Stretched Thin

Growing Gaps in California's Emergency Room Backup System

California Senate Office of Research

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Preface

The Senate Office of Research (SOR) is indebted to the many people who advised and assisted the office in collecting and reviewing information for preparing this report and who shared their perspectives on emergency room on-call coverage problems and solutions. SOR would like to thank especially the members of the AB 2611 working group (listed in Appendix A), who spent many months attending working group meetings and reviewing drafts of the report. SOR would also like to thank all participants at the four AB 2611 working group meetings that were held in 2001 and early 2002, as well as the dozens of other persons who provided comments on earlier drafts of this paper. Although all of these persons provided valuable assistance, SOR is ultimately responsible for the findings and recommendations contained in the report.

As a note, the public thinks of emergency care facilities at hospitals as "emergency rooms." Yet hospitals consider these complex facilities to be emergency departments. In deference to public perception, we use the term "emergency room" and acronym "ER" throughout the report, with some exceptions.

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Executive Summary

In October 1998, a patient was brought by ambulance to a California hospital emergency room with symptoms of abdominal distress and shortness of breath. The ER physician suspected an abdominal condition requiring surgery. As the patient continued to deteriorate, the physician twice phoned an on-call surgeon asking that he come in immediately to examine the patient. The surgeon repeatedly refused to come in, advising that the patient be admitted for him to see in the morning. As the patient's blood pressure and pulse rate dropped to life-threatening levels, the ER physician contacted hospital administrators in an apparent effort to compel the surgeon to come in. The patient suffered a cardiac arrhythmia and died despite a resuscitation attempt. The surgeon arrived during the resuscitation attempt.[1]

On a Saturday night in January 2000, a middle-age man came into a California hospital emergency room with an upper gastrointestinal bleed. The ER physician on duty treated the patient, but did not have the expertise to stop the bleeding. A gastroenterologist was asked to come in and perform an emergency endoscopy. Then another, and another, and another, and another. After three hours and six refusals, no GI specialist would come to the ER and the patient was at risk of bleeding to death. Finally, the ER medical director called a GI specialist he personally knew and told him he would pay him $500 in cash if he came in. The specialist accepted, came to the ER, performed the procedure, and stopped the bleeding.[2]

These cases, while isolated, illustrate the growing problems that are occurring with the state's system of ensuring "on-call" emergency services – backup services provided by specialists to hospital emergency departments. Under current law, hospitals that

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[1] "Questionable Hospitals: 527 Hospitals that Violated the Emergency Medical Treatment and Labor Act: A Detailed Look at 'Patient Dumping,'" Public Citizen, July 2001, pp. 27-28.

[2] American College of Emergency Physicians, California Chapter.

operate emergency departments are required to ensure continuous coverage for procedures and specialties that they normally offer to the public.

While most on-call physicians honor commitments to provide on-call services, and while these anecdotes illustrate isolated examples of on-call coverage problems, evidence is systematically mounting that gaps and problems with on-call coverage are contributing to delays in treatment and growing costs to hospitals across the state, as well as constituting a growing source of hospital and physician violations of anti-patient-dumping statutes.

AB 2611 Study Mandate

AB 2611 (Gallegos), passed in 2000, requires the Senate Office of Research to conduct a comprehensive study of the hospital emergency department on-call coverage issue in California. The study must include the magnitude of the challenges facing California emergency departments, including those in underserved and rural areas, the scope of the challenges facing other states, and how other states have addressed on-call coverage issues. The bill also requires SOR to convene a working group of affected California stakeholders, including hospitals, hospital organizations, physician organizations, other on-call specialists, payers, and state agencies.

To conduct this study, SOR collected extensive information from a wide variety of sources. Among other things, SOR commissioned, through the UC California Program on Access to Care (CPAC), a literature search of on-call coverage and related issues in California and other states. SOR also commissioned faculty from California State University at San Francisco to examine databases that might be used to better understand on-call coverage problems. Finally, as required by AB 2611, SOR convened a 30-member working group, which met four times in 2001 to discuss emergency on-call issues. The working group heard extensive input from experts in the area, including academics, emergency room physicians, attorneys, hospital administrators, and others. With the assistance of the working group, SOR developed a list of findings and principles for reform of the on-call coverage system that formed the basis for this report.

Findings

- Problems with access to emergency room on-call services in many specialties in many areas of the state are adversely impacting the quality of patient care and forcing hospitals, physicians, patients and, in some cases, medical groups and health plans to incur significant costs.

- Problems with access to on-call services are primarily the result of problems with reimbursement of physician specialists who provide on-call services. Problems with lack of payment or underpayment associated with on-call services extend to all payers – health plans, Medi-Cal, Medicare, and safety net programs for the uninsured – and act cumulatively to reduce the willingness of physicians to provide on-call services. Specific problems affecting payments for on-call services include:

  - Inadequate payments for on-call services for uninsured patients under safety net programs, including local Emergency Services Funds, county indigent health programs, the SB 855 disproportionate share hospital program, and the SB 1255 supplemental payment program.

  - Inadequate Medi-Cal payment rates.

  - Problems with managed care contracting and payment practices that affect the timing, level and certainty of reimbursement for on-call services to insured patients. These include:

    - Medical group insolvencies and financial difficulties.

    - Lack of contracts between health plans and sufficient numbers of physician specialists for on-call services.

    - Dissatisfaction of medical groups and their members with the terms of their contracts with health plans.

    - Dissatisfaction on the part of non-contracting physicians with the payment rates offered by health plans for on-call services.

    - Use of inconsistent coding and documentation standards by health plans.

- Regulatory limits on reimbursement of on-call services by Medi-Cal managed care plans.

- Delays in adjudication of providers' complaints about payments for on-call services by Medi-Cal managed care plans.

- On-call coverage problems are also being driven by a number of other significant factors:

  - Growing shortages of physician specialists.

  - Increasing ER utilization and acuity of ER visits.

  - Increasing number of uninsured.

  - Barriers to hospital sharing of on-call resources.

  - Barriers to certain contracting arrangements between hospitals and physicians or physician groups to provide payment guarantees for provision of on-call services.

  - Lack of consistent oversight of the accessibility and availability of emergency on-call services and of gaps or shortages that threaten patients' quality of care.

  - Increases in medical-legal risks facing physicians associated with changing standards of care, strict enforcement of the U.S. Emergency Medical Treatment and Active Labor Act, and reduced patient transfer options stemming from ER overcrowding and diversion.

According to a review of other states, California is not the only state experiencing these problems. A national survey of hospital administrators and emergency department heads conducted by the Schumacher Group in 2000 found that 21 percent of responding hospital administrators and emergency department heads indicated that the medical specialty coverage in their emergency departments was not appropriate for a hospital of their size.[3] Further, 13 percent of those responding indicated that lack of specialty coverage posed a significant health care risk to patients

[3] The Schumacher Group, "Year 2000 Emergency Department Staffing Survey," 2000.

and 11 percent would choose an emergency department other than their own to care for them in the event they were seriously hurt.[4]

Surveys indicate that in a number of states, including Pennsylvania, Indiana, and North Carolina, hospitals have either begun to provide supplemental payments or have taken other measures to maintain backup specialist capacity, or are close to doing so.[5]

Finally, press coverage has documented instances of physicians refusing to provide on-call coverage in several states, including Oregon,[6] Florida,[7] New Jersey, and Arizona.[8]

Principles and Recommendations

With the assistance of the AB 2611 working group, SOR developed the following 10 principles and accompanying recommendations for reforms to address on-call coverage problems in California. *An asterisk indicates principles and recommendations endorsed by a majority of working group members and participants.* Beginning with Principle 4, the recommendations are directly linked to implementing specific principles:

******Principle 1:* **Emergency medical care and related on-call services are essential services that must be available on a timely basis to all Californians regardless of insurance status or ability to pay.**

******Principle 2:* **The responsibility to provide, and to ensure the provision of, appropriate on-call coverage and services should be a shared responsibility of hospitals, medical staffs, health plans, medical groups, local Emergency Medical Services agencies, and public payers.**

******Principle 3:* **The burden of providing emergency and on-call services should be broadly shared among physicians who are qualified to provide them.**

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4 Ibid.

5 "Request for Information," VHA Affinity Group, September 2001.

6 "Local Doctors are Tired of Filling Emergency Care Gap," The Business Journal of Portland, December 18, 2000.

7 "State Takes Notice of Doctors Rejecting On-Call Care in ERs," Orlando Sentinel, July 19, 2001.

8 "Valley Doctors Shun ERs; Hospitals Scrambling for Help," The Arizona Republic, June 3, 2001. "A Care Crisis in ERs; Nation's Hospitals Plagued by Shortage of On-Call Specialists," USA Today, June 16, 1999.

***Principle 4:* Increased funding must be provided, and existing funding must be better targeted, to cover uncompensated and undercompensated costs related to provision of on-call services to uninsured, indigent, and Medi-Cal patients as well as for reasonable stipends and payment guarantees necessary to ensure adequate numbers of on-call physicians.**

Recommendations for Implementing Principle 4

- Require all counties to establish Emergency Medical Services (EMS) funds.

- *Simplify and standardize procedures for physician claims from the EMS funds, including standardizing fee schedules used among counties, requiring disbursements to be made at least quarterly as opposed to annually, and reducing the requirements on physicians to bill patients and insurers before submitting claims.

- *Require local EMS funds to increase the percentage of physicians' unreimbursed costs that the funds pay from 50 percent to 75 percent if the funds have surpluses in a given fiscal year and the volume of claims is not increasing.

- Allow counties with excess funds in their hospital accounts to use a portion of surplus funds for unreimbursed hospital on-call coverage costs, including the costs of stipends and payment guarantees.

- *Extend from January 1 to April 15 the date for counties to report revenues and payments from EMS funds to the state for the prior fiscal year.

- *Allow counties and the Medi-Cal program to adopt fee schedules that provide higher reimbursement for services performed after hours or on weekends.

- Require EMS fund balances, beyond a reasonable reserve level, to be transferred to a state equalization fund and redistributed to counties that have expended the balance of their funds.

- Require counties to make reasonable efforts to notify physicians of the availability of the EMS funds.

- Allow Medi-Cal managed care plans to pay rates above the Medi-Cal fee-for-service level for on-call services to non-contracted providers.

- *Commit sufficient resources to Medi-Cal physician payments and to local EMS funds to enable physicians to receive payments that are commensurate with Medicare payments for comparable services.

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

Recommendations for Implementing Principle 5

- Ensure greater consistency and accountability in the processing and handling of claims by plans and medical groups by requiring plans to disclose to physicians billing information, fee schedules, policies and rules used to adjudicate claims; standardizing the coding procedures used by plans to evaluate and pay claims; and by standardizing plans' and medical groups' procedural requirements for submitting and handling claims, including for submission of medical records in justification of claims. These reforms are addressed for the most part by pending regulations being developed by the state Department of Managed Health Care (DMHC).

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

- Allow physicians who are unhappy with the resolution of complaints they file through health plans' internal dispute-resolution processes concerning payments for emergency and

on-call services to take those complaints to court, unless they have a contract with the health plan that provides otherwise.

- Allow physicians to file complaints concerning payment issues involving Medi-Cal managed care plans with DMHC and require DMHC to evaluate the complaints as part of its overall assessment and identification of patterns of unfair payment practices.

- Require health care service plans and medical groups to provide hospitals within their service areas with updated lists of physicians who are on-call for particular services or provide a 24-hour staffed telephone line. Allow hospitals to determine what health plans and medical groups ER patients belong to, and contact physicians on the plans' or medical groups' lists if it would mean no delay in the provision of emergency services.

- *Improve required disclosures in commercial and Medi-Cal managed care contracts with providers concerning who is responsible for on-call services and the payment terms and conditions for on-call services.

- Prohibit commercial and Medi-Cal managed care plans from delegating risk for ER and on-call services to medical groups or independent practice associations (IPAs) if DMHC or the state Department of Health Services (DHS) finds them, or their contracting groups, to be in violation of prompt-payment provisions, including engaging in an unfair payment pattern.

- Devote additional resources to administrative hearings by the DHS Office of Administrative Hearings and Appeals of complaints by providers.

- Require DMHC and DHS to develop specific accessibility standards for on-call services that take into account the timeliness of care, based on national standards and standards in other states, as part of the mandate imposed by AB 2179 of 2002.

