

On Your Behalf ...

Legislative and Practice Affairs Division

CSA Brief Challenges Hospital-Controlled Corporate Practice of Medicine

By David E. Willett, Esq., CSA Legal Counsel



An amicus curiae (“friend of the court”) brief has been filed on CSA’s behalf in a case now pending in the California Court of Appeal. The suit, *Feather River Anesthesia Medical Group v. The Fremont-Rideout Health Group*, was brought against the hospital system operating the only hospitals in Yuba and Sutter counties by the group of anesthesiologists which practiced in those hospitals until dislodged by a new medical corporation formed by the hospital. The hospital’s action followed disagreement about appropriate stipends for coverage arrangements sought by the hospital, and the group’s decision to terminate their exclusive contract after lengthy and unproductive negotiations. The suit brought by the anesthesia group, challenging the hospital’s action and the use of a captive corporation, was dismissed by the trial court, which found no unlawful conduct. We believe the trial judge was wrong.

The new professional corporation, initially referred to as “Friendly PC” by the hospital, was labeled a sham by the plaintiff anesthesia group. California law does not permit lay persons or entities to engage in the practice of medicine. The nominal “owner” of Friendly PC was a family practitioner employed full-time as the hospital’s medical director. The hospital’s CFO effectively ran Friendly PC. The corporation was entirely financed by the hospital, which retained extensive rights of control over the corporation. CSA’s brief argues that “The rule that corporations cannot practice medicine is integral to California’s system for providing medical services to the public. As a consequence, this case and the disposition made by this court will affect the public generally, as well as all CSA members.”

CSA’s brief explains the role of a hospital medical director, and the director’s status and responsibilities as a hospital employee, pointing out that the medical director who became Friendly PC’s sole shareholder had no reason or incentive to form the corporation, except to satisfy the hospital’s goal of establishing a subordinate entity. After discussing the legal authorities that CSA believes demonstrate that Friendly PC violated the prohibition against corporate practice, the amicus brief concludes:

Amicus submits that the hospital gambled on a risky course of action, in preference to legitimate alternatives for assuring the delivery of anesthesia services. It is well established that California (like many other states)

forbids the corporate practice of medicine. It may be that the hospital misjudged the vitality of this prohibition, or believed that using a physician—employed full-time for other tasks—to front a professional corporation would provide cover. The error below was to ignore the full factual picture, concentrating only on those facts which were probably less important in determining whether the arrangement was bogus, or at least inadequate to insulate the hospital from the charge of corporate practice. The courts and the Attorney General have found that the prohibition enacted by the Legislature has public importance, serving valid purposes. Refusing to enforce the prohibition, under the factual circumstances presented by Plaintiffs and Appellants, would usurp a function which belongs to the Legislature.

The case is likely to be heard and decided by the Court of Appeal sometime next year. CSA's participation was made possible by CSA's Legal Defense Fund. The Fund is utilized in matters of general importance to California anesthesiologists. Clearly, the ability of hospitals to form controlled entities such as "Friendly PC" to employ anesthesiologists is such an issue.

CSA Sues Nursing Board, Challenging CRNA Policy

By David E. Willett, Esq., CSA Legal Counsel

CSA has gone to court to put an end to Board of Registered Nursing (BRN) expansion of CRNA scope of practice by extralegal declarations which ignore California law. A complaint filed by CSA on August 31 in Sacramento Superior Court particularly targets a policy statement released by the BRN last December, which announced that "The Board of Registered Nursing has no requirement ... for the physician, dentist or podiatrist to supervise the CRNA providing their anesthesia services. Therefore, the CRNA provides anesthesia services under the authority of his or her own license as a licensed independent practitioner when requested to provide anesthesia services...." CSA believes that this statement is directly contradicted by California law and by numerous opinions issued by California's Attorney General.

Moreover, the December policy statement recites that "It is within the scope of practice of the CRNA to provide acute and chronic pain management services and emergency procedures both inside and outside the operating room suite." For the first time, the Board has publicly asserted that CRNAs, who can neither diagnose nor prescribe, can practice pain medicine.

