

On Your Behalf ...

Legislative and Practice Affairs Division

Anesthesia Contracts: Ten Things to Think About

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Introduction

A continuing shortage of anesthesiologists nationwide, the proliferation of ambulatory surgery centers creating alternative practice locations, and increased concerns about sufficient emergency department backup to avoid violation of the Emergency Medical Transfers and Active Labor Act, or EMTALA, have hospital administrators looking for the certainty and security of a written contract for anesthesia services. I have previously written in these pages about the formation of integrated anesthesia groups out of the independent practitioners in a hospital anesthesiology department, while citing the administration's desire for an anesthesia contract as the primary reason for forming the group. In this article I will discuss 10 things to keep in mind when working out the terms of anesthesia contracts.

In discussing the following points, I assume that the hospital is proposing terms and providing a first draft of the contract to an anesthesia group, as opposed to the group providing a contract to the hospital. I realize that a hospital sometimes offers an anesthesia contract to an individual instead of a group comprised of most or all of the members of the anesthesiology department, but in my experience it has become exceedingly rare for an individual (as opposed to a group) to hold the contract. It is even rarer that the anesthesia group (or its legal counsel) prepares the first draft of the anesthesia contract, which is then presented to hospital administration. Accordingly, in the comments that will follow, I will assume the anesthesia contract is between an anesthesia group and the hospital, and not with a single anesthesiologist, and that the hospital presents the first draft of the contract. The following points are relevant to virtually all anesthesia contracts.

1. Exclusivity. Often, but not always, the hospital's governing board will "close" the anesthesia department in association with the negotiation of the anesthesia contract if the anesthesia department is not already closed. It is

possible, however, to have an anesthesia contract between a hospital and a group comprised of all members of the anesthesia department without a closed department. In such case, the hospital is not prohibited from granting privileges to other qualified anesthesiologists. I typically refer to the contract held by the group in the open department as a *service* contract, to distinguish it from the *exclusive* contract held by the group in the closed department. (Throughout this article I will use the more generic term “anesthesia contract” to refer to both exclusive and service contracts.) Even in the case of a service contract in an open anesthesiology department, one can seek to have a provision that the hospital will not contract with any other individual or group to provide the same services as the contracted group. In the closed department with the exclusive contract, I recommend that exclusivity be stated more broadly, so the hospital is not only prevented from contracting with anyone else, but also commits to prohibit any other person or entity from providing anesthesia services in the hospital.

If the anesthesia contract addresses exclusivity at all, it is necessary to define the scope of the exclusive services. Often, chronic pain management services, as distinct from acute postsurgical pain management services, are carved out of the scope of exclusivity. Sometimes, conscious sedation by other members of the medical staff is also excluded from the scope of exclusivity. On occasion, certain types of services that are unquestionably within the anesthesia department also are carved out of the scope of exclusivity. For instance, even an exclusive contract may not cover obstetrical or cardiac anesthesia because another anesthesia group is providing the service. Such carve-outs sometimes result from the insistence of the anesthesia group and sometimes from the insistence of the hospital. The scope of a group's exclusivity can be important in determining what the group is obligated to provide under the contract as well as its ability to exclude others.

2. Managed Care. The hospital always will want the contracted anesthesia group to be “managed care friendly.” Just how friendly the group has to be is often a contested matter in contract negotiations. On one extreme is the provision that requires the group *to contract* with any managed care organization the hospital designates. At the other extreme is the provision that only requires the group *to negotiate* with designated managed care organizations. Most anesthesia contracts end up with text somewhere between these two extremes. Often, the hospital will want the anesthesia group to commit to discounts and use Medicare reimbursement as the starting point for measuring discounts. Obviously, the degree of discount from Medicare reimbursement is not the proper measure for any reimbursement for anesthesia given Medicare's significant undercompensation of anesthesia services. Moreover, there is more to managed care contracts than the rate of reimbursement. To declare all

contracts that provide a certain ASA unit rate as acceptable makes the group susceptible to other onerous managed care contract provisions.