- *Require DHS and DMHC to facilitate informal, regional problem-solving approaches with hospitals, physicians, health plans, and physician groups to address local problems with payment and contracting for on-call services.

***Principle 6:* Health plan enrollees and health care consumers should be better protected from the impacts of contracting**

and payment disputes between health plans and physicians related to on-call services and from being required to pay out-of-pocket for services that are covered by their health plans.

Recommendations for Implementing Principle 6

- Require health plan disclosures to enrollees to include information about how and under what circumstances enrollees may be liable for costs of emergency and on-call services, the extent to which the plan relies on contracted versus non-contracted providers for emergency and on-call services, and the recourse enrollees have if they believe they are unfairly billed for services.

- Require physicians who provide emergency and on-call services to include a standard disclosure in any billing statements sent to patients to whom they have provided emergency or on-call services. The disclosure would state that the services may be covered by the patient's health plan, in which case the patient's payment obligation is limited to any applicable deductibles, copayments, or coinsurance, unless the plan denies payment on the grounds that the services are either not covered or are not medically necessary. The disclosure would also advise patients that they can contact the DMHC consumer hotline if they have questions about their payment obligations. Finally, physicians would be required to inform patients of whether the patient's health plan has been billed and whether any payments have been received from the plan.

- Clarify that a pattern of billing or receiving from patients fees clearly in excess of customary and reasonable charges for emergency or on-call services is grounds for disciplinary action by the Medical Board of California. Require the Medical Board to develop guidelines or regulations to implement this standard. Require DMHC to refer complaints regarding physician billing practices to the Medical Board.

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

that the providers bill their patients and the patients pay the remainder of the fees.

***Principle 7:* The state should remove legal and regulatory barriers to sharing on-call resources among hospitals.**

Recommendations for Implementing Principle 7

- *Codify federal guidelines on hospitals' flexibility to share and coordinate on-call resources.

- *Require DHS to establish standards under which hospitals may operate formal call-sharing arrangements, including regional arrangements and referrals for certain specialties, subject to the approval of DHS and local EMS agencies.

- *Provide hospitals with state action anti-trust immunity and protection under state emergency care access statutes to coordinate on-call schedules or share on-call specialists. Require the attorney general to supervise these arrangements to ensure their consistency with anti-trust principles.

- *Provide physicians, physician groups, and hospitals with state action anti-trust immunity to form independent practice associations or other physician organizations that are devoted to arranging emergency on-call services on a regional or local basis. Require the state attorney general to supervise these arrangements to ensure that they do not produce anti-competitive effects.

- Convene a task force to make recommendations on changes to the emergency department classification system that will more closely base ER classification on medical staff capabilities, more clearly distinguish levels of care provided by hospitals, facilitate patient transfer arrangements, and make it easier for patients to determine which emergency room to go to.

***Principle 8:* Further study should be given to the issue of whether physicians should be given additional liability protections for providing on-call services.**

Although California law provides immunity to physicians responding in many emergency situations, the scope of immunity that is afforded to on-call physicians responding for calls for assistance in hospital emergency rooms is unclear. The working group agreed that the issue required further study.

Recommendation to Implement Principle 8

- *The Emergency Medical Services Authority should study the scope of liability immunities to physicians who provide emergency on-call services and whether additional liability protections beyond those in existing law are warranted to encourage greater provision of on-call services.

***Principle 9:* The state should monitor gaps in the availability of specialists that manifest themselves in on-call shortages, including gaps in specific geographic areas and in specific specialties.**

Recommendations to Implement Principle 9

- *Require the Medical Board and Office of Statewide Health Planning and Development to periodically report on physician shortages in local geographic regions and among specialties using newly created data on physician practice arrangements and specialties established by AB 1586 of 2001.

- *DMHC and DHS should implement geographic accessibility standards for physician specialists governing HMOs and Medi-Cal managed care plans that are based on timeliness of access as a means of encouraging greater accessibility of specialists, taking into account variations in the availability of physician specialists by geographic region, as required by AB 2179 and AB 1282 of 2002.

- *Require the Office of Statewide Health Planning and Development (OSHPD) to conduct a study of the potential need for changes in University of California physician training programs to address imbalances in the demand and supply of physician specialists.

- *Require OSHPD to study the potential for telemedicine as a means of offsetting the on-call coverage problems of hospitals, particularly rural hospitals.

***Principle 10*: The state should more closely monitor problems with accessibility of on-call services.**

Recommendations to Implement Principle 10

- Require DHS to more frequently audit ER on-call coverage arrangements to identify areas where systematic problems are contributing to an unacceptable lack of access to on-call services and impacting the quality of patient care. Require DHS to share information on on-call access problems with DMHC and the DHS Managed Care Division.

- *Request the University of California and/or California State University to conduct studies of the underlying causes and costs of the on-call coverage problem in California and to make recommendations to the Legislature.

Introduction

What are On-Call Services?

On-call physicians are medical specialists and subspecialists who provide services to hospital emergency departments. Generally, these services are provided as part of the process of screening and stabilizing patients who arrive in emergency departments. According to some estimates, about 25 percent of the patients who come into ERs require the services of backup specialists.[9] While hospitals generally staff emergency departments around the clock with emergency physicians, patients with serious illnesses or injuries frequently require consultation and, in some cases, actual services from medical specialists.

EMTALA and State Anti-Patient-Dumping Statutes and Regulations

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) and state anti-patient-dumping statutes require hospital emergency departments to provide emergency screening and stabilization services without regard to patients' insurance status or ability to pay.[10] This requirement extends to emergency backup services, or on-call services, which are provided by physician specialists in the community and/or on the medical staff of the particular hospital.

Under EMTALA, each hospital is required to maintain an on-call roster of its specialists "in a manner that best meets the needs of its patients."[11] Physicians who agree to be on these rosters are

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[9] "Potential Solutions to the Lack of Physician Backup in Hospital Emergency Departments," CMA/CAL-ACEP Emergency On-Call Task Force, California Medical Association, 1999.

[10] U.S. Code, Title 42, Section 1395dd; California Health and Safety Code, Section 1317 et seq.

[11] CMS Question and Answer Program Memorandum on EMTALA On-Call Responsibilities, June 13, 2002.

legally bound to respond to requests for their services, with some exceptions. Physicians must respond to emergency calls in a timely manner or face stiff penalties. (The length of time in which on-call physicians must respond is not set by law or regulation, although the Centers for Medicare and Medicaid Services have applied a 30-minute standard.) Generally, the law requires that if a service or procedure is offered by a hospital on an elective basis, the hospital must arrange for medical specialists qualified to perform the service to be available to back up the emergency department or have other backup arrangements with other hospitals.[12]

Under hospital licensing regulations, hospitals that provide basic 24-hour emergency services must have full-time on-call physician coverage in a number of specialties (such as general surgery, anesthesia, general medicine and radiology).[13] On-call coverage is also required for other services (such as obstetrics, pediatrics and psychiatry) if offered by a hospital.[14] Facilities that are designated as trauma hospitals are subject to additional on-call coverage requirements depending on the level of the trauma designation.[15]

Outside of these areas, hospitals that offer a service or procedure to the public but have only a few specialists on their staffs who perform it are not required to provide 24/7 on-call coverage for that service. Instead, they are allowed to make reasonable efforts to provide on-call coverage, and can rely on transfer agreements with other hospitals for the remainder of coverage.[16] Hospitals with partial coverage can coordinate their call schedules to improve coverage in their areas or regions, and doctors are allowed to take call simultaneously for more than one emergency department, and to schedule and perform elective procedures while on call.

The federal Centers for Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG) oversee enforcement of EMTALA. Investigation of complaints is usually done by state survey agencies. Complaints come from patients, families, hospitals, or physicians. If CMS determines that EMTALA was violated, a date is set for terminating the hospital from the Medicare program. This date is generally 90 days from the date of the investigation survey. The hospital also receives a statement of deficiencies and plan of correction. Upon completion of plans of

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[12] "EMTALA Interpretive Guidelines," Centers for Medicare and Medicaid Medicare Services, 1998.
[13] Title, 22, Cal. Code of Regulations, §§ 70413.
[14] Ibid.
[15] Ibid., at §§ 70453.
[16] Ibid.

correction, the state agency resurveys the facility; if the hospital has taken corrective action to prevent future violations and comply with the act, the termination process is rescinded.[17] From EMTALA's enactment in 1986 through the end of fiscal year 1999, only six hospitals were terminated from participation in Medicare for EMTALA violations.[18]

The OIG can also pursue civil monetary penalties against the hospital. A hospital that negligently violates a requirement is subject to a civil monetary penalty of up to $50,000 ($25,000 in the case of a hospital with less than 100 beds). A physician responsible for an individual's exam, treatment, or transfer who violates the act is also subject to a civil penalty of up to $50,000 for each violation. If the physician's violation is gross and flagrant, or is repeated, the physician would be subject to expulsion from Medicare and state health programs[19]

Any individual who suffers harm, or any medical facility that suffers a financial loss as a direct result of a hospital's violation of the act may also bring an action in federal court against the violating hospital and may seek damages available under the law of the state in which the hospital is located.[20]

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[17] "Emergency Care: EMTALA Implementation and Enforcement Issues," General Accounting Office, June 2001.
[18] "Questionable Hospitals…," op. cit.
[19] "Emergency Care," op cit.
[20] "Questionable Hospitals…," op. cit.

State and Federal Laws Pertaining to Emergency Care Access

Access to emergency care in California is governed by both the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and by California statute (Health and Safety Code, Section 1317 et seq.). Generally, state and federal laws require the following:

- A hospital with an ER must provide a medical screening exam to anyone who arrives in the emergency department and requests examination or treatment for a medical condition.
- If the patient has an emergency medical condition, the hospital must provide, within its capabilities, further medical examination and treatment to stabilize the condition.
- Hospitals may not delay a medical screening exam or treatment to stabilize a patient's condition in order to inquire about the person's method of payment or insurance status.
- Hospitals must provide stabilizing care to the best of their ability and arrange transfer to other hospitals when they lack specialized services needed by a patient.
- Hospitals that offer emergency services must maintain a list of physicians who agree to be available to provide specialty services needed to stabilize emergency conditions. On-call physicians must respond to a request from the ER within a reasonable period of time, regardless of the patient's insurance status or ability to pay. On-call physicians must participate in the patient's emergency care to the point of stabilization.
- If a hospital offers a service to the public, the service is required to be available through on-call coverage of the emergency department, consistent with needs of its patients and the capabilities of the medical staff. The roster of on-call specialists must represent the specialty capabilities of the medical staff. The roster must be posted in the emergency department with date-specific lists of on-call physicians, by name.
- Except as required under hospital licensing regulations, hospitals with few specialists on staff (perhaps fewer than three or four in a given specialty) are required to cover only a "reasonable" portion of the 24/7 calendar of daily coverage and are allowed to rely on transfer agreements or arrangements with other hospitals to cover gaps.
- Hospitals with partial coverage can coordinate their call schedules to improve coverage in their areas or regions, and doctors are allowed to take call simultaneously for more than one emergency department, and to schedule and perform elective procedures while on call.
- If a hospital is unable to stabilize a patient, it must facilitate an appropriate transfer to another medical facility. The transferring physician must discuss the case with the receiving hospital's authorized representative and obtain the hospital's agreement to accept the patient. EMTALA requires a hospital to accept a patient from a transferring hospital if it can provide the specialized care the patient needs, and report any inappropriate transfers.
- A recipient hospital must report transfers to the Centers for Medicare and Medicaid Services any time it has reason to believe it may have received a patient transferred in an unstable emergency medical condition in violation of the act's requirements.
- Medicare-participating hospitals and physicians found to be in violation of EMTALA face civil penalties up to $50,000 per violation and under certain circumstances can be terminated from the Medicare and Medicaid programs.

