of several billion dollars each year. Nor can these costs be offset by payments from the disproportionate-share hospital (DSH) program that the authors describe, since only services to MediCal (California Medicaid) beneficiaries qualify hospitals for reimbursement.

Equal nonaccess. Californians should not expect that the emergency care system will operate at the capacity reported by Melnick and colleagues until we

decide who should pay the hospital bills of the 20 percent of state residents—most from low-income working households—who are not covered by public or private payers[12] Ironically, the best hope for a favorable outcome in this debate may hinge on the fact that on any given day in many areas, access to the necessary scope of timely emergency services is as much at risk for the most influential citizens of the Golden State as it is for the medically indigent for whom the ED is the last line of defense.

The views expressed are the author's and not those of the American College of Emergency Physicians (ACEP), the California chapter of ACEP, the University of California, or California Emergency Physicians Medical Group.

NOTES

1. G.A. Melnick et al., "Emergency Department Capacity and Access in California, 1990–2001: An Economic Analysis," *Health Affairs,* 24 March 2004, content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.136 (24 March 2004).
2. U.S. General Accounting Office, *Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities,* Pub. no. GAO-03-460 (Washington: GAO, 14 March 2003).
3. "New Nurse-to-Patient Staffing Ratios Challenge California," *Medical News Report* 13, no. 2 (2004): 1–21.
4. GAO, *Hospital Emergency Departments*.
5. S. Fox, "Court Agrees to Keep Rancho Open," *Los Angeles Times,* 6 February 2004.
6. D. Dauner, "Tenet Healthcare's Decision to Divest Nineteen California Hospitals Symptomatic of Broader Flaws in Health Care System," 30 January 2004, www.calhealth.org/public/press/doc.asp?ID=209 (26 February 2004).
7. GAO, *Hospital Emergency Departments*.
8. Ibid.
9. S. Lambe et al., "Trends in the Use of and Capacity of California's Emergency Departments, 1990–1999," *Annals of Emergency Medicine* 39, no. 4 (2002): 389–396.
10. J. Hadley and J. Holahan, "Covering the Uninsured: How Much Would It Cost?" *Health Affairs,* 4 June 2003, content.healthaffairs.org/cgi/content/abstract/hlthaff.w3.250 (27 February 2004).
11. W.W. Fields, ed., *Defending America's Safety Net* (Dallas: American College of Emergency Physicians Safety Net Task Force, 1999).
12. R.J. Mills and S. Bhandari, *Health Insurance Coverage in the United States: 2002 Current Population Reports,* September 2003, www.census.gov/prod/2003pubs/p60-223.pdf (1 March 2004).

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Read the original article by Glenn Melnick et al., and related papers by Bruce Siegel, Arthur Kellermann, C. Duane Dauner, and a response by Melnick et al.

Attachment 12

Stretched Thin

Growing Gaps in California's Emergency Room Backup System

Table of Contents

Preface

Executive Summary
AB 2611 Study Mandate
Findings
Principles and Recommendations

Introduction
What Are On-Call Services?
EMTALA and State Anti-Patient-Dumping Statutes and Regulations
State and Federal Laws Pertaining to Emergency Care Access (Chart)

Section I: Defining the Scope of the Issue
Extent of the On-Call Coverage Problem in California
Impact of On-Call Coverage Problems
Extent of the On-Call Problem in Other States

Section II: Factors Contributing to On-Call Coverage Problems
Increases in ER Utilization
Rising Number of Uninsured
Physician Shortages
Inadequate Reimbursement for Services to Uninsured Patients
Problems With Managed Care Contracting and Payment Arrangements
Increases in Medical-Legal Risks
Barriers to Hospital Sharing of On-Call Resources
Inadequate Monitoring of Accessibility and Availability of On-Call Services

Section IIII: Principles and Recommendations for Addressing On-Call Coverage Problems in California

Appendices
Appendix A: AB 2611 Working Group Members
Appendix B: AB 2611 Working Group Participants
Appendix C: Comments of Working Group Members on the Report
Appendix D: AB 2611 Meeting Agendas

Appendix E: AB 2611 Statute

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 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

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[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.

