

On Your Behalf . . .

News and Notes from the Legislative and Practice Affairs Division

What We Do for CSA

By William Barnaby, Sr., CSA Legislative Counsel, and William Barnaby, Jr., CSA Legislative Advocate

The role of lobbyists in representing private citizens and organizations before government often is unclear even to those who utilize their services. The role sometimes is depicted as mysterious, manipulative or even insidious. At the other end of the spectrum, the role is seen as putting the right kind of information before the right decision-makers to produce good public policy and the result most helpful to the client. We try to fit into the latter category.

As government becomes more complex and technology quickens communication, the challenge becomes greater. It entails far more than lurking around the halls of the Capitol.

For example, our work for CSA involves:

- Identifying proposed legislation and administrative regulations of immediate or potential interest. Usual issues of interest to CSA include physician licensing, Medi-Cal, workers' compensation, scope of practice, hospital and clinic regulation, managed care and medical malpractice. We analyze these measures, recommend positions to CSA leadership as appropriate, and work with allies to pass or defeat proposals as they are considered. For legislation, this requires development of background information, face-to-face conversations with legislators and staff, arranging expert witness testimony when necessary, monitoring amendments and following bills through as many as six committees, debates on the Senate and Assembly floors and to the Governor's desk. In sum, it is an effort to influence the outcome at each stage in a manner most favorable to the CSA.
- Understanding and articulating how these proposals substantively affect CSA members and their patients. This frequently means consulting with CSA members, officers, staff or other relevant experts.

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- Establishing relationships and credibility with decision-makers, whether they are members of the Legislature or the Executive Branch. Getting to know 120 legislators in this era of term limits, their staffs, and committee consultants is a full-time job in itself. But it is essential if one expects to make a difference at critical times. The same is true of those holding administrative positions in key agencies such as the Department of Health Services (DHS), the Medical Board of California (MBC) and an entire array of state agencies. And it does not hurt to have a few friends or acquaintances among the Governor’s key advisors located in the “horseshoe” within his “corner office.”
- Maintaining rapport with other lobbyists. Besides working with allies and coalitions on certain issues, especially those within the medical community, this is an important source of information. Early warning of impending actions is often gained and problems avoided before they become serious. Lobbying the lobbyists is not to be overlooked.
- Helping CSA members with problems associated with their practices, such as Medi-Cal reimbursement and Medical Board issues.
- Keeping track of almost continuous campaign fund raising events, both in Sacramento and in legislative districts. Invitations arrive by mail, fax and e-mail. For the month of February 2004, solicitations for over 100 events were received. This was an unusually high number due to the March 2nd primary election which included a number of multiple candidate races. But campaign fund raisers never cease and this function occupies a lot of our time. We coordinate GASPAC contributions to legislative and statewide office incumbents and candidates based on their sensitivity to issues of concern to CSA members and their accessibility. Campaigns for public office are expensive in California, and GASPAC helps greatly in maintaining the visibility of CSA. These donations are used for our attendance at Sacramento events (breakfasts, lunches and evening receptions) as well as for tickets to local events for GASPAC contributors. Key contacts between CSA members and legislators often are formed in this way. Discussion of specific issues, bills or votes with the recipient of a donation at these events is illegal and must be avoided. But conversations can establish social rapport or even pave the way for subsequent meetings of a substantive nature.
- Reporting to the CSA and the membership about state government and political activities that potentially impact their practices and patients. This

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can be much more difficult than is apparent at first glance and is a reason why our efforts are sometimes not all that visible to the membership. Legislative and political developments can move rapidly at times, which renders the *Bulletin* as an inappropriate reporting vehicle. There is just too much of a time lag inherent in a quarterly publication. The electronically transmitted Gasline usually is too brief for our material and usually is issued only after meetings of the Board of Directors or the Executive Committee. Instead, our normal practice is to keep the CSA leadership and central office informed on a timely basis and leave it to their judgment as to what may need broader, immediate distribution.

The foregoing is just an outline of what we do. It really does not fully describe the constant give and take between decision-makers and the so-called “Third House”—the lobbying community. Knowing partisan implications, intra-party relationships, and personal preferences of legislators all can be factors in tailoring how an issue is advocated. Good bills have been lost because a committee chair is angry at a legislative author or a sponsoring organization. Knowing what not to say can be more important at times than what is said.

Lobbying is not an office-based business. **The more time we spend in the office rather than in the Capitol, the less effective we are.** Answering telephone calls and responding to incessant e-mails are necessary but detract from our core tasks. As for representing CSA, it is important for us to be visible, ethically correct, tolerant of opposing points of view, truthful and careful not to be offensive. We are expected to have some knowledge about medical matters or at least be capable of obtaining reliable information when needed.