3. Group Restrictions. The converse of contract exclusivity is restrictions placed on the anesthesia group by the hospital. For instance, some anesthesia contracts will include a provision that the group and its members may not provide services at any other facility. Others limit the competing facilities at which the group and its members may provide anesthesia services. A common restriction is one that places freestanding surgery centers in the hospital's service area off limits. Often, hospitals that do not impose specific restrictions more generally prohibit the group and its members from taking on other commitments that interfere with their services at the hospital.

Careful attention has to be paid to these restrictive provisions to avoid unintentional violations. Consider the provision that prohibits both the group and its physicians from working at any freestanding surgery center within a five mile radius of the hospital. If "physicians" is defined to include part-time independent contractors, this type of restriction can create problems because of the group's lack of control of those independently contracting "members."

4. Deselection. One of the hospital administration's goals in most exclusive contracts is control. In pursuance of this goal, the hospital seeks the ability to deselect (i.e., get rid of) individual anesthesiologists. The hospital wants unfettered discretion in deselection and often will cite as one of the reasons to close the department and award an exclusive contract to make it easier to be rid of problem physicians. It is easy to understand why an anesthesiology group and its members want to deny hospital administration the ability to deselect an individual for no reason at all. At a minimum there should be some reason for hospital deselection and some process to ensure the reason is legitimate. The more subjective the reason for deselection, the more important it is to have a fair and reasonable process for establishing the substance of the objection.

5. Litigation Cooperation. Recently, it has become commonplace for anesthesia contracts to include a provision that the parties shall cooperate in any litigation other than litigation between the parties. The typical provision would cover the case of a malpractice lawsuit in which both the hospital and the anesthesia group or an individual anesthesiologist are parties. (This is one of the provisions that the anesthesia group should discuss with its malpractice carrier.) I often suggest including a clarification that the obligation to cooperate does not require the group to do anything contrary to the advice of its malpractice insurer or any counsel appointed to represent the anesthesia group in the case. This additional language, among other things, allows the anesthesia group to present a defense without requiring the hospital's approval. The hospital

should have no objection to this clarification because it may just as easily turn out to benefit the hospital.

Another desirable clarification is one that makes it clear that group anesthesiologists are not obligated to serve as experts (either witness or consultant) without receiving market rate compensation for the expert services. There should be reasonable compensation for these services, if for no other reason than to discourage the hospital from taking advantage.

6. Insurance and Indemnity. Most anesthesia contracts include details on the insurance coverage each party is to maintain. They often include mutual indemnification provisions as well. Sometimes the hospital asks for insurance commitments from the anesthesia group that the group simply cannot provide, and indemnity obligations the group should not assume without understanding their significance.

Often the insurance provisions applicable to the anesthesia group include a requirement that its malpractice insurance carrier provide notice to the hospital in advance of any changes in coverage. (This is another provision you should share with your malpractice company.) As a matter of prudent underwriting practice, most physician malpractice insurers will not agree to condition changes on advance notice to the hospital. To meet the hospital's concerns, the group might have the insurer "undertake" to provide notice but not "promise" to provide notice. Alternatively, the group can commit to provide immediate notice of any changes and take the insurance company out of the agreement altogether. Occasionally, the hospital will ask that it be an additional named insured on the group's malpractice policy. Most if not all malpractice insurers will not agree to this provision either.

A very common provision in anesthesia contracts is one that requires the group to indemnify the hospital for any loss occasioned by the group. Often these provisions are mutual, so the hospital agrees to indemnify the group if the loss is the hospital's fault. At first blush this may seem fair and reasonable, but anesthesia groups need to understand what they are taking on when they agree to such a provision. Consider the situation where a bad outcome results for a particular patient undergoing a surgical procedure at the hospital. A malpractice lawsuit ensues in which both the hospital and the anesthesia group are named as defendants. The case proceeds through trial where the anesthesia group is found liable and the hospital is exonerated. Under the typical indemnity provision, the hospital could then present a bill to the anesthesia group for \$100,000 or more, representing the hospital's costs to defend the lawsuit. If the anesthesia group asks its malpractice insurer to pay the bill, the insurer will refuse, citing language in its policy that it does not cover "contractually assumed indemnity." The fact that the group would have the same option to

seek indemnity if it had been exonerated and the hospital found liable should hold little attraction for the group because almost all physician malpractice coverage (at least in California) provides “first dollar” coverage. This means it is rare for a physician or medical group to have to pay any deductible under its malpractice policy. The same cannot be said for hospitals that are often self-insured or have high deductibles under their policies.