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

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.

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

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[16] Ibid.

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

[18] "Potential Solutions to the Lack of Physician Back-up in Hospital Emergency Departments," op. cit.

[19] UC-Irvine Medical Center, op. cit.

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

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]

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[20] "On-Call but not Responding," op cit.
[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.

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 par,t 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.

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[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.

Principle 5:* **Contracts between public and private health plans and providers, and payments by health plans to physicians, should be sufficient to reasonably ensure the availability of on-call physicians, ensure that payments by all payers for on-call services are commensurate with the reasonable cost of providing the services, and avoid practices that shift costs of on-call coverage to other entities, including hospitals, physicians, and consumers.

Recommendations for Implementing Principle 5

- Establish in statute a presumptive payment standard for payments by commercial health plans to non-contracting physicians who provide emergency and on-call services. The standard would be the physician's billed charges, the physician's usual charges, or a payment consistent with customary and reasonable charges for the service for the geographic area based on published surveys or databases as defined by DMHC. Provide that failure to follow the standard on a repeated basis is grounds for a finding of an unfair payment pattern.

Principle 6:* **Health plan enrollees and health care consumers should be better protected from the impacts of contracting and payment disputes between health plans and physicians related to on-call services and from being required to pay out-of-pocket for services that are covered by their health plans.

Recommendations for Implementing Principle 6

- Provide that a payment practice that indirectly harms a health plan enrollee by causing the enrollee to pay amounts in excess of applicable copayments, deductibles, or coinsurance for ER and on-call services that are covered by their health plan constitutes an unfair payment pattern and is subject to the remedies under the prompt payment statute. An example would be a plan that follows a practice of paying discounted fees to non-contracting providers for on-call services, with the result that the providers bill their patients and the patients pay the remainder of the fees.

Attachment 13

AB 1455 Team Meeting Minutes

Industry Collaboration Effort (ICE)
December 10, 2003
10:00 AM- 11:30 AM (Pacific Standard Time)

Presented By Co-Leaders: Mary Holloway, PacifiCare Health Systems, 714-226-8776
Keith Pugliese, Brown & Toland Medical Group, 415-972-4318

AB 1455 re: Non-Contracted Provider Balance-Billing Enrollees: The DMHC's formal position is that, should a payer pay a non-contracted provider claim an amount that is below billed charges and the non-contracted provider subsequently balance-bills then enrollee, then the payer is expected ensure that the enrollee is not in any way financially harmed or held responsible by considering one of the following three actions: 1) Try to negotiate with the non-contracted provider to agree to a rate that the provider would deem satisfactory; 2) Bring the non-contracted provider to court for a declaratory judgment action as to whether the payer's payment is unfair; or 3) Pay the claim in its entirety (i.e., "goodwill" payment). But the DMHC does not want the enrollee to pay the balance or face a collection agency.

Attachment 14

New Jersey Department of Banking and Insurance

News Release

Commissioner Steven M. Goldman

For Immediate Release: For Further Information: July 25, 2007 Jim Gardner (609) 292-5064

DOBI levies nearly $9.5 million in penalties against Aetna Health

Company refused fair reimbursement for covered services, Department alleges.

TRENTON -On Monday the Department of Banking and Insurance (DOBI) filed an administrative order levying $9,475,000 in fines against Aetna Health Inc. for refusing to appropriately cover certain services provided by out-of-network health care providers -including emergency treatment, in violation of New Jersey rules and regulations.

In June, DOBI received numerous complaints after Aetna issued a letter to health care providers stating that the company had determined what was "fair payment" for services rendered by non-participating physicians and health care facilities and that "additional reimbursement would not be considered." This included services by non-participating providers that were required under New Jersey law, such as emergency care, services provided by non-participating providers during an admission to a network hospital, and services rendered as the result of a referral or authorization by Aetna.

The letter stated that Aetna determined that 125 percent of the Medicare allowable amount was fair payment, and 75 percent for lab fees and durable medical equipment. As a result, many patients were subject to receiving bills for the amount Aetna would not pay, creating significant financial exposure. Under such circumstances, New Jersey regulations state that members of a health maintenance organization (HMO) have the right to "be free from balance billing by providers for medically necessary services..."