Section I: Defining the Scope of the Issue

Extent of the On-Call Coverage Problem in California

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

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

As recently as 1998, more than half of all hospitals in California were relying on mandatory call requirements. According to some estimates, that percentage may now be closer to one-third.[21] In addition, even where mandatory call requirements exist, hospitals reportedly have difficulty enforcing them. According to EMTALA experts in Los Angeles County, in some cases hospitals do not even bother to call physicians who are designated as being on call before transferring patients to other hospitals because they assume the physicians won't respond, particularly for uninsured patients. In some cases, these transfers result in citations against the transferring hospitals.[22]

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

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

[22] Mindel Spiegel, M.D., DHS hospital licensing consultant, personal communication, July 2001.

call physician backup as a very serious problem for their emergency departments and 42 percent indicated it was a somewhat serious problem.[23]

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

Generally, community hospitals with basic emergency departments reported the greatest problems, particularly those serving high numbers of uninsured and Medi-Cal patients. Teaching hospitals, county hospitals, and community hospitals with standby emergency departments generally report somewhat fewer problems.[24]

A high percentage of hospitals also report difficulty in transferring patients to other hospitals when they don't have the specialists to see them. For example, according to a 2001 survey, 67.1 percent of ER physicians report that they encounter problems transferring patients to higher-level-of-care hospitals, mostly due to the lack of accepting physician specialists (48.9 percent) and lack of nursing capacity at receiving hospitals.[25]

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

- Physicians do not equate hospital privileges with a duty to assist their hospital in fulfilling its public service responsibilities.

- Lack of adequate payment, or no payment for such services under managed care.

- Physicians resent not being paid for ER call, especially when they compare their incomes with the profits and salaries of corporate executives.

- Physicians' goals and outlooks in general have changed: in years past physicians were willing to make sacrifices to serve in

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

[24] Ibid.

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

emergency departments as a way of building their practices. With managed care penetration at current levels, such service is not as relevant to practice growth.

According to the survey, specialties facing the greatest gaps in ER care include neurosurgery; neurology; ear, nose, and throat specialists; thoracic and vascular surgery; and psychiatry.[26] According to a more recent survey, the seven specialties in which the greatest proportion of ERs report trouble with specialty response are plastic surgery (37.5 percent), ENT (35.9 percent), dentistry (34.9 percent), psychiatry (35.6 percent), neurosurgery (22.9 percent), ophthalmology (18.4 percent), and orthopedics (18.0 percent).[27]

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

Impact of On-Call Coverage Problems

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

Delays in Care

According to some estimates, lack of available on-call services accounts for one-third of the transfers of patients from one hospital to another.[28] According to many ER physicians, the bulk of these transferred patients could have been treated at the hospital of origin had adequate on-call coverage been available.

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[26] "Potential Solutions to the Lack of Physician Back-up in Hospital Emergency Departments," op. cit.
[27] UC-Irvine Medical Center, op. cit.
[28] "On-Call But Not Replying," op. cit.

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

Costs to Hospitals and Patients

According to the 1998 survey, a significant percentage of hospitals must pay physicians to provide on-call coverage under various arrangements. According to the survey, 38 percent of hospitals contract for on-call services, 22 percent provide daily stipends to specialists, 22 percent provide compensation for some portion of the uncompensated care rendered by on-call physicians, 11 percent provide insurance coverage for on-call physicians, and 8 percent contract with designated physicians (referred to as hospitalists) to provide backup ER coverage.[29]

According to a more recent survey, the percentage of hospitals that pay particular types of specialists for on-call availability or services varies by specialty. According to the survey, the percentage of hospitals paying for neurosurgery (29.7 percent) and orthopedics (29 percent) were the highest, followed by ENT (17.9 percent), plastic surgery (11 percent), and ophthalmology (10.3 percent).[30]

According to the 1998 survey, payment of stipends by hospitals is by specialty and generally ranges from $100 to $1,000 per day, with trauma surgeons, neurosurgeons, and obstetricians at the higher end. More recently, stipends as high as $1,900 per day and even as high as $2,500 have been cited.[31] In total, stipends cost California hospitals an estimated $200 million annually.[32] For the most part, these payments are not directly reimbursed to hospitals by third-party payers, although they may be reimbursed to some extent through the overall negotiated rates with health plans.

ER Overcrowding and Diversion Problems

Emergency room overcrowding and diversion are increasingly occurring in California and other states. In Sacramento County,

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

[30] UC Irvine Medical Center, Division of Emergency Medicine, op. cit.

[31] "On Call But Not Replying," op. cit.; "Contract Dispute Between Palomar Medical Center, Surgeons Prompts Trauma Center Closure," California Healthline, January 8, 2002.

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

emergency rooms were closed to ambulances a total of 22,290 hours in 2001, more than the double the 10,235 hours in 2000.[33] In the first six months of 2001, hospital emergency departments in Kern County were closed to ambulance traffic 24 percent of the time.[34] In Los Angeles, the number of hours emergency departments were diverting to other hospitals increased from 11,000 in March 2000 to 16,000 hours in March 2001.[35]

A survey of California emergency department directors in 1999 revealed that 71 percent thought that overcrowding was a problem.[36] Among the causes identified as contributing to ER overcrowding were increased patient acuity and hospital bed shortages.

According to ER physicians, delays and problems accessing on-call services are one of several causes of ER overcrowding and diversion, although not as significant a factor as availability of staffed beds and nursing vacancies.

On-Call-Related Violations of EMTALA

According to DHS, a number of licensing regulations govern the on-call coverage responsibilities of hospitals, including:

- Title 22, California Code of Regulations, Section 70415 (a) (3), requiring general acute care hospitals with basic emergency rooms to develop a roster of specialty physicians available for consultation at all times.

- Title 22, California Code of Regulations, Section 70653 (a) (3), requiring general acute care hospitals with standby emergency rooms to assure that physician coverage is available within a reasonable time, relative to a patient's illness or injury.

- Title 22, California Code of Regulations, Section 70653 (a) (4), requiring general acute care hospitals with standby emergency rooms to develop a roster of specialty physicians available for consultation at all times.

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[33] "Crisis Looms on ER Crowding," Sacramento Bee, February 8, 2002.

[34] "On-Call Staff Activity, July 1997 Through March 2001," Kern County EMS Department. Data provided by the Emergency Medical Services Authority.

[35] "ER Overcrowding Spreads Into Crisis Territory," Los Angeles Times, May 14, 2001.

[36] John R. Richards, et al., "Survey of Directors of Emergency Departments in California on Overcrowding," Western Journal of Medicine, 2000; 172:385-388.

- Title 42, Code of Federal Regulations, Section 482.55 (A Tag 302) (general acute care hospital regulations), requiring adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the hospital.

- Title 42, Code of Federal Regulations, Section 489.24 (a), (A Tag 406) (EMTALA regulations), requiring hospitals to offer services for emergency medical conditions within their capacity to do so.

- Title 42, Code of Federal Regulations, Section 489.20 (r) (2), (A Tag 404) (EMTALA regulations), requiring hospitals to have a list of physicians who are on call to the ER. The interpretive guidelines for this regulation state that the hospital must have policies and procedures to govern when a particular specialty is not available.

According to DHS, hospitals were cited for 221 violations of these regulations from 1995 through 2001, including 26 violations in 1998, 31 in 1999, 34 in 2000, and 53 in 2001. While DHS is unable to determine how many of these are related to on-call coverage per se, the department believes the data indicate a trend of potentially increasing violations of on-call regulations from 1998 through 2001.[37]

According to a recent General Accounting Office report, EMTALA violations usually involve failure to provide a medical screening exam, stabilizing treatment, or appropriate transfer of patients.[38] Despite increases in the number of EMTALA violations, the number is relatively small compared with the number of emergency department visits, says the GAO.[39] Few hospitals have been terminated from the Medicare program for EMTALA violations; in most cases, hospitals adopt corrective actions that resolve the deficiencies.

According to a 2001 report by the nonprofit group Public Citizen, 81 confirmed violations of EMTALA took place in California hospitals between October 1996 and December 2000. Of these, about 41 were transfer violations and/or violations of requirements

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[37] Data from the California Department of Health Services, Division of Licensing, June 2002.

[38] General Accounting Office (GAO), "Emergency Care: EMTALA Implementation and Enforcement Issues," June 2001, GAO-01-747.

[39] GAO, "Emergency Care," op. cit.

to have on-call lists. Some of these violations could have resulted from failure to provide on-call services.

Extent of the On-Call Problem in Other States

Problems with on-call coverage are documented in national as well as state surveys. For example, according to a national survey of hospital administrators and emergency department heads conducted by the Schumacher Group in 2000, 21 percent of responding hospital administrators and emergency department heads indicated that the medical specialty coverage in their emergency departments was not appropriate for a hospital of their size.[40] Further, 13 percent of those responding indicated that lack of specialty coverage poses a significant health care risk to patients and 11 percent would choose an emergency department other than their own to care for them in the event they were seriously hurt.[41]

Surveys in a number of other states, including Pennsylvania, Indiana, and North Carolina indicate that hospitals have either begun to provide supplemental payment or other measures to maintain backup specialist capacity, or are close to doing so.[42]

Finally, press coverage has documented instances of physicians refusing to provide on-call coverage in several states, including Oregon,[43] Florida,[44]New Jersey, and Arizona.[45]

According to the National Conference of State Legislatures, 46 states have adopted laws or regulations giving health plans a fixed amount of time – usually 30 to 45 days – to pay claims, and imposing monetary sanctions on those that fail to do so.[46]

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40 The Schumacher Group, op. cit.

41 Ibid.

42 "Request for Information," VHA Affinity Group, September, 2001.

43 "Local Doctors are Tired of Filling Emergency Care Gap," The Business Journal of Portland, December, 18, 2000.

44 "State Takes Notice of Doctors Rejecting On-Call Care in ERs," Orlando Sentinel, July 19, 2001.

45 "Valley Doctors Shun ERs; Hospitals Scrambling for Help," The Arizona Republic, June 3, 2001. "A Care Crisis in ERs; Nation's Hospitals Plagued by Shortage of On-Call Specialists," USA Today, June 16, 1999.

46 "Prompt Payment," Health Policy Tracking Service Issue Brief, National Conference of State Legislatures, October 1, 2001.

Some states, including Missouri, New Jersey, and West Virginia, have mandated maximum response times of 30 minutes for on-call physicians.[47]

[47] Loren Johnson, op. cit.

Section II: Factors Contributing to On-Call Coverage Problems

Increases in ER Utilization

Based on national health care surveys conducted from 1992 through 1999, hospital emergency departments accounted for about 10 percent of all ambulatory care in the United States.[48] Between 1992 and 1999, the number of visits to emergency departments nationwide increased by 14 percent, from 89 million to 102 million.[49] According to the national data, over half (7.8 million) of the increase occurred between 1997 and 1999.[50] Significant increases in visit rates were observed for persons 45 and older.

In California, hospital ER visits increased 12 percent between 1990 and 1999, from 8.4 million to 9.4 million visits. Critical care visits increased by 43 percent and urgent visits by 20 percent.[51] The total number of visits per emergency department increased by 27 percent during that time, but critical visits jumped by 59 percent and urgent visits by 36 percent.[52]

A number of reasons have been offered for the sharp upturn in emergency room utilization, including fewer constraints on access to emergency room services by health maintenance organizations in the wake of adoption of "prudent layperson" standards. These standards require health plans to cover and pay for screening and treatment of conditions that a prudent layperson would regard as emergency conditions. Other factors may be stricter enforcement of

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[48] "Trends in Hospital Emergency Department Utilization: United States, 1992-99," Centers for Disease Control and Prevention, Vital and Health Statistics, Series 13, No.150, September 2001.

[49] Ibid.

[50] Ibid.

[51] Susan Lambe, MD, et al., "Trends in the Use and Capacity of California's Emergency Departments," Annals of Emergency Medicine, April 2002.

[52] Ibid.

EMTALA and an increase in the number of patients without insurance who seek care in the ER.[53]

Physician organizations in California add that low Medi-Cal reimbursement rates result in diminished access to timely care for chronic conditions and result in a disproportionate number of Medi-Cal beneficiaries turning to emergency rooms for care. According to a report completed in 2001 by the California Medical Association, due to low payment rates for physicians, Medi-Cal patients are not able to access physician care in a timely manner for chronic and treatable diseases.[54]

Reasons put forth for increasing acuity of emergency room visits include the aging of the population and barriers to access to primary and specialty care by both commercially insured and publicly sponsored patients.