The anesthesia contract should include a provision under which the hospital provides insurance coverage for the administrative services provided by the medical director and others under the anesthesia contract. Claims brought against a medical director are rare, but they do occur. They are not certain to be covered under the group’s malpractice insurance policy.

7. Term and Termination. As a general rule with any contract, if the contract is favorable to a party, then that party wants the term of the contract to be as long as possible. Conversely, if the contract is unfavorable or uncertain, the party may want a short term or the ability to make a quick exit from the relationship on a relatively brief period of notice. In the case of an anesthesia contract with a hospital that is tax exempt, the guaranteed term (the period during which neither party can get out of the contract without cause) is unlikely to be longer than one year because of extremely esoteric rules on tax-exempt bond financing available to such hospitals. (In the case of for-profit hospitals, there is no such term limit imposed.) A fairly common term provision in an anesthesia contract with a tax-exempt hospital is one that fixes the term at three years but allows either party to terminate without cause on 90 days notice after the first anniversary.

Of course, most contracts are terminable by a party following a material breach by the other party, and this same general rule applies to anesthesia contracts. However, it is rare that anesthesia contracts simply defer to the general rule. Instead, they often contain detailed provisions on how, when and why the contract may be terminated. I want to comment on two common termination provisions.

The first of these is the “with cause” provision that describes the circumstances that create cause for termination by the hospital whether or not these circumstances would be considered a material breach. Often, the circumstances cited involve only one anesthesiologist. Where this is the case, the group should consider a clarification that the incident will not result in termination if the group removes the offending individual from providing services under the contract. (Such a provision is a corollary to deselection discussed above.) The second termination provision that has gained favor with hospitals recently is often styled “legal jeopardy.” The typical legal jeopardy provision gives the hospital or the group the ability to get out of the contract in fairly short order

if a regulatory or reimbursement problem develops. Often these provisions include an obligation on the parties to meet and confer on amending the contract to eliminate the problem with termination resulting only if the parties cannot agree on new terms. I advise that the option to renegotiate arise only where there is a truly significant problem in order to avoid an abuse of the privilege. This makes sense given that an illegal contract is generally unenforceable as a matter of law so that, in the case of true illegality, this provision is unnecessary.

The legal jeopardy provision is closely related to a boilerplate provision on “severability” found in many contracts even outside the anesthesia contract realm. The typical provision indicates that if one aspect of the contract is deemed invalid, the rest of the contract will survive. At a minimum this should be tempered so that the contract only survives when it is not materially altered by the elimination of the severed provision. Most anesthesia groups would not find acceptable that the compensation provision of the contract is eliminated while their service obligations remain in effect.

8. Services. Finally, we arrive at those provisions that are at the heart of every anesthesia contract: the services the group provides and the compensation the hospital pays for those services. I will begin with a discussion of the services, which can be divided into three categories in the most comprehensive anesthesia contracts: *coverage*, *call* and *administrative*.

By *coverage* services I mean, principally, the staffing of operating rooms, but coverage also can extend to elective procedures outside of the operating room—such as sedation in the radiology department for certain imaging procedures. (“Staffing” may be the better term in order to avoid confusion with “call,” which is sometimes referred to as call coverage or emergency department coverage, but I will use coverage here since this seems to be the more commonly used term.) Recently, hospitals have been asking for details on surgical anesthesia coverage, and I have embraced this trend wholeheartedly. Rather than having the group commit to the indefinite obligation to provide “all anesthesia services required by hospital,” I prefer to identify the number of operating rooms to be staffed and the hours for each. Some rooms may have cases scheduled to 3 p.m. and the others may be scheduled through 7 p.m. To make sure that the regularly scheduled hours are adhered to, the group may want to limit “add-ons” and may want to include text that cases shall be scheduled for the efficient use of anesthesia resources. Obviously, it is easier for a group to staff five rooms through 4 p.m. than six rooms through 2 p.m. The hospital may well have an economic incentive to schedule surgeries efficiently, so it does not have to staff any more rooms than is absolutely necessary. Even so, I often find surgeons’ desire for convenience overcomes the hospital’s desire