DOBI Commissioner Steven M. Goldman signed the order requiring Aetna to cease its limited reimbursement practice, to reprocess all claims for services rendered by non-participating providers adversely affected by Aetna's unfair practices, and make payment to those providers based on the billed amount plus 12 percent interest from the date the claim was initially paid, in addition to the monetary penalty.

Aetna has 30 days to request an administrative hearing objecting to the order. If no hearing I requested, the order will then become final.

Attachment 15

Issue	Cal/ACEP Option 1	Cal/ACEP Option 2
1. The process to be used.	A pilot program that creates a low-cost baseball style arbitration process available to health care providers for reimbursement of non-contracted services to HMO patients only. A separate program for disputes in excess of $10,000 would be developed, using other methods of arbitration to settle the disputes. The pilot program shall continue for 18 months; and after twelve months of data collection, the program would be evaluated by an independent consultant chosen by an appointed oversight board. The independent consultant would • Issue a report within three months to the oversight board • Evaluate the use of the program by providers • Evaluate the impact on provider reimbursement levels and payer payment levels • Make recommendations on its improvement. The arbitrators would consider, and select between, the initial billing and the initial payment for disputes over the reasonable value of services provided. The need for an ICDR was promoted on the basis that some providers overcharge, not on the basis that all provider's charges are excessive. To meet the departments safe harbor standard for initial claims payment, payers should pay claims of the lesser of the provider's charge or the 50th percentile of usual and customary charges, using a publicly available database of usual and customary charges for the most recently published year of service. The 'arbiter' will need to adjudicate disputes over coding, bundling, necessity and level of service, with the assistance of claims documentation and coding experts. For those disputes involving coding or bundling disputes, the arbitrator may dismiss a dispute without prejudice if the arbitrator finds that the health care provider has not attempted to resolve the matter through the payers internal dispute resolution process, or may find in favor of	For Option 5, CAL/ACEP has underlined substantive differences with CAL/ACEP's proposed Option 4. A pilot program that creates a low-cost baseball style arbitration process available to health care providers for reimbursement of non-contracted services to HMO patients only. A separate program for disputes in excess of $10,000 would be developed, using other methods of arbitration to settle the disputes. The pilot program shall continue for 18 months: and after twelve months of data collection, the program would be evaluated by an independent consultant chosen by an appointed oversight board. The independent consultant would • Issue a report within three months to the oversight board • Evaluate the use of the program by providers • Evaluate the impact on provider reimbursement levels and payer payment levels • Make recommendations on its improvement. The arbitrators would consider, and select between, the initial billing and the FINAL PROPOSED payment for disputes over the reasonable value of services provided. Payers would be required to pay the provider's initial charge in full, and require providers to enter into an ICDR if they felt the provider's charges exceeded the reasonable value of the service. The 'arbiter' will need to adjudicate disputes over coding, bundling, necessity and level of service, with the assistance of claims documentation and coding experts. For all disputes, the plan may request the provider to participate in the payer's internal dispute process, and if the provider declines, the provider would be required to participate in a binding ICDR process.

	the provider if the arbitrator finds that the payer has failed to make a good faith effort to resolve the dispute through the payer's internal dispute resolution process, or utilizes pre-payment claims editing programs that been found in court to be unfair and inappropriate. For those disputes involving reasonable value of the provider's services only, the provider may bypass the payer's internal dispute process and go directly to ICDR.	