Rising Number of Uninsured

Despite a decline in the number of uninsured Californians from 1998 to 1999, health insurance coverage of Californians remains a serious problem. Twenty-one percent were uninsured at the time of the interview or any time during the prior 12 months. Large ethnic and racial disparities in coverage exist, particularly for employment-based coverage among Latinos, Asian-Americans, and African-Americans.[55]

In Los Angeles County, the state's most populous, nearly 20 percent of non-elderly persons are uninsured,[56] meaning that, on average, physicians who provide on-call services there can expect at least one of every five non-elderly patients who need their services to be uninsured, with some specialties more impacted than others.

The uninsured pose two problems for the on-call coverage system. First, due to the fact that they have less access to preventive care and ongoing care for chronic conditions, the uninsured constitute a disproportionate portion of the ER caseload. Second, due to the fact that payment opportunities for treating the uninsured are

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[53] "Emergency Room Diversions: A Symptom of Hospitals Under Stress," Center for Studying Health System Change, Issue Brief #38, May 2001.

[54] "Every Patient Deserves a Doctor: Improving Access to Care for Medi-Cal Patients," California Medical Association, April 2001.

[55] Ibid.

[56] Ibid.

limited (see section below) physicians have fewer incentives to volunteer to provide on-call services.

Physician Shortages

A number of studies have documented that California's overall supply of physicians is increasing. For example, a 2001 study by the Center for the Health Professions at the University of California, San Francisco, found that the number of physicians in California outpaced population growth between 1994 and 2000, rising from 177 for every 100,000 residents to 190 per 100,000 residents.[57] The report found that the state overall has an adequate number of primary care and specialist physicians – with the exception of the state's 25 predominantly rural counties. A few areas within counties that otherwise have adequate numbers of physicians also are in short supply.[58]

However, these studies have not tracked the availability of physicians by specialty at the county or sub-county level. There is growing evidence that in many areas of the state, including urban and metropolitan areas, there are inadequate numbers of specialists. While definitive research on the extent and causes of this problem has not been conducted, it appears that regional/specialty shortages are growing, driven by a number of interacting factors. These include declines in the number of doctors being trained nationally in certain specialties, physicians leaving practice earlier in their careers (see page 17), continuing growth of managed care, and California's growing unattractiveness vis-à-vis other states as a practice location for physicians recently completing residency based on its high cost of living and low reimbursement rates under Medi-Cal and Medicare.

Reductions in Medical Training Slots

According to information from the American Medical Association's Graduate Medical Education Directory, nationally the number of residency training programs in orthopedics declined from 157 in 1995 to 152 in 2000; and the number of training slots for individual doctors declined from 3,228 to 3,043.[59] Information from the Center for Health Workforce Studies at the University of

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[57] "The Practice of Medicine in California: A Profile of the Physician Workforce," UCSF Center for the Health Professions, February 2001.

[58] Ibid.

[59] Graduate Medical Education Directory, American Medical Association, 1995-96; 2000-01.

Albany suggests that the number of anesthesiology graduates in the U.S. declined from 1,740 in 1993 to 891 in 1999.[60] According to the head of physician recruiting for Permanente Medical Group in Northern California, despite a nationwide need for 300 new cardiologists each year, only 50 are currently being trained nationally.[61]

According to many experts, declines in Medicare hospital reimbursement for teaching expenses is the single largest factor driving the reductions in training slots in many specialties. In addition, many experts conclude that marketplace needs for specialists are not reflected in many specialty training programs.[62]

Difficulties Recruiting Physicians

According to medical group representatives, medical groups and practices are having increasing difficulties recruiting physician specialists in certain specialties, including orthopedic surgery, gastroenterology, cardiology, neurology, neurosurgery, urology, and medical subspecialties. Medical group representatives blame this on the reduced number of training slots for physician specialists and California's diminished attractiveness, as previously mentioned. According to some experts, these factors are offsetting what historically have been attributes, such as climate and geography, that made California a desirable place to practice.[63]

According to a 2001 survey of its members by the California Medical Association, 58 percent of physicians have experienced difficulty attracting other physicians to join a practice.[64]

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[60] Comments of Edward Salsberg, Director, Center for Health Workforce Studies, University at Albany, "Assessing the Status of California's Physician Workforce: Shortage or Surplus?" California Health Policy Roundtable, California Capitol, October 24, 2001.

[61] Comments of Sharon Levine, MD, "Assessing the Status of California's Physician Workforce: Shortage or Surplus?" California Health Policy Roundtable, California Capitol, October 24, 2001.

[62] Ibid.

[63] Ibid.

[64] "…And Then There Were None: The Coming Physician Supply Problem," California Medical Association, 2001 Physician Survey Findings.

Physicians Leaving Practice Earlier?

There is also some evidence that physicians are leaving practice in California earlier, generally due to dissatisfaction with managed care. In 2001, the California Medical Association conducted a survey of 19,000 of its members.[65] Approximately 2,000, or 12 percent, responded. Based on the responses:

- 75 percent of physicians have become less satisfied with medical practice in the past five years.
- Low reimbursement, managed care hassles, and government regulation are the greatest sources of dissatisfaction.
- 43 percent of physicians plan to leave medical practice in the next three years and another 12 percent plan to reduce the amount of time spent in patient care.
- More than a quarter of physicians would no longer choose medicine as a career if starting over today and, of those who would still choose medicine, more than one-third would not choose to practice in California.
- Although medicine traditionally has been a profession that often runs in families, two-thirds of responding physicians are advising their children not to go into the practice of medicine.

Difficulties Monitoring the Number of Physicians

Determining the extent of physician shortages is hampered by a lack of accurate data. Although the number of licensed physicians in California is known, the state does not collect data on how many are in active practice or what specialty they practice in. While the American Medical Association maintains a database of practicing physicians, many believe it overstates the number of actively practicing physicians by including those who practice as little as 20 hours per week.

The state's role in monitoring and ensuring accessibility of physicians is currently very limited. Until 1990 the state conducted annual health care manpower availability studies, which identified areas of the state with too few and too many physicians, by specialty. However, the studies were discontinued as a cost-saving measure.

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[65] Ibid.

The state will begin to have better data on the numbers of physicians in practice in 2003, through the enactment of AB 1586 (Negrete-McLeod) of 2001. AB 1586 requires physicians to report to the Medical Board of California any specialty certifications they hold and their practice status at the time of licensure renewal.

Other Shifts Affecting Availability of On-Call Specialists

In addition to the structural changes outlined above, there is evidence that increasing numbers of physicians, especially younger physicians, are choosing to reduce the number of hours they practice and reduce the amount of emergency work at night or on weekends as lifestyle choices.

In addition, more physicians are working in outpatient centers – for example, outpatient surgery centers – and no longer need to have medical staff privileges at hospitals, which come with expectations, if not requirements, for ER call.

Health Plan Requirements for Accessibility of Physicians

The Knox-Keene Act and regulations governing Medi-Cal managed care plans contain a number of provisions dealing with accessibility of services. Health care service plans regulated under the Knox-Keene Act must ensure that health care services, including emergency medical services and services of medical specialists, are readily available and accessible to enrollees without entailing delays that are detrimental to enrollees' health.[66] There must be at least one full-time equivalent physician to each 1,200 enrollees and one full-time equivalent primary care physician for each 2,000 enrollees. A similar requirement applies to Medi-Cal managed care plans.[67] According to DMHC staff, Knox-Keene Act accessibility standards are enforced through semi-annual medical surveys of plans and through review of enrollee complaints.

Plans are required to have documented systems for monitoring and evaluating accessibility of care and their compliance with statutory and regulatory requirements of accessibility and availability of services. This must include a system for addressing problems that develop, including waiting times for appointments.[68]

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[66] Health and Safety Code, Section 1367. Title 28, California Code of Regulations, Section 1300.67.2.1.

[67] Title 22, California Code of Regulations, Section 53853.

[68] Department of Managed Health Care, Draft Medical Survey Standards.

However, this does not include specific standards for accessibility of physicians to enrollees by specialty, in particular for the timeliness of access to specialists. DMHC recently convened an advisory group to review and consider modifications of existing Knox-Keene accessibility standards, including incorporation of timeliness standards for access to primary care physicians and specialists.

Health plans and medical groups frequently report that they are unable to contract with sufficient numbers of physicians. Under the Knox-Keene Act, plans may propose alternative standards for accessibility of services based on factors including, but not limited to, the existence of exclusive contracts among plans and providers operating in the area, driving times, and waiting times for appointments.[69]

Inadequate Reimbursement for Services to Uninsured Patients

While a number of programs provide funding that can be used to reimburse hospitals and physicians for emergency and on-call services for uninsured patients, limits on who may access them and under what circumstances restricts their availability to physicians as a source of reimbursement. These programs include local Emergency Medical Services (EMS) funds, county indigent health programs, and supplemental payment programs for hospitals, including the SB 855 disproportionate share hospital program, SB 1255 hospital supplemental payment program, and the California Health Care for Indigents Program (CHIP).

Lack of payment for services to the uninsured is not a trivial problem. As noted above, in Los Angeles County an estimated one-fifth of the non-elderly population is uninsured. Given an estimated payment rate by the Los Angeles County EMS fund of approximately 50 percent, this means that, on average, unless they receive a stipend or payment guarantee from their hospital, on-call physicians in Los Angeles County can expect 10 percent of their services to non-elderly patients to be unreimbursed, a significant disincentive to providing on-call services.

[69] Title 28, California Code of Regulations, Section 1300.67.2.1.

Local EMS Funds

Under current law, counties are authorized to create Emergency Medical Services funds.[70] To date, 45 counties have established the funds, and there are two sources of money for them. The first is penalty assessments on certain criminal offenses and motor vehicle violations. Second, under CHIP, a portion of the revenues the state receives from the Proposition 99 levy on tobacco products is allocated to the funds. Counties with EMS funds must establish physician services accounts within their EMS funds to receive tobacco-tax monies.

Funds from penalty assessments must be used to reimburse physicians and hospitals for patients who do not make payment for emergency medical services and have no private third-party or government source of payment. Fifty-eight percent of these funds, after administrative costs, must be distributed to physicians for emergency services, 25 percent to hospitals providing disproportionate levels of trauma and emergency medical services, and 17 percent to other emergency medical services as determined by each county, including regional poison centers.

By law, the amount that any physician may be reimbursed is limited to 50 percent of his or her reported losses. Existing law further requires that to be eligible for funding, physicians must first bill for the services and make reasonable efforts to obtain reimbursement for the next three months, unless they have received notification from the patient or third-party source that no payment will be made. Physicians must also agree to stop collection efforts against the patient upon the receipt of funds. Counties must use the Physicians Current Procedural Terminology for coding claims but are free to adopt their own fee schedules for reimbursement of claims.

Proposition 99 physician services account funds must be used to reimburse physicians for services provided to patients who cannot afford to pay for those services and for whom payment will not be made through any private coverage or public program. Funds may be used to reimburse losses on emergency, obstetric, and pediatric services. As with the penalty assessment funds, physicians can be reimbursed up to 50 percent of the losses submitted.

Existing law does not prescribe how counties must allocate funds to hospitals. According to anecdotal information, some counties

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[70] Health and Safety Code, Section 1797.98a et seq.

allocate funds based on volume of uncompensated care or emergency room visits while others require hospitals to bill based on services provided.

In the 1999-00 fiscal year, a little over $21 million in penalty assessment revenue and approximately $4.9 million in Proposition 99 funds was deposited into county EMS fund physician accounts. SB 2132 (Dunn) of 2000 provided an augmentation of Proposition 99 funds to the EMS funds of $14.7 million for reimbursement of physician services for the 2000-01 fiscal year. The 2001-02 and 2002-03 budgets continued this supplemental funding.[71]

Local EMS funds are probably the most extensively used funding source for on-call services to uninsured patients. Physicians who provide on-call services can bill directly for the services; in addition, counties that allocate hospital funds based on formulas indirectly compensate hospitals for the costs of stipends and payment guarantees.

However, a number of problems limit the availability of funding for on-call services. First, not all counties have established the funds. Second, several counties are carrying large surpluses of unused funds due to under-utilization of the funds, limits on the percentage of claims that can reimbursed, and complex processes for seeking reimbursement from the funds.