for efficiency, especially where the hospital has to compete with a freestanding surgery center or even another hospital.

As regards call, the usual issues are how specialized, how deep, and whether any call is in-house. The call most likely to be in-house and most likely to be specifically mentioned in the anesthesia contract is that for obstetrics. In my experience, the less necessity for being in-house, the more the hospital wants it. If the hospital has a very busy obstetrical service, the physician on call would be in-house simply because one or more epidurals will be running at all times. Where the service is not very busy, the hospital may ask that the physician on obstetrics call be in-house for the convenience of the patients and obstetricians—and inconvenience of the anesthesiologist. The other area of specialized call likely to be addressed in the anesthesia contract is cardiac, especially where not all group members provide cardiac anesthesia. It is not uncommon in hospitals that have both cardiac and obstetric services to have three anesthesiologists (or more) on call at all times: one for obstetrics, one for cardiac and one for general operating room. Where the services are not busy, the group should look to have an on-call anesthesiologist perform double (or even triple) duty when possible. It may then have some depth to the call in case the first call gets tied up with a case. If the call obligation can be reduced by efficiencies, then this should be made clear in the anesthesia contract.

With regard to “administrative” duties, anesthesia contracts often include provisions for the designation of an anesthesia medical director with very specific duties delineated under the contract. Typically, the hospital wants to designate the director and this is rarely a problem in the first instance. I recommend designating an alternate or two and getting approval from hospital administration for the alternates when the contract is signed. It has become commonplace that the director be required to fill out time sheets to memorialize the administrative services rendered. In describing the administrative services the director provides, I advise liberal use of the “reasonable” qualifier. For instance, if the director’s duties include “attending such meetings as hospital shall request,” I recommend it be rewritten as “such meetings as hospital **reasonably** requests.” Often the amount of compensation paid by the hospital is determined in part by how many hours of administrative services are performed, so there may be an incentive to perform more, as opposed to fewer, services, except that in most cases providing anesthesia services pays better than providing administrative services.

9. Compensation. Most anesthesia contracts provide a fixed monthly stipend for the call and coverage services provided by the group. Many include an hourly rate for medical director services or a monthly stipend conditioned on a minimum number of hours of administrative service. Less common, but

not unheard of, is an income guarantee where the hospital ensures a certain level of income for the group based on the number of full-time equivalents required to perform all services under the contract. In such cases, the contract takes into consideration the revenues that the group collects from patients and third-party payers for services at the hospital. Regardless of which approach is used, the hospital's patient mix is taken into consideration, as a practical matter. This makes it difficult to use the amount paid under the anesthesia contract at one hospital to define what should be paid at another. If one hospital has a heavy Medicare and Medi-Cal patient mix, it might pay more compensation to its anesthesia group for coverage, call, and administrative services than another hospital in the same town that has a better patient mix. Given this circumstance, it is not possible (or advisable) to draw any firm and specific conclusions on the amount of compensation that should be paid under any anesthesia contract. Instead, compensation should be a rather fluid concept worked out in negotiations, as described below.

10. Negotiations. A few basic points about negotiating an anesthesia contract beyond the contract terms discussed should be kept in mind. First and foremost, anesthesiologists should recognize that they are almost always at a disadvantage when negotiating with hospital administrators as a simple matter of education, training and experience. It should not be surprising that an MBA has an advantage over an M.D. in contract negotiation any more than it would be surprising to find an M.D. has an advantage over an MBA in administering deep sedation. Anesthesiologists should recognize their limitations and level the playing field by securing the assistance of experienced consultants, and they should secure professional assistance sooner as opposed to later. I often find hospital administrators refuse very reasonable compromises when I come into negotiations late in the process, asserting that I am raising a point that "has already been settled."