2. The standards to be followed in making a determination.	Existing Gould criteria will be used to determine the reasonable value of non-contracted services. The AMA CPT coding manual and standard billing protocols would b used for those disputes involving coding or level-of service disputes. All relevant evidence consistent with the California Evidence Code would be considered for disputes involving coding, necessity of care, and level of services, and for all claim disputes in excess of $10,000.	Existing Gould criteria will be used to determine the reasonable value of non-contracted services. The AMA CPT coding manual and standard billing protocols would b used for those disputes involving coding or level-of service disputes. All relevant evidence consistent with the California Evidence Code would be considered for disputes involving coding, necessity of care, and level of services, and for all claim disputes in excess of $10,000.
3. Whether to be administered by DMHC or a 3rd party	The pilot program shall be administered by an independent third party with an appointed Oversight Board consisting of one representative from each of the stakeholder groups.. The Board shall agree on a third party administrator who shall establish a panel of arbitrators that posses minimum qualifications as established by the Oversight Board to review both legal and medical disputes, and credential these arbitrators. The independent third party administrator shall collect information about the results from the dispute resolution process and present aggregate information to the DMHC and to the Oversight Board on a monthly basis.	The pilot program shall be administered by an independent third party with an appointed Oversight Board consisting of one representative from each of the stakeholder groups.. The Board shall agree on a third party administrator who shall establish a panel of arbitrators that posses minimum qualifications as established by the Oversight Board to review both legal and medical disputes, and credential these arbitrators. The independent third party administrator shall collect information about the results from the dispute resolution process and present aggregate information to the DMHC and to the Oversight Board on a monthly basis.
4. Mandatory vs. Voluntary.	Voluntary for providers / mandatory for payers. Since outliers may be discouraged from accessing the system after one or two failed arbitrations; information collected over the pilot project would show whether plans were continuing to	Voluntary for payers / mandatory for providers during the pilot program.

	underpay claims after losing arbitration repeatedly, and whether providers were declining to participate in the ICDR after losing arbitration repeatedly. Since outlier providers might be discouraged from accessing the system after one or two failed arbitrations; information collected over the pilot project would show whether and how often providers were requested by the plan to participate and chose not to; and the project should also collect data on how often the plans continued to underpay claims after losing in arbitration.	
5. Who pays for the program.	Obtain foundation funding or other grant funding for start-up costs. The payer shall be responsible for the entire cost of the arbitration unless the provider loses the arbitration, in which case the provider and the payer should split the cost of the arbitration, during this pilot project; since the Department has already established in policy that it is the responsibility of the payer to protect the patient from a balance bill by paying the claim in full and disputing the alleged overcharge in court. This approach will encourage providers to participate in the ICDR, rather than balance bill the patient.	Obtain foundation funding or other grant funding for start-up costs. <u>The loser of the arbitration will cover the cost of the arbitration, or pay a penalty not to exceed 5% of the total contested amount for amounts less than $10,000.</u>
6. How to integrate a prohibition on balance billing.	Provider agrees not to balance bill the patient if utilizing the ICDR pilot program as outlined above. Before the start of the pilot program, clarification must be reached on what constitutes a "successful" program. All parties must agree that the program has succeeded in providing a fair, fast and cost effective method for resolving disputes of HMO claims before any statewide prohibition against balance billing is recommended to the State Legislature. The success of the ICDR should not solely be based on the level of participation in the program, but also on the financial consequence of the program: the ICDR should not facilitate a revenue or profit windfall for either payers or providers.	<u>Balance billing would be eliminated for all HMO claims, as payment in full eliminates the need for balance billing.</u> Before the start of the pilot program, clarification must be reached on what constitutes a "successful" program. All parties must agree that the program has succeeded in providing a fair, fast and cost effective method for resolving disputes of HMO claims before any statewide prohibition against balance billing is recommended to the State Legislature. The success of the ICDR should not solely be based on the level of participation in the program, but also on the financial consequence of the program: the ICDR should not facilitate a revenue or profit windfall for either payers or providers.