CSA's complaint asks the court to declare that both statements are nullities and without legal effect. CSA also asks the court to issue an injunction prohibiting utilization, issuance, or enforcement of these policies, unless and until they are adopted as formal regulations under California's Administrative Procedure Act. That law requires

publication of proposed regulations, opportunity for public comment, and hearings before their adoption. Most importantly, regulations which exceed the Board's authority, or which have no legal basis, can be challenged in the administrative process and in court, before they become effective. Rules or policies adopted without APA compliance are referred to as "underground regulations" and may be challenged in the courts.

This suit does not ask the court to decide the bounds of permissible CRNA scope of practice. It instead asks the court to invalidate these Board efforts to expand scope of practice, pending full compliance with Administrative Procedure Act requirements. In CSA counsel's opinion, these regulations would not pass legal muster under the APA. By raising only the procedural objection at this time, protracted litigation on the underlying questions as to what CRNAs can do in California is at least deferred, in the interests of a prompt ruling establishing what will be permitted pending adoption and the upholding of new regulations.

A hearing on CSA's complaint had not been scheduled when the *Bulletin* went to press, but an early date will be sought. The complaint is available to members on the CSA web site (www.csahq.org).

CSA sued after efforts undertaken by the Department of Consumer Affairs (which is responsible for the Board) to resolve complaints from both CSA and the Medical Board about Nursing Board actions, foundered.

2005 End of Session Report The Strangest Session We Can Remember

By William E. Barnaby, Esq., CSA Legislative Counsel, and William E. Barnaby III, Esq., CSA Legislative Advocate

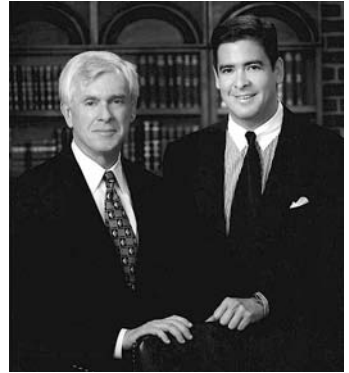
The State Legislature ended its 2005 session a day early, a fitting finish to a session that was overshadowed by the special statewide election called by Governor Schwarzenegger for November 8. The threat to order the off-year election was made in the Governor's State of the State message in early January. It triggered an undercurrent of partisanship that colored most debate. Positioning for the fall election seemed to produce straight party-line votes on all but the most innocuous measures.

Nevertheless, the Legislature found plenty to do. The competitive forces of society continued to promote and protect their interests through legislation. And the annual need to extend, update, refine or otherwise tinker with existing statutes is part of every session. The consequences affect virtually every walk of life.

For CSA, the issues were few in number, but very contentious in some areas.

Legislative & Practice Affairs (cont'd)

Balance Billing: By far, this was the biggest challenge to CSA during the 2005 session. It was a direct threat to non-contracting anesthesiologists who care for patients covered by various managed care plans. Legislators hear from constituents who complain of receiving “unexpected” bills largely from hospital-based physicians for care thought to be fully covered. Even though the balance billings people receive usually are caused by the plans and insurers that fail to have fair contracts or pay reasonably, some blame the practitioner.



Anesthesiologists and emergency physicians are the most frequently cited, but it is a situation that increasingly affects other specialists. The ability to balance bill is one of the few weapons physicians have in trying to negotiate reasonable contracts with corporate payers. Non-contracting physicians are forced to seek patient involvement in reimbursement disputes as many managed care plans and insurers refuse to accept or respond to claim appeals directly from treating practitioners.

The balance billing controversy became even more visible in 2005 than previous years but ended in stalemate once again. It was the focus of several bills, numerous hearings, heated debate, on-again off-again negotiations and endless meetings. But there was little movement by any of the parties.

As with CSA, the California Medical Association (CMA) made retention of the right to balance bill its number one priority for the year. Also taking the same position was the California Chapter of the American College of Physicians (CAL-ACEP). Additionally, the California Radiological Society and the California Society of Pathologists opposed any change to the legality of balance billing.

Assembly Bill (AB) 1321 (Yee) kicked off the debate by proposing to prohibit balance billing by hospital-based physicians for services to health plan enrollees with violations subject to Medical Board discipline as unprofessional conduct. AB 1321 was written and sponsored by the California Association of Health Plans as admitted by its author, Assemblymember Leland Yee, Ph.D., a Democratic child psychologist from San Francisco. The bill passed the Assembly Health Committee after the unprofessional conduct language was removed and a state-operated dispute resolution system was made part of the proposal. As such, it died on the Assembly Appropriations Committee suspense file due to the projected cost of the dispute resolution system.