Of course, the group's position should be that nothing is settled until everything is settled because every provision relates to every other provision. Nowhere is this premise more evident and more important than in the relationship of the services provided by the group and the compensation paid by the hospital. I routinely advise that the anesthesia group be flexible in how it accommodates the hospital's desires for deeper call coverage, flexibility in staffing operating rooms, and in cooperating with managed care organizations, as long as the hospital recognizes that if it wants more, it needs to be prepared to give more. (You may have heard the expression that you cannot get a Cadillac for the price of a Chevy. The same holds true, or should hold true, for anesthesia contracts.) This interrelationship of the anesthesia contract terms should be viewed as an opportunity and not as a problem. The anesthesia group should also keep in mind that the hospital administration has interests

conflicting with those of the group; the hospital administration will certainly be thinking about it.

Ultimately, most anesthesia contracts get down to matters of money, which is true for most contract negotiations. The anesthesia group usually has the opportunity to depersonalize the financial discussions. A point to make is that a certain level of compensation from the hospital is necessary to “recruit and retain” qualified anesthesiologists to provide the desired level of service. If the hospital is insisting on terms that mean the members of the anesthesia department will work harder and get paid less than would be the case at the hospital across town, or down the road, then the department soon will find itself understaffed.

It is important that the anesthesia group keep matters in perspective. Too often the group feels that it needs a contract at all costs and makes concessions it should not. This often happens late in the negotiations. I recommend that the group keep in mind throughout the negotiations what I refer to as “the point of relative indifference,” but others call the “best alternative to a negotiated agreement.” This means recognizing that in some circumstances the hospital’s last best offer should be declined. In determining where the point of relative indifference is, some things should be kept in mind. Most important, the anesthesia group should remember that the hospital cannot operate without anesthesia services and that qualified anesthesiologists are still scarce. The continuing nationwide shortage of qualified anesthesiologists creates tremendous leverage for anesthesia groups. This is especially true for larger groups. It is much more difficult for a hospital administrator to replace a 12-person group than a five-person group, but it is not easy to replace either group. Often, the hospital’s only immediate alternative is locums services which are usually very expensive for the hospital because they have to pay for the services and usually recoup very little from patients and third party payers. When it comes to negotiations, anesthesia groups are well advised to remember their strengths rather than focus on their weaknesses.

Conclusion

The anesthesia group in contract negotiations with a hospital has many things to keep in mind, and not all are readily apparent to most anesthesiologists. Anesthesia groups should not be hesitant to ask for what they want and get appropriate assistance for their negotiations. The foregoing points are some of the important issues to be addressed. Moreover, what is important to one anesthesia group may not be important to another. As such, each group needs to establish its own priorities and point of relevant indifference in its negotiations.

CAPG's Proposal for a New Definition of "Reasonable Fees"

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



The California Association of Physician Groups has asked the Department of Managed Health Care to adopt rules which change the definition of "reasonable fees" when noncontracting physicians seek payment. Present DMHC regulations follow the criteria defining "reasonable" compensation set out by the California Court of Appeal in *Gould v. Workers Compensation Appeal Board*. CAPG asks for new rules permitting HMOs and their subcontracting medical groups to pay "average contract rates" in the geographic area, or "rates paid pursuant to established fee schedules by governmental payers (e.g., Medicare, Medi-Cal, Healthy Families Program)," or average amounts "accepted by noncontracted providers" in the geographic area. Under CAPG's proposal, payments which reflect health plan fee schedules, rates under Medicare or other government programs, or payments accepted under voluntary agreements would be "reasonable," satisfying all obligations to noncontracted physicians, even physicians who rejected contracts offering those payments because they were so low as to be unreasonable.