Reputations are gained over time and are passed on from previous to current office holders. A good reputation is a great asset. Lobbyists with questionable reputations usually are not around very long. Longevity for those who survive over the years can also be an asset as the elder of our team can attest. Having known parents, relatives and friends of current office holders can be most beneficial. Experience also gives perspective on how laws and programs began, evolved, and why they need to be continued or changed, especially in this term-limited era.

In our case, the father and son team works well. Our appearance together at fund raisers tends to be remembered better than that of individuals. It does not bother us at all to be known around the Capitol as the “Barnaby boys,” or the “Barnaby brothers,” or “Team Barnaby.” The younger member of our firm is

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the designated contact for his contemporaries in the Capitol for obvious reasons.

Lobbyists, or “legislative advocates,” are defined by law as individuals who are paid to “attempt to influence state action.” We are attorneys although being a member of the State Bar is not necessary to be a lobbyist and many are not. But it helps to understand how laws are constructed, interpreted and enforced.

Lobbying is a dynamic, ever-changing field. Issues and public officials come and go. Over the years more and more interests and organizations have found formal representation before government as helpful, if not essential. We strive to bring timely information to bear on how proposed government actions will affect our clients and their patients.

Lobbying can be exciting, exhausting and frustrating. But representing solid clients who perform services valuable to society, such as the CSA and its members, makes it worthwhile.

Superior Court Permits Balance Billing

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

Repeatedly and throughout the State, anesthesiologists and other specialists, particularly those who are hospital based, are told by health plans or their contracting IPAs that enrollees cannot be billed directly, under the Knox-Keene Act, the law regulating health plans. The Department of Managed Care has given informal support to health plans making this claim. However, a late December ruling by Los Angeles Superior Court Judge Linda Lefkowitz threw out a suit by an IPA making such a claim against emergency department physicians who had no contract with the IPA. Because this was a trial court ruling, not an appellate decision, court’s order does not establish the law in other disputes. Nonetheless, Judge Lefkowitz’s analysis parallels the analysis offered in previous *Bulletin* articles on the subject of patient responsibility to anesthesiologists who have no contract with the health plan that covers the patient.

In *Prospect Health Service Medical Group v. St. Johns Emergency Medical Group*, Prospect, an IPA, argued that Health and Safety Code Section 1379 prohibited St. Johns, which had no contract with Prospect, from billing patients the difference between the Medicare rate, which was all that Prospect would

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pay, and Prospect’s usual charge. The argument was based on Health and Safety Code Section 1379, which reads:

(a) Every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan.

(b) In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan.

(c) No contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan.

Prospect argued that accepting payment of the Medicare rate created an implied contract, so that St. Johns was precluded from billing the patient, and asked for declaratory relief to this effect. The ruling finds that “It is certain from the pleadings that the defendants have not acceded to any contractual terms,” stating that Section 1379 contemplates a traditional contract which reflects a meeting of the minds. The Court dismissed a May 5, 2003, Department of Managed Health Care letter supporting Prospect as being without legal support, under California law. DMHC relied solely upon Tennessee cases, where a statute prohibits balance billing.

The Court’s ruling concludes by saying “Certainly, every resident of California has concerns regarding the cost of medical service. However, in the absence of legislative and/or regulatory imposition of a proscription against balance billing in the non-contracting emergency service context, and in light of the legislative and/or regulatory inaction regarding a proposal to expressly so proscribe, the Court finds that the plaintiff’s claims do not survive demurrer.” The Court further refused to find that Medicare rates constitute “reasonable” payment.

With some frequency, health plans or IPAs have sought to impose their fee schedules on non-contracting anesthesiologists, often citing Section 1379 as precluding patient responsibility. This decision shows that argument does not survive impartial analysis. At the same time, anesthesiologists should be aware that the legislature could change the rules. A patient who faces personal respon-

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sibility should be an ally in forcing the responsible health plan to pay what is indeed “reasonable” when the health plan has not met its responsibility to arrange for services, arranging for contracts with physicians regularly treating plan patients. The best course is to explain the situation to patients in advance of surgery, if patient responsibility will be enforced. Alternatively, patients who have difficulty in paying reasonable charges can assign claims against health plans, and otherwise assist in collection.

Department of Managed Health Care Fails as HMO Watchdog

By Joetta Cox

This is the second in a series of articles that address billing dilemmas faced by anesthesiologists and their patients in dealing with health insurance plans that knowingly fail to provide contracted anesthesiologists, therein coercing their subscribers to be penalized financially for their plans’ fraudulently deceptive and incomplete coverage.