According to information from the state Emergency Medical Services Authority, counties collectively carried forward $28.2 million in unused physician account funds from 1999-00 to 2000-01, down from $31.1 million in carryover funds in 1998-99 from the prior year.[72] According to this information, in 1999-00 counties paid 300,148 out of 335,614 claims submitted and paid nearly 48 percent of the total amount of claims received, close to the 50 percent maximum allowed by law.

Finally, administration of the funds, including use of fee schedules and frequency of payment of claims, differ significantly from county to county, resulting in physicians in some counties receiving a higher percentage of their uncompensated costs than in others.

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[71] County Health Services Unit, Department of Health Services.

[72] Data tables from Emergency Medical Services Authority.

County Indigent Health Programs

County indigent health programs mandated by Section 17000 of the Welfare and Institutions Code generally serve medically indigent adults and low-income persons who are not eligible for Medi-Cal. The programs provide services comparable to Medi-Cal services to persons using income and asset requirements similar to those applied to public assistance recipients. In addition, many county indigent health programs provide services to uninsured persons with higher incomes on a sliding scale basis. County health programs provide wholly or partially subsidized services to about 1.5 million persons per year, but also serve self-paying patients. Funding for county indigent health service programs comes from state-county realignment funds, Proposition 99 tobacco funds, Medicaid supplemental payments to disproportionate share hospitals, and county matching funds.

A number of problems limit the extent to which these programs provide payment for on-call services performed by physicians for uninsured residents. First, due to limits in eligibility, the population that is served by the programs is considerably smaller than the uninsured population in general. According to some estimates, the programs reach anywhere from 14 percent to 50 percent of the uninsured.[73] Second, many counties only reimburse for services that are provided in county-administered facilities or by county-employed physicians, or by facilities or physicians with whom the county contracts for services to county indigent patients. Third, counties frequently pay highly discounted fees to providers for services.

State and Federal Supplemental Payment Programs to Hospitals

A number of state and federal programs make supplemental Medi-Cal payments to hospitals that serve a high percentage of Medi-Cal and uninsured patients. Under the SB 855 program, approximately $1 billion in federal revenues are distributed annually to over 130 qualifying public and private hospitals. The SB 1255 program provides about $700 million annually to between 65 and 70 hospitals. Finally, CHIP provides a small amount of funds to private hospitals based on uncompensated care loads. Hospitals generally use these supplemental revenues to offset the costs of

[73] Lucien Wulsin, JD, et al., "Clinics, Counties, and the Uninsured," Insure the Uninsured Project, Santa Monica, CA, February 1999.

treating uninsured and Medi-Cal patients and to provide additional services to these populations.

Although there are no data to confirm it, it is likely that some hospitals receiving these funds use them in part for stipends and supplemental payments to physicians providing on-call services as part of their overall strategy for ensuring the availability of on-call services. However, use of these funds for on-call services is limited by a number of factors. First, the funds are only available to hospitals that serve relatively large numbers of uninsured and Medi-Cal patients. Second, the funds go to hospitals and there is no way for physicians to bill against them directly. Third, use of the funds for on-call services must compete with other priorities for the funds at hospitals receiving them.

In addition, a number of pending federal Medicaid payment changes, including a scheduled reduction in disproportionate share hospital payments in 2003 or 2004, pending reductions in Medicaid upper-payment limits for public hospitals, and changes in allowable payments under California's Medi-Cal Selective Provider Contracting Program, are likely to reduce the amount of Medicaid supplemental payments to hospitals. This would reduce a source of revenue hospitals may have for support of ER on-call services.

Inadequacy of Medi-Cal Rates

Low Medi-Cal fee-for-service rates affect the utilization of emergency on-call services and the willingness of physicians to provide on-call services to Medi-Cal beneficiaries in a number of ways. First, low fee-for-service rates limit the willingness of specialists to see fee-for-service Medi-Cal patients, increasing the probability that the patients will at some point require emergency on-call services. Second, low fees also reduce the willingness of specialists to provide on-call services as non-contracted providers when those patients do enter the emergency room. Finally, low rates limit the capitation and fee-for-service rates Medi-Cal managed care plans are able to offer to contracted providers, thus limiting the ability of Medi-Cal managed care plans to develop contracts with specialists that include on-call services.

Numerous studies have shown that Medi-Cal payments for physician services are low relative compared to other payers. In 1998, an Urban Institute study reported that Medi-Cal physician payments averaged 47 percent of Medicare, compared to a national

average of 64 percent.[74] In 1999, an Urban Institute study of Medi-Cal managed care rates concluded that California's Medi-Cal capitation rates were the lowest in the nation, reflecting the low fee-for-service payment levels.[75] A study for the Medi-Cal Policy Institute in 2001 found that California's physician rates ranked from 46th to 24th in the nation, depending on the type of service.[76] According to the California Legislative Analyst's Office, the across-the-board increase in physicians' rates in the 2000-01 state budget raised rates on average to about 60 percent of applicable Medicare rates, up from about 50 percent in the prior year.[77] The governor's proposed mid-year budget changes for 2002-03 and proposed budget for 2003-04 would reduce provider rates 15 percent for most physician services.

State law requires Medi-Cal physician rates to be sufficient to provide Medi-Cal beneficiaries with reasonable access to medical care services. State law also requires DHS to annually review and periodically revise Medi-Cal physician and dental rates to ensure reasonable access to services. Based on findings that Medi-Cal rates impede access to care, the Legislative Analyst's Office recommended in February 2001 that the state use Medicare rates as a benchmark for Medi-Cal rates.[78]

Problems with Managed Care Contracting and Payment Arrangements

Currently, over 23 million Californians receive their health care services through commercial managed care health plans that are licensed under the Knox-Keene Act, up from 16 million in 1993.[79] Another 2.7 million Medi-Cal beneficiaries receive health care through Medi-Cal managed care plans certified by the Department of Health Services.[80]

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74 "Recent Trends in Medicaid Physicians' Fees, 1993-98," Urban Institute, September 1999.

75 "Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey," Urban Institute, May 1999.

76 "Comparing Physician and Dentist Fees Among Medicaid Programs," Medi-Cal Policy Institute, California Health Care Foundations, June 2001.

77 "A More Rational Approach to Setting Medi-Cal Physician Rates," Legislative Analyst's Office, February 1, 2001.

78 "A More Rational Approach…," op. cit. LAO recommends 80 percent of applicable Medicare rates as a benchmark.

79 Department of Managed Health Care data.

80 Department of Health Services, Medical Statistics Unit.

While physicians historically provided on-call coverage as a way of building and sustaining their practices, managed care has changed their ability to do that. Under managed care, most paying patients coming to the ER already have a personal physician and receive care from designated providers. While non-designated physicians frequently provide emergency or on-call services, most plans require the patient to resume care with one or more contracting physicians once the emergency condition is stabilized.

Under existing law and regulations, both commercial and Medi-Cal managed care plans have a duty to arrange and pay for emergency medical services, including on-call services, necessary to stabilize the patient.[81] Current law prohibits plans from requiring providers to obtain authorization prior to provision of emergency services and services necessary to stabilize the enrollee's condition.[82] Further, current law imposes these requirements whether the physician providing them contracts with the plan or not.

Delegation of ER and On-Call Risk to Medical Groups

Health plans frequently delegate risk or responsibility for on-call services to the medical groups or independent practice associations with which they contract. According to various estimates, approximately 250 medical groups and individual practice associations operate in California.[83] Medical groups range in size from a few physicians to over 100 physicians and may consist of only primary care physicians or specialty physicians, or a combination (referred to as a multi-specialty group).

Where medical groups and IPAs are assigned the risk or responsibility for providing emergency and on-call services, on-call services are either included in the overall capitated payment to the medical group or IPA, or are paid separately by the plan based on a discounted fee-for-service fee schedule. Where medical groups and IPAs have contracted with plans for provision of emergency and on-call services, they and the individual providers who are affiliated with the group or IPA are precluded by state law from billing patients for any residual charges or collecting any payment beyond the contracted amount, other than applicable deductibles or copayments, unless the plan denies payment on the grounds that the services are not covered or are not medically necessary. While

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[81] Health and Safety Code, Section 1371.4.

[82] Ibid.

[83] James Robinson, "Physician Organization in California: Crisis and Opportunity," Health Affairs, July/August 2001.

HMO plans may delegate the risk and responsibility for providing emergency and on-call services to medical groups and IPAs, the plan continues to be responsible for ensuring timely payment of claims and is liable for interest penalties on claims that are not paid in the 30- or 45-day window outlined in Health and Safety Code, Sections 1371 and 1371.35.

In cases where medical group or IPA providers are not available to provide on-call services, or where the medical group or IPA has not accepted the responsibility and risk for providing the services, non-contracted providers on hospitals' on-call rosters or otherwise arranged by the ER provide them. Non-contracted providers bill the plan or medical group and usually receive fee-for-service payments for the services, often based on usual, customary, and reasonable charges for similar services, but sometimes based on discounted fee schedules of various kinds.

According to the Department of Managed Health Care, although the Knox-Keene Act requires plans to arrange and pay for on-call services provided as part of emergency care, it does not require them to contract directly with providers or medical groups to provide the services. Instead, plans may pay non-contracted providers who are arranged or brought in by emergency departments to provide the services.[84]

While this model of providing emergency and on-call services works in theory, in practice a number of problems undermine the model and reduce the incentives for physicians, both contracted and non-contracted, to provide ER on-call services, including:

- Delays in payment for on-call services due to medical group insolvencies and financial problems,

- Lack of contracts between health plans and sufficient numbers of physician specialists for on-call services,

- Dissatisfaction on the part of medical groups and their members with the terms of contracts with health plans,

- Dissatisfaction on the part of non-contracting physicians with the payment rates offered by health plans and medical groups for on-call services,

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[84] Communication from Department of Managed Health Care counsel, November 2001.

- Inconsistent procedural and coding and documentation practices used by health plans for handling claims,

- Regulatory limits on reimbursement for on-call services by Medi-Cal managed care plans,

- Delays in conducting adjudicating provider complaints vis-à-vis payments from Medi-Cal managed care plans.

Medical Group Insolvencies and Financial Problems

As a result of financial problems, many medical groups and IPAs do not make timely payments for on-call and other services to providers. According to the Department of Managed Health Care, for the first quarter of 2001, 23 percent of the 250 entities meeting the definition of a risk-bearing organization failed to reimburse, contest, or deny at least 95 percent of claims within 45 days.[85] Overall, only 44 percent of reporting entities were judged by the department to meet all four solvency standards, including timely payment of claims, timely calculation of incurred but not reported claims, positive net equity, and positive working capital.

The department cautions that its findings are based on a single quarter. In addition, medical groups maintain that unfair billing practices by specialists that contribute to the delays in payment are not reflected in the timeliness measures. Finally, due to litigation, DMHC has discontinued collection of financial information about medical groups.

According to an audit of Medi-Cal managed care plans' practices in reimbursing emergency room services conducted in 2000, medical groups and IPAs that have been delegated risk for ER professional services are frequently in violation of the 45-day standard for paying claims.[86] By contrast, the audit found that plans that do not delegate risk for these services to a subcontractor plan or medical group are generally not tardy in paying ER professional service claims. The DHS audit report concludes that the problem is likely rooted in the large number of contracted groups that appear to be financially unstable.[87]

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[85] "Risk-Bearing Organizations: First Quarter Reporting of 2001 Financial Reporting Results," Department of Managed Health Care, October 2001.

[86] "Review of Emergency Room Professional Services Claims Payment Practices," Medi-Cal Managed Care Division, Department of Health Services, December 2000.

[87] Ibid.

Lack of Contracts Between Health Plans and Physician Specialists for On-Call Services

According to testimony from both health plans and provider groups, lack of sufficient contracts between health plans and physician specialists covering on-call services is frequently a problem that contributes to gaps and delays in provision of on-call services. According to plans, the problems usually stem from the failure of physicians and medical groups to accept contracts at what the plans believe are reasonable rates. Medi-Cal managed care plans cite this concern especially, and express frustration that their capitation rates from the state frequently do not allow them to pay the rates for services demanded by specialists. According to provider groups, the problems stem from under-contracting on the part of plans, in which they contract with limited numbers of specialists to generate more favorable discounted rates.

Either way, when too few specialists are under contract to provide on-call services within a given area, the demands fall on non-contracting physicians who, as discussed below, may have other reasons for not volunteering to provide on-call services on a regular basis.