CAPG's Web Site states that "The California Association of Physician Groups (CAPG) is the voice of organized medicine in California." In fact, CAPG is a trade association representing entities whose primary interest is buying and selling physicians' services, an activity which cannot always be reconciled with the concerns or views of working physicians who provide patient care. Under the heading "Balance Billing by Non-Contracted Hospital-Based Physicians is Hostage-Taking," CAPG's Web Site explains, "CAPG opposes the practice of billing HMO enrollees who obtain services in a network hospital, only to discover that they are being threatened by noncontracted physicians who refuse to accept reasonable and customary payment for their services." At issue, of course, is what is "reasonable and customary." The CAPG proposal would allow health plans and their subcontractors to decide, by using fee schedules which they control or which are mandated by government programs as the basis for their calculations.

CSA has responded to the CAPG proposal in the following letter from President Mark Singleton, M.D., to Cindy Ehnes, Director of the Department of Managed Health Care.

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Letter to Cindy Ehnes, Director, California Department of Managed Health Care from CSA President Mark Singleton, M.D., on May 25, 2006, regarding the request for amendment of the Gould Criteria by CAPG.

Dear Ms. Ehnes:

The request submitted by the California Association of Physician Groups to amend the criteria which determine the calculation of “reasonable” fees to be paid to noncontracted physicians pursuant to 28 CCR 1300.71 invites the Department to violate the law and ensnare itself in a morass which the Department has so far avoided.

Smarting from the outcome in *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, CAPG asks the Department to redefine “reasonable” in a fashion which has no legal basis, ignoring all precedent. Now that the Supreme Court has granted review in *Prospect*, there is clearly no reason to proceed down the path CAPG would like the Department to take. Nonetheless, the California Society of Anesthesiologists would like to record its response to the CAPG request, should it be revived if the Supreme Court agrees with the decision below.

CAPG clearly believes that the way to avoid balance billing issues is to allow health plans and their subcontractors to determine payment to noncontracting physicians on the basis of what they pay contracting physicians. CAPG’s suggested approach will not stand scrutiny. In both *Prospect* and *Bell v. Blue Cross*, the courts have pointed to the difference between fees determined by voluntarily negotiated contracts and fees due noncontracting physicians. Amounts paid by contract can be determined according to nearly infinite criteria, depending on factors important to the two respective parties. In contrast, the law requires health plans to pay noncontracting physicians “reasonable” fees. The determination of a “reasonable fee” does not depend upon the subjective desires of either party. Health plans have consistently sought to impose unilaterally determined fee schedules on providers, particularly physicians. The determination of a reasonable fee is a factual assessment, taking the factors set out in *Gould* into account. CAPG attempts to spin *Gould* by claiming that the measure of fees paid under the Workers’ Compensation program is somehow different than “reasonable fees” otherwise. This is an unsupportable claim. Section 4600 of the Labor Code makes the employer liable for “reasonable” expenses, and what is “reasonable” in that context is no different than what is reasonable when charged a patient or a health plan.

The request to utilize what physicians may receive under voluntarily negotiated contracts as a measure of reasonableness would give health plans and their

subcontractors the benefit of agreements made by their competitors, without requiring consideration in return. It would at least dilute the incentive to offer fair and competitive contracts to physicians, by putting a floor under any eventual obligations. Conversely, it discourages physicians from contracting with third parties who might otherwise be given greater discounts because of the population served, institutional or religious affiliation, or other good reason.

If the Department were to incorporate such a standard, it would be required to make individual, fact-specific assessments of physician practices in order to make decisions which are far better left to the courts. To even begin to reconcile the apple-and-orange difference between voluntary contracts and the marketplace otherwise, the basis for the compensation afforded by each voluntary arrangement would have to be taken into account. In the process, noncontracting health plans apparently would insist on access to data regarding agreements with competitors. As a policy matter, it seems apparent that the way for a health plan or subcontractor to protect itself against claims by noncontracted physicians is to offer those physicians contracts which are competitive in the marketplace.