As the director of the Reimbursement Advocacy Program for the Santa Clara County Medical Association, Joetta Cox has compiled the facts, as presented to her by the patient (Mary) who initially called with a specific complaint. The following case report is based on documents compiled by Ms. Cox and the patient, who is committed to share the facts with the readers of this Bulletin.

Introduction

The Department of Managed Health Care (DMHC) was established in 1999 to regulate the Knox-Keene Act. With the passage of AB 1455 in 2000, the DMHC was mandated to assist patients and find healthcare plans that practiced unfair payments to physicians. However, this law was not effective until this year.

The following case presentation is an exceptionally well-documented complaint initiated by a patient, not a physician, who is eager to share the following information with all physicians. Be assured that this case that arose in 2003 is not the only scenario of the DMHC’s failure to enforce the spirit and intent of the Knox-Keene Act.

Mary, anticipating the birth of her first child, did her homework on her financial responsibilities for her obstetric and related care. Her obstetrician was a contracted provider with her health plan (Blue Cross), and so was the hospital in Los Gatos (suburb of San Jose) where she planned to deliver her child. Mary

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also did her homework in relation to pain management for her labor, knowing that she would want an epidural for her labor analgesia, and of course, anesthesia for any necessary cesarean. She knew that she would need the services of an anesthesiologist.

Outdated Provider Lists Supplied to the Patient by Blue Cross

Months before her due date, Mary attempted to find an anesthesiologist within her insurance network. She contacted Blue Cross for a current list of contracted anesthesiologists in the Los Gatos area, and she was provided with one name. She then called that anesthesiologist’s office, and much to her surprise, she was notified that he had recently terminated his contract with Blue Cross.

In response, Mary once again phoned Blue Cross and asked for a list of contracting anesthesiologists with privileges at the Los Gatos hospital. Furthermore, just in case this didn’t provide her with the list that she sought, she also requested a list of anesthesiologists in the neighboring city of San Jose. Blue Cross sent her a list of 27 “matches.” Some were, in fact, duplicate, so the list actually contained 22 anesthesiologists. Mary then dutifully called each anesthesiologist’s office to inquire if the physician was, indeed, contracted with Blue Cross, and also if that physician had privileges at the hospital in Los Gatos. Of those 22, five had moved out of California, and nine practiced at other facilities. One had retired, and one was deceased! Three were not contracted at that time with Blue Cross, and the other three phone numbers listed by Blue Cross had been disconnected. Not one of these 22 had privileges at the hospital in question!

For all intents and purposes, Mary had no choice but to use a non-contracted anesthesiologist. Not only had Blue Cross failed to provide her with a contracted specialist, but they also had failed to provide an accurate and updated list of their providers. According to Health and Safety Code Section 1367.26, health plans are mandated to provide, upon request, a list of contracting providers. Moreover, this list must be updated at least quarterly, and if a request is made by phone, the response must be accurate. This list must: (1) indicate that it is subject to change without notice; (2) include a toll-free number where enrollees can obtain current information, including whether or not a specific provider is accepting new patients; and (3) be provided in writing or, with the enrollee’s permission, on the health plan’s website.

I, personally, previously had filed a complaint with the DMHC on April 14, 2003, regarding the failure of Blue Cross to discharge its duty by complying

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with this Health and Safety Code for a different case, and again, as part of this case on August 26, 2003. My efforts notwithstanding, Blue Cross continued to supply outdated provider lists to its patients.

After the patient’s delivery, Blue Cross refused to pay the non-contracted anesthesiologist’s full charges. The result: Mary was penalized financially for going out of network, although in fact, Mary had no choice but to do so. This fact is clear: Mary had no choice because Blue Cross did not comply with the law: it did not provide a contracting specialist. Numerous appeals were sent to Blue Cross, which denied all of them on the grounds that the patient did have a choice prior to delivery, and that she elected to seek an anesthesiologist out of network. The fact that Mary had no choice was completely ignored by Blue Cross!

The Department of Managed Health Care Refuses to Intervene

Following my advice, Mary submitted a complaint to the DMHC, which claims to be an advocate for the consumers of California. Mary states that the DMHC totally ignored the documentation that she supplied to them and refused to assist her in resolving this issue. The DMHC merely gave her the names of three anesthesiologists who Blue Cross declared were its contracted providers, the same anesthesiologists previously named who still were neither contracting anesthesiologists nor credentialed at the Los Gatos hospital.