Attachment 16

CEP AB 1455 Claim Disputes by Insurance Carrier
Mar-Dec, 2004 pg 1 of 23

Ins Name	Paid		Unpaid		Total # Disputes	Total $ Paid Following PDR	% Of Disputes w/ Pmts Following Dispute
	# Disputes	$ Paid Following PDR	# Disputes	$ Paid Following PDR			
HEALTHNET HMO	9,628	$1,937,036	3,205	$0	12,833	$1,937,036	75%
KAISER SOUTHERN CALIFORNIA	840	$87,219	2,479	$0	3,319	$87,219	25%
KAISER PERMANENTE	1,380	$102,547	983	$0	2,363	$102,547	58%
BLUE SHIELD	1,050	$65,013	996	$0	2,046	$65,013	51%
HILL PHYSICIANS	1,395	$101,823	370	$0	1,765	$101,823	79%
AETNA PPO/AETNA DIRECT HMO	988	$62,274	612	$0	1,600	$62,274	62%
CIGNA	688	$78,292	840	$0	1,528	$78,292	45%
REGAL MEDICAL GROUP	838	$119,531	466	$0	1,304	$119,531	64%
HEALTHNET PPO	800	$147,351	358	$0	1,158	$147,351	69%
KAISER - ELECTRONIC - SOUTH	452	$41,915	658	$0	1,110	$41,915	41%
CONVERTED MISCELLANEOUS INSKEY	313	$43,226	681	$0	994	$43,226	31%
DESERT MED GRP /OASIS IPA	111	$16,971	719	$0	830	$16,971	13%
UNITED HEALTHCARE	97	$12,999	676	$0	773	$12,999	13%
INLAND HEALTHCARE	136	$13,887	628	$0	764	$13,887	18%
PACIFICARE/HMO	297	$41,978	400	$0	697	$41,978	43%
BLUE CROSS	142	$16,469	536	$0	678	$16,469	21%
BAY VALLEY MED GRP	17	$2,195	660	$0	677	$2,195	3%
PACIFICARE/PPO	300	$19,744	296	$0	596	$19,744	50%
GREAT WEST	66	$10,363	481	$0	547	$10,363	12%
REDLANDS CMNTY HOSP	18	$1,727	519	$0	537	$1,727	3%
BLUE SHIELD-OUT OF STATE	69	$4,272	458	$0	527	$4,272	13%
PRIMECARE OF CORONA	162	$17,303	362	$0	524	$17,303	31%
CONTRA COSTA HEALTH PLAN	256	$13,288	266	$0	522	$13,288	49%
JMHN/HEALTH NET	9	$1,402	466	$0	475	$1,402	2%
BLUE CROSS HF	260	$14,480	212	$0	472	$14,480	55%
PREFERRED IPA	214	$6,624	246	$0	460	$6,624	47%
BROWN AND TOLAND MED GRP	320	$19,607	132	$0	452	$19,607	71%
AFFINITY	197	$30,360	245	$0	442	$30,360	45%
INLAND EMPR HLTH PLN	153	$9,201	279	$0	432	$9,201	35%
**KAISER	110	$8,741	288	$0	398	$8,741	28%
PRINCIPAL LIFE INSURANCE	34	$3,361	338	$0	372	$3,361	9%
MOLINA MEDICAL CENTER	133	$5,722	237	$0	370	$5,722	36%
SANTA CLARA-IPA	175	$21,473	169	$0	344	$21,473	51%
NOBLE	30	$2,618	279	$0	309	$2,618	10%
MEDICARE/PARTICIPATING PHYS	83	$4,066	225	$0	308	$4,066	27%
PHYSICIANS HEALTH NETWORK	33	$1,550	274	$0	307	$1,550	11%
UNIVERSAL CARE	84	$9,475	220	$0	304	$9,475	28%
LAVIDA	121	$9,669	168	$0	289	$9,669	42%
SHARP COMM. MEDICAL GROUP	74	$12,453	205	$0	279	$12,453	27%
LA VIDA MULTI SPEC MED CTR	181	$22,254	74	$0	255	$22,254	71%
JOHN MUIR/MT DIABLO HEALTH	9	$535	245	$0	254	$535	4%
CARE FIRST HEALTH PLAN	27	$958	223	$0	250	$958	11%
MCKINLEY MEDICAL GROUP	19	$619	229	$0	248	$619	8%
PROSPECT MEDICAL GRP OF ORANGE	68	$9,531	156	$0	224	$9,531	30%
BRISTOL PARK MED GRP	134	$15,228	80	$0	214	$15,228	63%
COMMUNITY HEALTH	33	$1,535	181	$0	214	$1,535	15%
BLUE SHIELD HMO	138	$5,287	75	$0	213	$5,287	65%
**CIGNA	89	$10,460	116	$0	205	$10,460	43%
PACIFICARE/SECURE HORIZONS	83	$10,383	122	$0	205	$10,383	40%
DESERT VALLEY MEDICAL GROUP	21	$4,827	181	$0	202	$4,827	10%
HEALTHCARE PARTNERS	84	$12,712	117	$0	201	$12,712	42%