With few exceptions, anesthesiologists contract with the health plans covering their patients. Only when a health plan presents contracts on a “take it or leave it” basis, refusing to negotiate, is a contract unlikely, and even then a competitive contract is likely to be accepted. Under the CAPG approach, the “take it or leave it” approach is bolstered by the implicit threat that the acceptance of the proffered agreement by others will de facto result in the imposition of the same terms on all anesthesiologists in the area.

The degree of overreaching in this proposal is most evident in the provision allowing health plans to take payments under Medicare, Medi-Cal or other government program payments into account. As the *Prospect* court noted, the Department has already determined that “these government programs are not designed to reimburse the provider for the fair and reasonable value of the services rendered and are, therefore, an inappropriate criteria.” Under Medicare, California anesthesiologists receive between 25 percent and 40 percent of the average amount paid by health plans under contracts with anesthesiologists. That could hardly be “reasonable” under anyone’s definition, yet CAPG members seek to use these payment rates to their advantage.

The *Gould* definition of the components of “reasonable,” and the present regulation, are comprehensive, but sufficiently flexible to allow consideration of any factors which California courts are likely to take into account in this assessment. The additional factors suggested by CAPG are unlikely to receive judicial approval. Their incorporation would profoundly change California’s

managed care system, by converting it from a system characterized by *agreements* linking plans, patients and providers to one in which health plans and their subcontractors are given disproportionate authority and control over providers who have no relationship with them. The fact that health plans are dwindling in number, and centralizing this control into a few very large plans, means that the CAPG proposal is even more pernicious. Health plans are free to address the same arguments to the courts (as *Prospect* did unsuccessfully as to Medicare payments), but the Department should neither accept them nor defend them.

We appreciate your consideration of these comments. CSA remains ready to cooperate with the Department in seeking solutions to the public concerns which are before it.

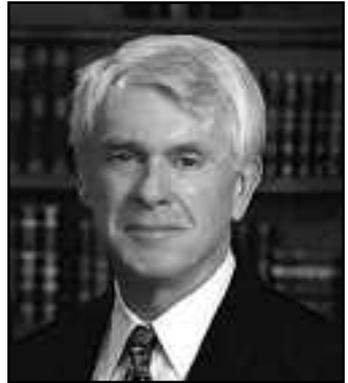
Medi-Cal Reimbursement; A Historical Flatline

By *William E. Barnaby, Esq.*
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Medi-Cal officials recently celebrated the program's 40th anniversary. While we did not attend the festivities, we hear that not many provider representatives were on hand either.

When Medi-Cal was enacted, payment for medical services rendered was to be at "reasonable and customary" rates. For a number of the early years, the Rate Development Branch routinely conducted surveys of providers' business expenses and made cost-of-living recommendations which usually were adopted without much controversy. That changed in the early 1980s.

A national recession in 1981 and 1982 caused a major drop in state tax receipts—which, in turn, brought about a significant state budget deficit. Sound familiar? Medi-Cal was quickly targeted for reductions. Most noninstitutional providers, including physicians, suffered a 10 percent rate cut and a new law was passed allowing a Medi-Cal "czar" to negotiate discounted contracts with hospitals. The impact on California healthcare did not stop with the "czar." Big health insurers argued that if discounted contracts were legally permissible for Medi-Cal, the same authority should be extended to the private sector. And it was. It took a few years for the incipient managed-care



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industry to realize the leverage that had been granted but, once understood, California healthcare has never been the same.

The state budgets enacted in 1984 and 1985 contained modest, single-digit cost-of-living-adjustments for physicians and others. For the final four years of Governor George Deukmejian and the entire eight years of Governor Pete Wilson, there were no Medi-Cal rate increases, with one exception—obstetrical services. During the late 1980s, expectant Medi-Cal mothers were increasingly limited to county hospitals for prenatal, labor and delivery services. When threatened with a lawsuit over the obvious lack of patient access, Medi-Cal agreed to a near doubling of fees for global obstetrical services.

On the other hand, the early 1990s produced another economic recession, another major budget deficit, and—guess what—a rate cut for some physicians. In 1992, Medicare imposed a reimbursement reduction of 10 percent on anesthesiologists, pathologists, radiologists, and emergency physicians. Medi-Cal quickly followed suit.