I phoned DMHC and pointed out the fact that they ignored Mary’s documentation in their findings. They proceeded to inform me that the patient should have gone to a hospital that had a contracted anesthesiologist. I replied that Mary’s attending obstetrician practiced only at the Los Gatos hospital, which was, in fact, a contracted Blue Cross hospital.

I reminded DMHC that when Blue Cross sold their policy to Mary, she had been informed that she could utilize any of the physicians [obstetricians] and facilities [the Los Gatos hospital] on the Blue Cross participating provider list. I queried the DMHC if they were now stating that Blue Cross can commit fraud and insist that Mary could not have services provided by physicians and facilities on the Blue Cross participating provider list. The DMHC responded by blaming the situation on the hospital in Los Gatos for not granting practice privileges to those three anesthesiologists that they claimed were contracted (Mary had already informed DMHC that these three were, in fact, not contracted). This DMHC contention was made without its knowing for a fact

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whether these three anesthesiologists had been refused privileges, or even if they wanted to have privileges in that hospital.

Numerous appeals submitted to Blue Cross have been denied despite their awareness that they were not able to provide the patient with a contracted anesthesiologist. The patient has e-mailed the medical director of Blue Cross to intervene on her behalf. He replied that he was sorry that he could not help her and advised her to file a complaint with the DMHC! The patient believes that she is a victim and that Blue Cross is penalizing her for something over which she had no control. She believes that Blue Cross is in breach of contract.

Where Did the System Fail?

Knox-Keene regulates against “unfair payment practices.” The problem is a lack of enforcement, one that is the legislatively assigned responsibility of the DMHC. Let’s look at a couple of issues: the first is the lack of DMHC’s failure to enforce, and the second is the penalty levied against health plans that practice “unfair payment.” With respect to the first, because there is no enforcement, physicians realistically have no responsive state agency to which to turn for assistance. Secondly, the penalty for violation of Knox-Keene should be severe enough to stop such “unfair payment practices.” Indeed, the DMHC has levied fines against health care plans only three times since 1999, their total being less than \$610,000. The plans, meanwhile, continue to make huge profits through their outrageous and seemingly unchecked reimbursement practices. These three fines are, in fact, a “drop in the bucket,” and it remains wholly profitable for the plans to continue with the status quo.

CMA Trustee James Hinsdale, M.D., has actually traveled to DMHC in an attempt to ferret out their dismissive and abusive behavior. Whether DMHC will be held fully accountable, made to mend their behavior and to adhere to the letter of the law remains to be seen.

Meeting with Assemblyman Manny Diaz

Because Assemblyman Manny Diaz has shown a great concern for the evolving healthcare crisis within our state, I requested a meeting with him to discuss the reimbursement practices of health plans. Mr. Diaz is very aware of the fact that physicians are leaving his constituency area (Silicon Valley) and that new physicians refuse to start practice in this area due to the high cost of living and poor reimbursement from health plans. These unresolved issues of unfair payment practice not only cause financial hardship for patients and physicians, but also create an “access to care” problem. I met with Mr. Diaz and presented this

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specific case to him as we discussed the “lack of enforcement” by the DMHC for unfair payment practice by health plans. As a result of these meetings, Mr. Diaz has placed a request for an audit of the DMHC.

Have I Got a Deal for You, Says the ASC Operator!

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

Members report that some ambulatory surgical center (ASC) operators with heavy workers’ compensation practices are suggesting that it is time to make a deal. The ASC, dismayed at new workers’ compensation ASC rates in California, propose to offer package deals, in which the anesthesiologist and facility will offer a combined rate. Needless to say, the facility’s share of the pie will be larger than the workers’ compensation rate would provide, and the anesthesiologist, who does not control the referral, will take less. The incentive offered the anesthesiologist is the opportunity to work, that is, patient referral.

Paying or receiving consideration for patient referral is prohibited by Business & Professions Code Section 650, the “anti-kickback law.” Where Workers’ Compensation is involved, the law is even more explicit, and the penalties may be greater. As of January 1, 2004, the California Labor Code provides:

3219. (a) (1) Except as otherwise permitted by law, any person acting individually or through his or her employees or agents, who offers or delivers any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration to any adjuster of claims for compensation, as defined in Section 3207, as compensation, inducement, or reward for the referral or settlement of any claim, is guilty of a felony....