Assemblymember Yee did not give up easily, however. Through the “gut and amend” process, he inserted the same language into another of his bills (AB 1116) that had passed the Assembly but stalled in the Senate Business and Professions Committee. Near session’s end Yee, an announced candidate to succeed Jackie Speier in Senate District 10 (parts of San Francisco and San Mateo counties), used this bill for yet another unrelated purpose. CSA, CMA, CAL-ACEP and other allies adamantly opposed AB 1321.

Senate Bill (SB) 417 (Ortiz) took a different approach. As Chair of the Senate Health Committee, Senator Deborah Ortiz, a Democratic former Sacramento City Councilwoman and legislative staffer, proposed to limit balance billing to situations where the patient's health plan or insurer had first been billed and had denied payment "in full or in part." SB 417 faltered in the Assembly Health Committee due to disagreements over several provisions, including the resolution of disputed claims. CSA and all the cited physician groups supported SB 417.

SB 364 (Perata) called for managed care plans to stand behind their contracts with providers when subcontracted "risk bearing organizations" fail to meet delegated payment obligations. Authored by Senate President pro Tempore Don Perata, a Democratic former Alameda County Supervisor and school teacher, SB 364 passed the Senate but was set aside in the Assembly to give more time for the Department of Managed Health Care (DMHC) to find a regulatory solution. Again, CSA and allies were in support.

All of the above legislation was heavily lobbied. On one side were organizations representing physicians rendering "hands on" care. On the other side was the economic clout of individual corporate health plans and insurers and their respective trade organizations. Also engaged were business and employer entities (e.g., Chamber of Commerce and the California Manufacturing & Technology Association) that view managed care as the best means of controlling health care costs. The California Association of Physician Groups (CAP-G), the risk bearing medical groups that often are the most troublesome payers for emergency and specialized care, has become a major player in the effort to ban balance billing. Having the CAP-G physicians line up with the corporate payers and the business community has undercut the balance billing message of treating practitioners. It is seen by many legislators as a clear division in the house of medicine.

To some extent the balance billing issue has been infected with partisanship. Most legislative Democrats, but not all (e.g., Yee), side with treating practitioners. Most, but again not all, Republicans support corporate payers and their allies.

Managed Care: A variety of managed care issues besides balance billing also were in the legislative mix.

SB 367 (Speier) extends to insurers, regulated by the Department of Insurance (DOI), many of the contractual specifications presently mandated for health plans under the jurisdiction of the DMHC. All such contracts must include provisions for a "fast, fair and cost-effective dispute resolution mechanism" that must be accessible to non-contracting providers. The measure received final legislative passage and awaits action by the Governor. SB 367 is sponsored by CMA, supported by CSA, the Ob-Gyns and the California Hospital Association.

SB 634 (Speier) extends to DOI-regulated insurers a number of the prompt payment requirements presently applicable to DMHC-regulated managed care plans including

deadlines for claims receipt and processing. Also, it requires disclosure by insurers of a number of specific items, including fee schedules, coding methodologies, items included in global fees, payment policies for consolidation of services and payments to assistant surgeons. The measure is sponsored by CMA, and supported by CSA and a wide array of provider organizations. It awaits action by the Governor.

AB 598 (De La Torre) proposed to require approval by DOI or DMHC of contracts with providers to assure they are “fair” as required by existing law. Execution of contracts by providers would be mandated at least every three years. Waivers of provider rights to resolve disputes through the courts would be prohibited. AB 598 died on the Assembly Appropriations Committee suspense file due to cost implications. It was sponsored by CMA and supported by CSA and numerous provider organizations. Opposition came from the usual corporate payer suspects.

AB 757 (Chan), known as the “silent PPO” bill, proposed to prohibit the selling, leasing or transferring lists of contracted providers to other payers without the knowledge and consent of the affected providers. The measure specified a number of contractual requirements and protections for providers. It, too, was derailed on the Assembly Appropriations Committee suspense file due to cost implications. AB 757 was sponsored by CMA and supported by CSA. Opposition came from insurer and managed care trade groups plus Blue Cross and Health Net.