With the exception of the 1988 to 1989 obstetrical rate increase and the 1992 rate cut for “hospital-based” physicians, Medi-Cal rates were a flatline between 1986 and 1999.

The “Northridge” Medi-Cal epidural controversy erupted on June 14, 1998, a day when the CSA leadership was in Washington, D.C., for the annual ASA Legislative Conference. Without rehashing the details of a public relations disaster, the media was full of accusations that low-income parturient patients were being forced by anesthesiologists to pay cash for epidurals, notwithstanding their Medi-Cal eligibility. Suffice it to say, the political climate in Sacramento was not all that friendly for anesthesiologists for awhile.

Even so, in the next year the “hospital-based” physicians were able to gain restoration of the 10 percent cut imposed in 1992. In addition, the only other physician fee increase granted in 1999 was 21.8 percent for obstetrical anesthesia services. In medical lobbying circles, it was regarded as a coup for the CSA.

Finally, in 2000, an across-the-board rate increase was granted to virtually all Medi-Cal providers. Physicians received an average increase of 16.7 percent, which was used to increase anesthesia-based units from 82 percent to 93 percent of ASA RVG. That approach was used in large measure to discourage managed care/insurers from using Medi-Cal base units because they were less than ASA units. The increase approved in 2000 by Governor Gray Davis, a Democrat, was the first real upward blip in the Medi-Cal rate flatline since the terms of his two Republican predecessors. Davis has since been heavily criticized for putting some of the dot-com revenue surplus into ongoing programs.

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But, if the investment had not been made in the “safety net” in 2000, the Medi-Cal program certainly would be in even worse shape today. For the bail-out of Medi-Cal during his watch, Davis got little credit, as everyone may recall.

So where is Medi-Cal today? It is a \$34 billion a year program with 6.7 million eligible beneficiaries. Its provider payment rates have slipped from 48th back to 50th among state Medicaid programs. It spends less per patient than virtually any other state. Fewer and fewer physicians are accepting new Medi-Cal patients. Access to care definitely is at risk, but the U.S. 9th Circuit Court of Appeals ruled last year that neither patients nor providers have standing to sue on the basis of inadequate access. At the same time, any significant boost in payments to physicians, clinics and other “noninstitutional” providers would cost so much that gaining approval from the Legislature and a governor, either present or future, would be difficult at best.

While institutional providers—e.g., hospitals and nursing homes—account for the largest Medi-Cal expenses, their system of payments operates under different legal structures. Hospitals either negotiate discounted contracts, or they bill under a complicated cost-based formula. Nursing homes have a cost-of-living “pass-through” under the law to assure adequate staffing levels and pay.

Stagnant Medi-Cal payment levels amidst constantly rising business costs result in de facto reductions over time. This year, the coalition of Medi-Cal patient and provider advocacy organizations, the Alliance for Patient Care, itself headed by the California Medical Association, proposed a 15 percent rate increase along with an annual cost-of-living adjustment. The proposal failed, despite the state having tax receipts of \$7.5 billion more than estimated when the budget was submitted last January.

Anesthesiologists are at a special disadvantage when it comes to serving Medi-Cal patients at abysmal payment levels. When providing anesthesia for surgery, anesthesiologists often do not know the payer status of the patient, so it is difficult to refuse service even if the anesthesiologist does not want to participate in Medi-Cal. Under federal law, the Emergency Medical Treatment and Active Labor Act, patients presenting at emergency rooms cannot be turned away without being stabilized or treated. Approximately 43 percent of all newborns in California are covered by Medi-Cal. Violations are subject to heavy fines and licensing sanctions. In this context, anesthesiologists are virtual “captives” of the system, as once conceded by Medi-Cal Director Stan Rosenstein.

The outlook for the future is not terribly optimistic. The CMA-led coalition, the Alliance for Patient Care, of which CSA is an active member, soon will regroup to consider alternative strategies for the next budget year. Any significant developments will be reported.