(b) Any contract for professional services secured by any medical clinic, laboratory, physician or other health care provider in this state in violation of Section 550 of the Penal Code, Section 1871.4 of the Insurance Code, Section 650 or 651 of the Business and Professions Code, or Section 3215 or subdivision (a) of Section 3219 of this code is void. In any action against any medical clinic, laboratory, physician, or other health care provider, or the owners or operators thereof, under Chapter 4 (commencing with Section 17000) or Chapter 5 (commencing with Section 17200) of Division 7 of the Business and Professions Code, any judgment shall include an order divesting the medical clinic, laboratory, physician, or other health care provider, and the owners and operators thereof, of any

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fees and other compensation received pursuant to any such void contract. Those fees and compensation shall be recoverable as additional civil penalties under Chapter 4 (commencing with Section 17000) or Chapter 5 (commencing with Section 17200) of Division 7 of the Business and Professions Code. The judgment may also include an order prohibiting the person from further participating in any manner in the entity in which that person directly or indirectly owned or operated for a time period that the court deems appropriate. For the purpose of this section, “operated” means participated in the management, direction, or control of the entity.

. . . .

3820. (a) In enacting this section, the Legislature declares that there exists a compelling interest in eliminating fraud in the workers’ compensation system. The Legislature recognizes that the conduct prohibited by this section is, for the most part, already subject to criminal penalties pursuant to other provisions of law. However, the Legislature finds and declares that the addition of civil money penalties will provide necessary enforcement flexibility.

The Legislature, in exercising its plenary authority related to workers’ compensation, declares that these sections are both necessary and carefully tailored to combat the fraud and abuse that is rampant in the workers’ compensation system.

(b) It is unlawful to do any of the following:

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(3) Knowingly solicit, receive, offer, pay, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for soliciting or referring clients or patients to obtain services or benefits pursuant to Division 4 (commencing with Section 3200) unless the payment or receipt of consideration for services other than the referral of clients or patients is lawful pursuant to Section 650 of the Business and Professions Code or expressly permitted by the Rules of Professional Conduct of the State Bar.

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(d) Any person who violates any provision of this section shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than four thousand dollars (\$4,000) nor more than ten thousand dollars (\$10,000), plus an assessment of not more than three times the amount of the medical treatment expenses paid pursuant to Article 2 (commencing with Section 4600) and medical-legal expenses paid pursuant to Article 2.5 (commencing with Section 4620) for each claim for compensation submitted in violation of this section.

Anesthesiologists should tell ASC operators considering such arrangements that they are illegal, period.

GASPAC Honor Roll

By Virgil Airola, M.D., Chair, CSA Legislative and Practice Affairs Division

At the 2004 ASA House of Delegates Meeting last October outgoing President James Cottrell said, “compassion and science are not enough, the third pillar required to support Anesthesiology today is political involvement.” In essence, he said that when issues of concern to anesthesiologists are “on the table,” you and other CSA representatives must show up, speak out, and be willing to work with our legislators and others in Sacramento to “get it right.”

Those CSA members who make voluntary contributions to GASPAC (The Greater Anesthesia Service Political Action Committee) help CSA get your message to those who more and more are making the rules we physicians must follow while we care for our patients. It’s important that they “get it right” the first time in Sacramento! GASPAC donates to political campaigns and fund raisers so you and other CSA representatives can build a working relationship with legislators and their staffs in your local area or in Sacramento. Getting to know these influential individuals and getting your ideas to them is essential today.

Many of you have already learned that politics is simple: participate, donate, and vote! Consequently, GASPAC has created (beginning in the 2004-05 contribution year) an additional recognition category for those many CSA members who have begun contributing \$500 or more each year to GASPAC.

Conversely, and with serious ramifications to the political effectiveness of CSA, GASPAC contribution have dramatically declined from last year. In 2003

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GASPAC had 640 members, **or thirty-one percent (31%) of CSA members**. This year GASPAC has only received the support of 470 members, **or nineteen percent (19%)**. To maintain CSA’s ability to have a “seat at the table” for many serious issues confronting us today, such as workers’ compensation reform and the state budget process, GASPAC must be fully funded. If you have not already contributed to GASPAC, I ask that you become a GASPAC member now and send the requested \$200 (made payable to “GASPAC”) to the CSA office. GASPAC contributions can also be made via Visa/Mastercard. **It is also important to note that unlike Federal Election Commission mandates, California laws ALLOW contributions by corporations.** This means that if you, or your medical group, is incorporated you can still make a contribution to GASPAC, which is governed by California law and the Fair Political Practices Commission.

The 2003-04 GASPAC Honor Roll follows below. CSA and all its leaders recognize these contributing physicians, and others, for their commitment to our profession and the well-being of our collective patients. They have with their unselfish contributions opened the doors to many legislative offices for CSA. Thank you all.

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