Attachment 17

Date: Fri, 17 Mar 2006 14:17:07 -0700
Subject: History of relations with DMHC
From: "R. Myles Riner, M.D." <mriner@inreach.com>
To: Monica Wagoner <mwagoner@calacep.org>,
Irv Edwards <iedwards@emergentmed.com>
Message-ID: <C0407563.12216%mriner@inreach.com>

Monica, in addition to the Blue Cross, Blue Shield and HealthNet complaints that Irv has submitted to the DMHC, I thought it would be helpful for you to see the other complaints and requests that we submitted to the Department in the last couple of years.

Myles

1/23/06 Complaint filed electronically re underpayment by Inland HealthCare Group along with EOBs etc. - no response yet

1/06 Requested that the Department advise John Muir Medical Group that payment to non-contracting providers can not be " based on non-contracting payment guidelines at 130% of Medicare fee schedule" - copy of letter from medical group also sent. - no action taken

10/05 Requested clarification from Mr. Donohue regarding his letter to Plans and RBOs outlining four safe harbor standards for minimum payment that payers needed to meet: whether the payer must meet all four criteria, or only one of the criteria. - no response received

7/05 Request from MBSI for DMHC action against Desert Medical Group using spreadsheet and single EOB with 142 accounts that demonstrated: 54 commercial accounts that were disputed because they were paid at a so called usual and customary amount that was about 52% of charges ($9,190 in payments on $17,672 in charges), and other issues. Response from DMHC:

> "As you know the standard for reimbursement of non-contracted claims is the
> reasonable and customary value of the services rendered - not "billed
> charges". Without documentation demonstrating that your billed charges reflect
> the reasonable and customary value of the services rendered, there is not a
> reasonable basis to initiate further investigation or enforcement."

I.e. - we were asked to prove that our billed charges were reasonable, rather than having the payer prove that the payments met AB 1455 standards. Contrast the above quote with this from Mr. Donohue in 1/06:

> The emergency room physicians contribute to delays, by failing to use the
> Department's Provider Complaint Unit which was created to respond to claims
> payment disputes. I explained in my early email, if any emergency room
> physicians are in possession of actual claim payment determinations that they
> believe resulted in an underpayment, to please submit the disputed claim
> through the Department's Provider Complaint Unit with supporting documentation
> and it will be investigated thoroughly.

6/05 Responded to DMCH request, below, to identify RBOs that are the most 'problematic' with regard to claims underpayment, inappropriate downcoding, and denials - several IPAs and Medical Groups identified - not aware of any action taken

> Can you please identify the payors you believe clearly disregard the Gould
> criteria in formulating their reimbursement calculations. I will then focus
> the plans' oversight activity in this direction.

6 and 7/05 Complaints from Dr. Edwards sent regarding Chino Medical Group and Caremore Medical Group with claims data, DMHC did make contact with Chino with some resultant temporary improvement but some issues remain, Caremore issue successfully resolved by DMHC

3/05 Request to get HealthNet subcontracted delegated payers to pay non-contracted providers according the HealthNet consent agreement - no response

2/05 Provided detailed information on 63,000 disputed claims indicating and identifying many Plans and RBOs that fail to respond appropriately to most if not all disputes, compared to those that do respond appropriattely to most disputes, requesting that the poorly responding payers be addressed - no known action taken.

10/04 Requested to know why, in DMHC contracting guidelines and agreements, there is not obligation for Plans to include emergency care providers in their contracted networks'. Response: It would be unfair to force plans to contract with hospital based providers.