Medical Group Dissatisfaction With the Terms of Contracts

Medical groups and IPAs frequently view the capitation rates paid by plans as being inadequate to cover emergency and on-call services but believe they have no alternative but to accept them to maintain access to patients. Groups also have expressed concern that the contracts frequently reserve to the plans the right to alter reimbursement rates without consultation with the medical group or contracting provider. This latter problem has been addressed by the passage of AB 2907 (Cohn) of 2002, which, effective January 1, 2003, prohibits any contract between a plan and a provider from giving the plan authority to change a material term of the contract unless the change has first been negotiated and agreed to by the provider and the plan, with some exceptions.

Medical groups and IPAs also complain that the terms of contracts between medical groups and plans are sometimes unclear about who is responsible for on-call services. Finally, the groups may refuse to provide them because they don't believe on-call services are part of the contract.

Non-contracting Providers' Dissatisfaction with Payments Provided by Plans for On-Call Services

The working group received extensive testimony from physician representatives that health plans frequently pay non-contracting physicians less than their usual or customary and reasonable rates for on-call services. Instead, plans frequently pay discounted fees based on a percentage of Medicare or usual, customary, and reasonable rates. Section 1371.4 of the Knox-Keene Act requires health care service plans to provide emergency medical services to enrollees without prior authorization and requires plans to reimburse providers for those services. Health and Safety Code Section 1317.2a makes insurers and health plans liable for physicians' and hospitals' "reasonable charges" for emergency services provided pursuant to the state's anti-patient-dumping statute, unless they have contracted for a different payment rate or arrangement, but doesn't define the term.

According to provider groups and to DMHC, these provisions obligate health plans to pay non-contracted physicians either their billed charges or customary and reasonable charges for on-call services. Health plans generally argue that the fees they pay are reasonable because they are based on national databases or surveys. However, there appear to be instances in which plans first offer the provider a discounted payment and only pay billed charges or customary and reasonable charges if the provider complains to the plan.[88]

Health plans and medical groups also argue that some amount of the delay that physicians experience in getting reimbursed for on-call services is due to over-billing on the part of physicians.[89]

Inconsistent Coding and Documentation Requirements

Plans and medical groups use a variety of techniques to control utilization and payment of ER and on-call services. However, there are clear limits in law as to how plans and medical groups may do this. First, plans may not deny payment for bona fide emergency or on-call services on the basis that the provider did not obtain prior authorization for the services. Second, plans are subject to monetary penalties if they do not reimburse emergency and on-call claims within certain timeframes. Third, with the passage of

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[88] Based on a review of routine examinations of several health plans.

[89] Communication from the California Association of Physician Organizations, August 2002.

AB 1455 and SB 1177 in 2000, plans may not arbitrarily reduce or delay payments for emergency and on-call services or engage in other "patterns of unfair claims practices." Despite these legal protections, providers represent that plans and medical groups frequently inappropriately deny or delay payments or fail to include penalties for late payment.

Nothing in law or regulation prohibits plans from "downcoding" claims they receive for emergency and on-call services, i.e. reducing the coding of the claims to reflect a lower level of service or service intensity from that contained in the claim, if they feel the provider has not properly coded the claim – and, in fact, it is done frequently. For example, the previously referenced DHS audit of emergency services claims reimbursement practices found that about 23 percent of ER professional claims were downcoded by plans and contracting intermediaries over the time period it examined.[90] The report notes that downcoding is allowable under current regulations and is appropriate in some cases to correct for upcoding on the part of providers. However, the report acknowledges that due to the absence of contracts in most cases between Medi-Cal plans and ER physician groups, it will inevitably be a source of continuing dispute between plans and providers.[91]

Nothing in state law or regulations currently requires plans to use consistent coding or documentation requirements to evaluate and pay claims. However, federal requirements that health plans and other health care entities adopt standard transaction and code sets under the Health Insurance Portability and Accountability Act (HIPAA) for paying and processing medical claims may result in greater consistency when they take effect.

Limits on Physician Reimbursement Under Medi-Cal Managed Care Plans

As noted above, payments to contracted physicians by Medi-Cal managed care plans are constrained by the fact that capitated payments to plans are derived from Medi-Cal fee-for-service expenditures and reimbursement rates, which are historically low.

Where plans rely on fee-for-service payments to physician specialists for on-call services, for example, as non-contracted providers, the fee-for-service payments are further limited by

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[90] "Review of Emergency Room Professional Services Claims Practices," Medi-Cal Managed Care Division, Department of Health Services, December 2000.

[91] Ibid.

existing regulations, which place maximum limits on the payments. Regulations limit payment for emergency and on-call services by Medi-Cal managed care plans to the lessor of usual charges made to the general public, the maximum Medi-Cal fee-for-service rate, or the rate negotiated between the plan and the provider.[92] In general, this means that, for non-contracted providers, the maximum rate they can receive for on-call services is the Medi-Cal fee-for-service rate.

In addition, physician groups claim that plans frequently do not pass along to physicians the legislated reimbursement rate increases for emergency and on-call services in their capitation rates with providers.[93]

Delays in Adjudication of Providers Complaints vis-à-vis Payments from Medi-Cal Managed Care Plans

Non-contracted providers may submit disputes concerning payment for emergency care to DHS within 120 days and may ultimately request administrative hearings to resolve the disputes. Administrative decisions are required to be submitted for the director's approval within 60 days after completion of the hearing and must be adopted, supported, or remanded for further hearing within 30 days (Title 22, 53692).

According to data submitted by DHS, 5,866 claims regarding payments for ER services from Medi-Cal managed care plans were filed with the department in 2001.[94] Of these, 1,829 were withdrawn after being filed, 1,671 were dismissed pursuant to a request from the provider, and 210 were declared defective by DHS after submission, leaving 2,366 claims to be processed by the department. Of these, only 585 resulted in formal hearings by the department, which indicates that the bulk of the complaints that DHS received in 2001 that were not withdrawn or dismissed were still pending at the end of the year.

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[92] Title 22, Code of California Regulations, Section 53855.

[93] Comments of Loren Johnson, past president, California Chapter of American College of Emergency Physicians, to AB 2611 working group, November 2001.

[94] Data from Medi-Cal Managed Care Division, Department of Health Services, January 2002.

Impact of Managed Care Contracting and Payment Practices on Providers and Patients

It is clear that problems with managed care contracting and payment practices are major factors that impact the willingness of physicians to provide on-call services. According to a 2000 survey by the California Medical Association, 80 percent of physicians report that they have had difficulty getting paid for on-call services. That survey found that 30 percent of responding physicians either reduced the amount of call coverage provided or no longer provided call coverage due to problems with lack of payment.[95]

One-half of the physicians surveyed by the state auditor for a report in 1999 indicated that they had experienced delays in payments for one or more health care payers (plans, medical groups or IPAs) with whom they had experience.[96] Similarly, 74 percent of medical groups reported experiencing some type of delayed payment from HMOs or IPAs for either capitation or fee-for-service payments. Twenty-eight percent of physicians and 38 percent of medical groups stated that delayed payments negatively affected the fiscal aspects of their practices. Finally, three-quarters of medical groups reported rarely or never receiving interest on delayed payments from health plans.[97]

The report cited responses from plans and medical groups indicating that they believed they made timely capitation and fee-for-service payments. However, 25 percent cited some experience with inaccurate enrollment data that may have hindered their making timely payments.[98]

Commercial HMOs state that they pay the vast majority of claims on a timely basis. For example, Blue Cross represents that it pays 97 to 99 percent of claims received within 30 days or less and Blue Shield represents that it pays 98 percent of claims within 45 days.[99] However, even these high percentages indicate that potentially hundreds of thousands of claims annually are not being

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[95] "CMA Survey: Payment for Emergency On-Call Services," California Medical Association, July 2000.

[96] "Health Care Payment Surveys: Providers and Payers Have Differing Views Over a Complex, Sometimes Unregulated Health Care System," California State Auditor, March 1999.

[97] Ibid.

[98] Ibid.

[99] "HMOs to Face Payment Pressure: State regulations would force insurers to disclose reimbursement rates and settle claims with providers promptly," Los Angeles Times, May 26, 2002.

reimbursed on a timely basis. Regardless, the bigger problems affecting physicians appear to be problems caused by instability of medical groups and IPAs as claims payers and disputes between plans and physicians over coding of claims.

Impacts on Patients

Gaps in health plans' contracts for on-call services and lack of willingness by physicians to provide on-call services to insured patients also impact emergency room patients themselves. Although the Knox-Keene Act prevents contracting providers from billing enrollees for the portion of their customary charge that is not paid by plans, other than any applicable copayment, coinsurance, or deductible, it does permit non-contracted providers to bill enrollees in full for services. It also allows contracted providers to bill for services when a plan has denied payment for services.

The Senate Office of Research received input that, in most cases, providers take the step of first billing the patient's plan and that patients are generally only billed directly after some period of time or in the event a plan makes some payment on the claim. At that point, patients are usually billed only for the difference between the plan's payment and the provider's billed charges. However, in some cases, SOR received information that physicians bill patients for their fully billed charges, either in lieu of billing the patient's plan or simultaneously with billing the plan. In limited cases, physicians may do this when they are a contracted provider under the plan, which is prohibited under existing law unless the plan has denied payment on the grounds that the services are not covered or are not medically necessary. Business and Professions Code Section 732 generally requires physicians to return over-payments to patients in the event they receive duplicate payments from a plan, but it is unknown to what extent this is enforced.

As a result, patients who receive bills for emergency and on-call services in some cases pay providers for the services, either because they do not know that the services may be covered by their health plan, or in order to avoid collection actions from providers. In some cases, patients end up filing complaints with the DMHC consumer hotline, but most cases are probably not brought to the attention of regulatory authorities. According to the DMHC, it received 173 complaints from health plan enrollees regarding billing issues associated with emergency care and urgent

care in 2001.[100] The department regards these complaints as the tip of the iceberg and, for that reason, sponsored legislation in the 2001-02 session to require non-contracting providers to first bill health plans before billing patients who are health plan enrollees.

Recent Legislation Related to Health Plan Payment and Contracting Practices

The Legislature enacted a number of reforms beginning in 1999 to address problems related to health plan payment and contracting practices vis-à-vis physicians.

- Sections 1367(h) and 1371.38 of the Health and Safety Code, as amended or added by SB 1177 and AB 1455 of 2000, require plans to have fast, fair, and cost-effective dispute resolution mechanisms for providers, including non-contracting providers. According to the DMHC, based on the first year of reporting the outcomes of these disputes to DMHC, a sizeable percentage of disputes are resolved internally by health plans in favor of providers.[101]

- Sections 1371, 1371.35, 1371.37, and 1371.39 as added or amended by AB 1455 (Scott) and SB 1177 (Perata) of 2000 increase the interest penalties on plans and medical groups for delayed payments of appropriate claims, allow physicians to file complaints with DMHC regarding what they believe to be unfair payment patterns, and give DMHC authority to levy monetary and other penalties in the event it determines that a plan or its contracting entities has engaged in an unfair payment pattern. The bills also provide that the interest penalties contained in Section 1371.35 cannot be waived when a plan requires medical groups or other contracting entities to pay claims for services.

  At the time of this writing, DMHC was in the process of finalizing regulations to implement AB 1455 and SB 1177. The draft regulations define the requirements for health plans' internal provider dispute processes; standardize plans' and medical groups' procedural requirements for submitting and handling claims; require health plans to disclose to physicians the fee schedules, payment policies, and rules used to adjudicate and pay claims; and standardize the procedural

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[100] Communication from Herb Shultz, deputy director, DMHC, October 21, 2002.

[101] Ibid.

coding systems used by plans and medical groups to calculate payments to physicians.

- Section 1375.4, added by SB 260 of 1999, requires plans and risk-bearing organizations with which they contract to exchange financial information. This is done so that risk-bearing organizations can be informed of the financial risks they are assuming and so plans can evaluate the financial stability of these organizations. Section 1375.4(b) has not been implemented due to litigation. That subsection requires the DMHC director to adopt regulations to establish a process for reviewing or grading risk-bearing organizations and for implementing corrective actions when this process indicates deficiencies.