Workers’ Compensation: After doing such a great job on “reforming” the workers’ compensation system during 2003-04, there was little legislative appetite for any substantive action this year. Changes to the Official Medical Fee Schedule (OMFS) likely will be made in 2006 through administrative regulations. Barbara Baldwin has been in touch with some of her contacts in the Division of Workers’ Compensation (DWC) to emphasize how detrimental it would be to apply Medicare conversion factors to anesthesiologist reimbursement.

AB 681 (Vargas) proposed to freeze the current OMFS until 2011. Opposition came from business, labor, insurers, Kaiser-Permanente, and the California Academy of Family Physicians among others. The proposed freeze was shortened to 2008 by amendment but did not lessen the opposition. The measure died on the Assembly Appropriations suspense file.

Third Party Liability: Providers who treat Medi-Cal patients for injuries caused by other persons (tortfeasors in legal parlance) are limited to Medi-Cal reimbursement for services rendered under existing law. A 2003 California Supreme Court decision invalidated a Medi-Cal lien law because it was inconsistent with applicable federal statutes. Writing the unanimous decision was Justice Janice Rogers Brown who since was appointed by President Bush to the federal appellate bench. She urged the Legislature to “remedy this anomaly” which, she said, gives “the third party tortfeasor a windfall at the expense of the innocent health care provider.” Last year, remedial legislation, SB 494 (Escutia) was passed but vetoed.

SB 399 (Escutia) is the 2005 offering as a refined, even better bill to remedy the problem. Co-sponsored by CMA and the Consumer Attorneys of California (CAOC), it is supported by CSA, CAL-ACEP, the University of California, and the California State Association of Counties among others. Unsurprisingly, auto and homeowners insurers oppose SB 399, fully content to let the taxpayers pay for the medical injuries caused by their insureds and unconcerned about forcing providers to accept Medi-Cal rates as payment in full. Also in opposition are the Civil Justice Association of California, Kaiser-Permanente and other elements of the business community that apparently believe that anything even co-sponsored by the plaintiffs' bar (CAOC) must be bad. SB 399 is on the Governor's desk where a veto would be no surprise.

Medi-Cal: Provider reimbursement rates were not an issue in the 2005-06 State Budget, much to the relief of the provider community. The Legislature rejected the Administration's proposal to move 550,000 aged, blind and disabled beneficiaries from fee-for-service to Medi-Cal managed care. Provider rates became an issue in August when the U.S. Court of Appeals for the 9th Circuit lifted the injunction that earlier blocked a 5 percent rate cut that was to take effect on January 1, 2004. In response, the Governor's office floated a proposal to forego a retroactive cut back to 2004 but, instead, to authorize the 5 percent rate reduction commencing July 1, 2006, through June 30, 2009. Negotiations with a CMA-led provider coalition, including CSA, ensued.

AB 1735 (De La Torre) was the result. It formally repeals the statutory authority for the rate reduction back to 2004 and allows the entire rollback authorization to expire on January 1, 2007. A strong bipartisan vote in both houses sent the measure to the Governor on the last night of the session.

Physician Peer Review: The 2005 meeting of the CMA House of Delegates adopted a resolution calling for changes in the hospital medical staff and appellate review process. The proposal was to require that peer review hearings be conducted by an independent Judicial Review Panel Organization (IJPRO) along with changes in the rules governing peer review hearings.

SB 932 (Kuehl) was sponsored by CMA for this purpose. Once introduced, however, it encountered significant concern from physicians, including CSA, and was shelved.

Manipulation Under Anesthesia (MUA): The Board of Chiropractic Examiners initiated and adopted a proposed regulation to allow licensed chiropractors to perform manipulation under anesthesia under specified conditions (e.g., procedure performed in a licensed hospital or ambulatory surgical center, patient evaluated by a medical or osteopathic doctor and approved for MUA and anesthesia). CSA and other physician organizations opposed the regulation as being outside the lawful scope of practice of chiropractors. The regulation is pending before the Office of Administrative Law (OAL) where a decision is due by October 7, 2005.

We will update you on the above, and certainly other, issues in the next *Bulletin*.