1/04 I requested that DMHC respond in writing to Bay Valley Medical Group's deliberate misquoting of Gould criteria in letters to balance billed patients ("the prevailing provider rates ACCEPTED in the general geographic area...") to justify paying at 88% of Medicare rates - initial response from Donohue:

> I have spoken with Bay Valley at least 4 times to address the situation. They
> will be sending you a corrected letter that accurately sets forth the
> criteria. I have explained to them that a benchmark of 80% level of Medicare
> is not appropriate unless it is supported by statistically credible
> information verfiying that providers in the geographic area are billing that
> amount. But the reference to that rate was not in its letter.
>
> If they don't adjust their payment methodology I will accept their offer to

> provide the department with the statistical credible information that supports
> their calculation.

And subsequently:

> I spoke with Bay Valley concerning the accuracy of the criteria it listed in
> its correspondence to a number of non-contracted providers. After speaking
> with their attorney, Bay Valley conceded that their correspondence was
> inaccurate and confirmed they any future correspondence to non-contracted
> providers would accurately set forth the Gould criteria. Bay Valley also
> indicated it would try to track down the identity of any providers that
> received the incorrect information and forwarded a corrected letter to their
> attention.

By the way, we also tried to get HealthNet involved with these underpaid claims, and HealthNet advised MBSI to "go ahead and send the patient to collections" if Bay Valley did not pay the underpaid portion of the claims. HN also said:
> Court rulings have agreed that Health
> Plans are not responsible for claims that the Medical Groups are at risk
> for. This is an issue which CA Emergency Physicians must settle with Bay
> Valley Medical Group.

Kevin responded to this info with:

> It is still the position of the Department that balance billing enrollees is
> inappropriate where reimbursement for the health care services are the
> responsibility of the plan/IPA. You are reading too much into the a trial
> court decision that was dismissed on a procedural basis especially when there
> have been a number of other trial court decisions that have held to the
> contrary.
>
> Trial court opinions do not have any precedential value and can not be used to
> support other cases or situations.

To which I responded on 3/15/04: "Kevin, that is exactly the position of CAL/ACEP and the CMA: neither trial court decisions nor the legal opinion of a DMHC staff attorney can be used to support policy that has not been rendered into either regulation or signed legislation, especially when this policy would deny the civil rights of non-contracted providers. The DMHC has attempted on multiple occasions to suppress these rights, first through SB 1881, then through AB 1455, and then through emergency regulations, and in each case you have had neither the support of the executive branch, the Legislature nor, in the only case that looked specifically at this issue (Prospect vs St. Johns), the judge. By the way, the attorney in the case, Andrew Selesnick, does not feel that the judge's decision in Prospect was based on procedural issues, but was based on substantive issues of law.

The only way to effectively address this issue, and eliminate the need for balance billing, is to ensure that non-contracted providers are paid by plans appropriately, and that there is a mechanism to define what reasonable payment is. AB 1455 does not accomplish this: giving the Plans and IPAs the right to 'use' the Gould criteria, instead of mandating that these criteria be applied by an impartial judge, is no solution. The DMHC is apparently not willing to step up to the plate to address it; as evidenced in part by the clearly ineffective slap on the wrist to Bay Valley. Thus, CAL/ACEP has had to develop an equitable solution with SB 1679 (attached). If you really want a solution to balance billing, lend your department's support to this legislation, and perhaps there will never be another balance bill sent again."

Eventually, EIGHT MONTHS from the initial request, on 9/8/04, Donohue advised us that BV felt our dispute was a 'contractual dispute, implying that CEP was under contract with BV for ED services (the contract in question was for services at one of CEP's old UCCs which was no longer in operation, not for ED services), and that:

> I did inform Bay Valley that it could not simply rely on a disputed
> contract to determine reimbursement and that steps would need to be taken to
> determine if the disputed contract applies to the subject claims. Bay Valley
> will also be preparing an overview of its reasonable and customary methodology
> for the department's review.

and:

> I encourage both parties to work diligently towards a mutually agreeable
> contractual arrangement which should eliminate these billing disputes.

At no time did Kevin ever tell Bay Valley in writing that they were not in compliance with AB 1455 when paying at 88% of Medicare rates, nor would he opine on whether our contract for services at the defunct UCC also covered ED services, when BV finally sent him a copy of the contract.