- Section 1375.5, added by SB 260 of 1999, prohibits contracts between plans and medical groups and IPAs from including provisions that require a medical group or IPA to be at financial risk for any service unless the provision has been negotiated and agreed to by the parties.

- Section 1375.7, enacted by AB 2907 of 2002, prohibits health plans from changing a material term of a contract with a provider, unless the change has first been negotiated and agreed to by the provider and the plan.

- Section 1367.03, added by AB 2179 of 2002, requires DMHC to develop and adopt regulations to ensure that health plan enrollees have access to needed services in a timely manner. Many argue that providing greater access to specialists would delay or defer emergency room visits that necessitate services from a backup specialist.

Medi-Cal law and regulations contain a number of similar provisions governing payment to providers:

- California regulations require plans to pay all properly documented claims within 30 to 45 days of receipt of a valid invoice (Title 22, Section 53855) and set out a process for handling disputes over claims submitted by providers.

- The regulations also require plans to advise providers of the process for resolving payment disputes through the plans' provider claims appeal systems. If disputes remain unresolved after going through this system, providers may appeal a disputed claim to the DHS within 120 days of the dispute. Plans

and providers may ultimately request an administrative hearing on the dispute.

- California regulations prohibit providers from directly billing Medi-Cal beneficiaries, except for allowable copayments.

DMHC does not adjudicate individual complaints from providers but, as noted above, has authority to levy penalties in response to demonstrated unfair payment patterns. According to DMHC staff, physicians are able to file complaints concerning Medi-Cal managed care plans' payment practices with the DMHC, and DMHC can use them to investigate patterns of unfair payment practices. Thus, Medi-Cal managed care plans are subject to the same prompt and fair payment standards and sanctions under the Knox-Keene Act as commercial plans.

DMHC Enforcement of Provider Prompt-Payment Laws

According to DMHC staff, enactment of prompt payment and related legislation has had a positive effect on plans' payments to providers, including for ER and on-call services. According to a summary of complaints handled by health plans' provider dispute resolution programs in 2001, the first year for which health plans were required to report to DMHC the outcomes of their provider dispute resolution programs, 21,338 disputes involving claims were resolved in favor of providers and 12,984 in favor of plans.

In addition, according to DMHC, the department levied fines against 12 plans totaling close to $500,000 between July 2000 and September 30, 2002, for failure to pay claims on a timely basis or to pay interest on late claims.

Increases in Medical-Legal Risks

Physicians, including those who participated in the AB 2611 working group, state that increases in medical-legal risks facing physicians associated with changing standards of care, stricter enforcement of EMTALA, disruptions in referral practices stemming from ER overcrowding and diversion, and requirements to repatriate managed care patients to established care networks contribute significantly to the unwillingness of many physicians to provide on-call services.

EMTALA Penalties

Under EMTALA, the penalties for violation of on-call requirements are potentially very severe. While enforcement of EMTALA was initially spotty, new funding authorized under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 enabled the Office of the Inspector General at the U.S. Department of Health and Human Services (HHS) to step up its enforcement. In 1998, the federal government issued interpretive guidelines providing guidance to hospitals on several issues, including what is a medical screening exam, what is required to stabilize a patient, and the on-call physician roster requirement.[102] In 1999, the Centers for Medicare and Medicaid Services and the HHS Office of Inspector General jointly issued an advisory bulletin that focused on the application of EMTALA provisions for persons covered by managed care plans and provided some best practices for hospitals.[103] According to many experts, these guidelines and the stepped up enforcement led to significant increases in emergency room usage in the late 1990s.[104]

According to a 2001 report by Public Citizen, fines levied against physicians for violations of EMTALA from June 1997 through April 2001 averaged close to $20,000.[105]

Patient Abandonment and Medical Malpractice

Physician groups point out that litigation involving physicians' responsibilities under EMTALA is evolving and expanding. For example, while there are allowable exceptions to the requirement that a physician on an on-call roster must respond to a request for services, in 1999 a civil court in Missouri found that an on-call physician was liable for patient abandonment on the rationale that the physician's on-call status constituted a physician-patient relationship.[106]

Generally, an agreement to provide a specific service – for example, a medically stabilizing service or the consultation provided by an

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[102] "Interpretive Guidelines: Responsibilities of Medicare Participating Hospitals in Emergency Cases," Centers for Medicare and Medicaid Services, May 1998.

[103] "OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute," HHS Office of Inspector General and Health Care Financing Administration, November 10, 1999.

[104] "Emergency Room Diversions…," op. cit.

[105] "Questionable Hospitals…," op. cit.

[106] Loren Johnson, op. cit.

on-call physician – does not trigger a physician-patient relationship on which a claim of patient abandonment can be based.

At least two statutes offer general immunity from civil damages to emergency and on-call physicians who provide emergency care in hospital ERs. Business and Professions Code, Section 2395, provides that physicians who in good faith render emergency care at the scene of an emergency, including in emergency rooms in the event of a medical disaster, are not liable for civil damages resulting from any acts or omissions, except for willful acts and omissions. Business and Professions Code, Section 2396, provides that no physician who, in good faith and upon the request of another physician, renders emergency medical care to a person for medical complications arising from prior care by another physician shall be liable for any civil damages as a result of any acts or omissions.

A number of California cases have upheld the immunity of on-call physicians in responding to requests for assistance from hospital ERs, including in cases where the emergency was initially stabilized and the patient subsequently became unstable.[107]

However, there is conflicting statutory guidance on the extent of physician immunity. For example, Health and Safety Code Section 1799.110 withholds a general grant of immunity from civil liability to physicians in cases arising out of emergency medical services provided in a general acute care hospital emergency department. Instead, it instructs courts to consider the totality of the circumstances constituting the emergency, and the degree of care and skill ordinarily exercised by other similar physicians in the same community in similar cases and under similar circumstances. As a result, the scope of civil liability immunities for on-call physicians remains unclear.

Risks Associated with ER Overcrowding and Diversion

ER overcrowding and diversion, which are becoming frequent phenomena in California and other states, expose specialists to increasing levels of medical-legal risk. Although hospitals have long diverted patients during peak demand periods such as the winter flu season, ER overflows are now a year-round problem. ER overcrowding, diversions and, in worst cases, closures provide

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[107] *Breazal v. Henry Mayho Newhall Memorial Hospital*, 286 California Reporter 207 (California Court of Appeal, October 2, 1991).

physicians with less certainty that they will be able to transfer complicated cases to higher-level-of-care hospitals.

With normal transfer options disrupted, many specialists conclude that the degree of risk associated with taking call is too great, leading them to curtail or forgo providing on-call services. Lack of availability of intensive care beds and nurse staffing also increases the risks for specialists who consider providing on-call services.

Repatriation Issues

Some working group members cited problems with provision of post-stabilization care and repatriation of patients to their health care networks after they are stabilized as factors that increase the medical-legal risks faced by physicians who provide on-call services. Risk of subsequent deterioration in a patient's condition, coupled with an inability to provide and be reimbursed for services after a patient is stabilized (absent a health care plan's prior authorization) puts on-call physicians at risk for things that are often out of their control.

Others point out that repatriation of patients for post-stabilization care can reduce the risk of bad outcomes if the transfer is done correctly and the patient is transferred to a facility with more specialized care capabilities.

Barriers to Hospital Sharing of On-Call Resources

Federal guidelines concerning implementation of EMTALA allow hospitals to share on-call coverage and enter into "community plans," which enable them to collectively provide around-the-clock coverage for particular specialties.[108] Federal guidelines require that all hospitals involved in the sharing arrangement are aware of the joint on-call schedule and all continue to independently meet the EMTALA requirements of screening, examining, and providing initial treatment to stabilize emergency conditions.[109] These arrangements can include agreements under which hospitals rotate the lead responsibility for providing particular services, under which a common group of specialists rotates among

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[108] "Interpretive Guidelines…," op. cit.; "On-Call Requirements – EMTALA," Centers for Medicare and Medicaid Services, letter to associate regional administrators, reference number S&C-02-34; "Simultaneously On-Call," Centers for Medicare and Medicaid Services, letter to associate regional administrators, reference number S&C-02035.

[109] Ibid.

hospitals, and under which a particular hospital is recognized as a regional referral center for a particular specialty.

Despite this flexibility, hospitals face a number of barriers to greater coordination and regionalization of emergency and on-call services. These include anti-trust barriers to coordination of on-call resources, contractual provisions between hospitals and managed care organizations that can require hospitals to provide all services within the capability of their medical staffs, outdated emergency department licensing requirements, barriers to some contracting and payment guarantee arrangements between hospitals and physicians, and potential conflicts between federal and state guidance to hospitals on their on-call responsibilities.

EMS agencies point out that reforms to promote greater regionalization of ER and on-call services and to facilitate coordination of resources among hospitals need to be implemented carefully so as not to exacerbate ER overcrowding, tie up ambulances or inter-facility transport services, or jeopardize patient health by requiring patients to travel great distances to obtain relatively common services such as orthopedics, general surgery, or internal medicine.

Anti-trust Barriers to Coordination of On-Call Resources

Federal anti-trust law prohibits entities from engaging in anti-competitive behavior or actions that have the effect of restraining trade or commerce. Generally, federal anti-trust policy is fairly permissive in the area of hospital joint ventures or agreements to provide specialized clinical services, including on-call services. Federal guidance recognizes that such ventures often create efficiencies in the delivery of health care that lead to lower prices for the services or the provision of a service that may not have been provided absent the joint venture.[110] However, joint ventures or agreements are scrutinized on a case-by-case basis and may be blocked if their anti-competitive effects outweigh their benefits to consumers.[111]

According to input from hospital representatives, hospitals sometimes are dissuaded from undertaking ventures or

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[110] "Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Hospital Joint Ventures Involving Specialized Clinical or Other Expensive Health Care Services," U.S. Department of Justice and Federal Trade Commission.

[111] Ibid.

agreements for provision of on-call emergency services by uncertainty over whether the arrangements would withstand medical-legal scrutiny.

A state may, under the state-action exemption doctrine, oversee or regulate collaborations otherwise prohibited under anti-trust law if the state determines they are in the interests of the state. In the context of emergency on-call services, the state could declare that allowing hospitals to collaborate in providing emergency on-call services serves the state interest. For this to be permissible under the state-action exemption doctrine, the state would have to actively supervise the exempted conduct to ensure that individual agreements do in fact meet the goals of enhancing access to and lowering the costs of on-call services.[112]

Outdated Hospital Emergency Room Licensing Regulations

Under California law and regulations, hospital emergency departments are licensed under three categories – basic, comprehensive, and standby. Basic emergency departments, which constitute the bulk of emergency departments in the state, must have a physician on duty 24 hours a day who is experienced in emergency medical care, and must provide laboratory, radiological, and surgical services for life-threatening situations. According to the regulations, basic departments must also maintain a roster of specialty physicians available for consultation at all times.[113]

Comprehensive emergency departments must provide 24-hour staffing with physicians trained in emergency medical service as well as in specialty categories including, but not limited to, medicine, surgery, anesthesiology, orthopedics, neurosurgery, pediatrics, and obstetrics-gynecology. Comprehensive departments must also maintain a roster of specialty physicians immediately available for consultation and/or assistance and must have a burn center, which limits the category to nine centers in California.

Stand-by emergency departments must be under the general direction of a physician and must develop a system for assuring physician on-call coverage 24 hours per day. Standby departments must also maintain a roster of specialty physicians available for consultation at all times.[114]

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[112] Analysis of AB 1600 as Amended April 30, 2001, California Assembly Committee on Judiciary, May 10, 2001.
[113] Title 22, California Code of Regulations, Section 70415.
[114] Title 22, California Code of Regulations, Section 70653.

According to some working group members, the absence of licensing distinctions between hospitals with relatively higher on-call coverage capabilities and those without makes it difficult for hospitals and emergency departments to effectuate transfers and enter into transfer arrangements that might better utilize on-call resources available in the community.

Perceived Conflicts Between Federal and State Guidance

While EMTALA requires hospitals that offer emergency services to maintain a list of physicians who are available to provide specialty services needed to stabilize emergency conditions and requires the roster of on-call specialists to represent the specialty capability of the medical staff, federal guidelines allow hospitals flexibility in how they meet these requirements.

For example, federal interpretation of EMTALA allows hospitals to make best-faith efforts to provide 24/7 coverage in specialties in which they are understaffed and to rely on transfer arrangements with other hospitals to fill in the gaps. Federal interpretive guidelines also refer to "community plans" for provision of emergency services, which DHS has used to approve some arrangements among hospitals involving coordination or sharing of on-call resources.[115]

In addition, the EMTALA State Operations Manual provides that each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients.[116] The manual further provides that physician specialists and subspecialists are not required to be on call at all times and that the hospital must have policies and procedures to be followed when a particular specialty is not available to ensure that backup is accessible or patients are transferred to other facilities.[117]

The federal Centers for Medicare and Medicaid Services (CMS) have also issued guidelines stating that there are no set requirements concerning how frequently staff physicians are expected to be on call nor is there a ratio identifying how many days of on-call coverage per week a hospital must provide based on the number of physicians on staff for a particular specialty.[118] CMS guidelines

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[115] "Interpretive Guidelines...," op. cit.; Centers for Medicare and Medicaid Services, letter to associate regional administrators, op. cit..

[116] "Interpretive Guidelines...," op. cit.

[117] Ibid.

[118] Centers for Medicare and Medicaid Services, letter to associate regional administrators, op. cit.

also allow hospitals to share on-call coverage and to enter into "community plans" for provision of ER and on-call services, so that together they are providing 100 percent call coverage for a particular specialty. This is done with the provisos that all hospitals involved in the sharing arrangement much be aware of the joint on-call schedule and continue to independently perform the functions of screening, examining and providing initial treatment to stabilize emergency conditions.[119]

CMS has also opined that physicians may schedule elective surgery while being on call provided they have arranged with another physician to provide backup coverage, and that they may simultaneously be on call at more than one hospital.[120]

However, hospital representatives participating in the working group indicated that state licensing guidelines are not as flexible as EMTALA guidelines and may in some cases negate the flexibilities granted under EMTALA. In particular, the representatives questioned whether DHS would allow hospitals to share on-call resources under the scenarios outlined above. DHS licensing staff interviewed for this study were unaware of any state guidelines that are in conflict with those issued by CMS and indicated that CMS guidelines would guide state licensing staff in reviewing hospitals' on-call arrangements.[121]

Barriers to Contracting by Hospitals for On-Call Services

According to 1998 survey data, 38 percent of California hospitals contract with physicians or physician groups for on-call coverage, 22 percent provide daily stipends to ensure availability of physicians, and 22 percent provide compensation for some portion of the uncompensated care rendered on call.[122] In the latter cases, the hospital often guarantees a minimum payment rate to participating physicians, i.e., whatever the group or IPA doesn't collect, the hospital picks up. These payment arrangements, although expensive for the hospital, appear to have been effective in some cases in filling gaps in emergency room backup services, particularly when implemented on a regional level.

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[119] "Interpretive Guidelines…," op. cit.; Centers for Medicare and Medicaid Services, letter to associate regional administrators, op. cit.

[120] Centers for Medicare and Medicaid Services, letter to associate regional administrators, op. cit.

[121] Comments of Anthony Way, MD, MBA, chief medical consultant, Licensing and Certification Division, DHS, August 2002.

[122] "Potential Solutions…," op. cit.

A number of constraints limit, but do not preclude, the use of these agreements:

- ***Corporate Practice of Medicine Doctrine***. Arrangements under which hospitals guarantee a minimum payment level to physicians as a means of inducing them to provide on-call services may, depending on how they are structured, violate California's prohibition on the corporate practice of medicine. Business and Professions Code Section 2400 generally prohibits lay individuals, corporations, and organizations such as hospitals from employing physicians or otherwise interfering with the physician's practice of medicine. It also prohibits lay entities from providing health care services indirectly by contracting with health care professionals and paying them directly to render services.

  There appear to be many ways in which hospitals can work around these limitations. For example, certain hospitals are exempted from the prohibition, including county and University of California hospitals.[123] In addition, district hospitals are allowed to contract with, but not employ, physicians for provision of professional services.[124]

  In addition, contracting arrangements between hospitals and physicians or physician groups to guarantee certain payment levels for on-call services that do not involve direct payments for services do not raise corporate practice issues. As an example, nine hospitals in San Diego County currently contract with an IPA for provision of emergency on-call services. The IPA, which physicians who wish to provide emergency on-call services belong to, guarantees payment to physicians for on-call services and acts as a billing intermediary. The guaranteed payments are approximately 120 to 130 percent of Medicare rates for comparable services. Periodic financial assessments on participating hospitals act to cover the residual liabilities of the IPA on payments for the uninsured and underpayments from third-party payers and Medi-Cal. The IPA has reportedly succeeded in attracting a waiting list of physicians wishing to join.[125]

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123 "Notes of Decisions," Section 2400, Business and Professions Code, West's Annotated California Codes.

124 Ibid.

125 Comments of Joseph Viglotti, MD, Director of Emergency Medical Services, Sharp Health Care.

Hospitals may also organize and help capitalize IPAs for the purposes of providing on-call services, provided that operations and decisions of the IPA are controlled by physicians and net income of the IPAs is not shared with hospitals. The administrative and financing barriers associated with funding or organizing an IPA or other payment intermediary can be formidable for individual hospitals, and hospitals' and physicians' ability to jointly undertake those activities is limited by anti-trust law.

- ***Anti-kickback Limitations***. Both federal and state law (Business and Professions Code Section 650, Insurance Code 750, Labor Code 325) prohibit the offering or acceptance of anything of value in exchange for the referral of patients. These laws, more commonly known as "anti-kickback," "fraud and abuse," or "fee-splitting" statutes, recognize that payments made or accepted in return for the referral of patients could result in patient harm or over-utilization of health care procedures. To comply with these laws, courts and regulators have insisted that any financial arrangement between physicians and hospitals be directly related to fair market value of services provided. Depending on the nature of the payment agreement, the arrangement may raise a question of whether the hospital is paying the physician a "kick-back" or inducement in exchange for the physician's referral of patients to the hospital.

Inadequate Monitoring of Accessibility and Availability of On-Call Services

Despite the fact that a number of state agencies enforce requirements on health plans, hospitals, and physicians relating to availability and accessibility of on-call services, none collects data on an ongoing basis to identify areas where problems with access to on-call services are occurring.

For example, hospital licensing surveys are required only to be conducted at least every three years. The surveys focus on the adequacy of the hospitals' on-call rosters but do not examine waiting times for on-call services or audit medical records to determine whether failure to provide timely on-call services contributed to poor patient outcomes. Medical surveys of health care service plans and Medi-Cal managed care plans, which have the potential to identify systematic problems with accessibility to on-call services, are also done infrequently.

Enforcement of on-call requirements under EMTALA relies largely on reports and complaints from hospitals, emergency room staff, and patients. But there can be tremendous disincentives to report noncompliant physicians and hospitals. For ER physicians, the disincentives can include a desire not to disrupt relationships with specialists.

Section III: Principles and Recommendations for Addressing On-Call Coverage Problems

With the assistance of the working group, the Senate Office of Research (SOR) developed a set of principles to guide reforms designed to address on-call coverage problems. Working group participants then presented and discussed recommendations for state policy to implement the principles.

This section presents SOR's summary of the principles discussed by the working group and SOR's recommendations for implementing Principles 4 through 10, based in part on the working group discussions. Some of the principles and recommendations reflect general consensus among working group members, while others do not. Those that reflect general consensus are denoted with an asterisk(*).

***Principle 1: Emergency medical care and related on-call services are essential and must be available on a timely basis to all Californians regardless of insurance status or ability to pay.**

Despite the importance of emergency medical services and related on-call services, the state lacks an integrated set of policies designed to ensure their timely availability to all Californians at all times. The sense of the working group was that California must enact specific regulatory, organizational, payment and other reforms to ensure the availability of ER backup services and coverage on an ongoing basis.

***Principle 2: The responsibility to provide, and to ensure the provision of, appropriate on-call coverage and services should be a shared responsibility among hospitals, medical staffs, health plans, medical groups, local EMS agencies, and public payers.**

Under EMTALA and state licensing regulations, hospitals are primarily responsible for ensuring the availability of ER on-call services. While other parties, including hospital medical staffs, medical groups, health plans, local EMS agencies, Medi-Cal, and government programs for the uninsured have a role and responsibility for providing, arranging, and paying for on-call services, the liability for breakdowns in those arrangements currently rests with hospitals operating ERs. As noted previously, the legal and financial risks of not meeting this requirement are significant for hospitals.

The sense of the working group was that responsibility for providing and ensuring the provision of on-call services should be more broadly shared among the various entities with a stake in the provision of those services. This could be done either through assignment of legal responsibility or through other reforms that make all parties accountable for ensuring the accessibility of on-call services.

Regarding reimbursement problems, the sense of most working group members and participants was that payment problems associated with on-call services cannot be simply assigned to any one payer – health plans, Medi-Cal, or safety net programs for the uninsured. Although the extent to which any one payer source is responsible for on-call coverage problems may differ from area to area within the state, the working group found that access problems with on-call services derive from the cumulative and interactive effect of lack of payment and underpayment attributable to all payers. As a result, SOR concludes, reform of payment levels and practices must involve all payers to fully address problems with access to on-call services.

***Principle 3: The burden of providing emergency and on-call services should be broadly shared among physicians who are qualified to provide them.**

Provision of on-call services is required as a condition of hospital privileges only by about one-third to one-half of California hospitals; the remainder depend on voluntary arrangements with their medical staffs. As noted previously, due to a number of disincentives, many physicians choose not to participate in providing on-call services, or limit their participation, while a smaller number end up shouldering a progressively larger burden.

The sense of the working group was that over the long run this is not a sustainable system and that reforms, either regulatory or

incentive-oriented in nature, must be enacted to broaden the pool of physicians who are able and willing to provide on-call services.

One option for doing this would be to require physicians to provide on-call services as a condition of hospital privileges or of licensure. This was the intent of AB 2611 as originally introduced. Although an appealing idea on the surface, this option could actually worsen the problem by causing physicians to drop hospital privileges altogether, or to further reduce their hospital privileges, particularly at hospitals with large numbers of uninsured or Medi-Cal patients, leaving those hospitals even more stretched to maintain on-call capacity. Requiring provision of on-call services as a condition of licensure would entail further administrative burdens in defining the scope of active-duty physicians who would be subject to the requirement. SOR concludes that a preferable approach would be to address the factors that discourage greater numbers of physicians from providing the services, including concerns about the level and certainty of payments associated with insured, Medi-Cal, and uninsured patients.

***Principle 4: Increased funding must be provided, and existing funding must be better targeted, to cover uncompensated and under-compensated costs related to provision of on-call services to uninsured, indigent, and Medi-Cal patients, as well as for reasonable stipends and payment guarantees necessary to ensure adequate numbers of on-call physicians.**

As noted previously, physician services provided to uninsured patients are largely uncompensated due to problems with local EMS funds and restrictions on eligibility for county indigent health programs. In some cases, these costs are picked up by hospitals either directly through payment guarantee arrangements with physicians, or indirectly through payment of stipends for providing standby coverage. Hospitals may or may not be able to recoup these costs from other payers.

In addition, Medi-Cal fee-for-service reimbursement rates for on-call and other services are the lowest of any payer, leading to under-compensation of physician costs for providing on-call services to Medi-Cal patients.

Recommendations

In the short run, changes should be made to administration of county EMS funds to ensure that the funds are better used to pay for uncompensated emergency and on-call services and to remove

payment ceilings for on-call services by Medi-Cal managed care plans. Among the specific short-term changes that should be made are the following:

- Require all counties to establish Emergency Medical Services funds.

- *Simplify and standardize procedures for physician claims from the EMS funds, including standardizing fee schedules among counties, requiring disbursements to be made at least quarterly as opposed to annually, and reducing the requirements physicians have to go through to bill patients and insurers before submitting claims.

- *Require local EMS funds to increase their payments from 50 percent to 75 percent of physicians' otherwise unreimbursed costs if the funds have surpluses in a given fiscal year and their volume of claims is not increasing.

- Allow counties with excess funds in their hospital accounts to use a portion of surplus funds for unreimbursed hospital on-call coverage costs, including the costs of stipends and payment guarantees.

- *Extend the date for counties to report revenues and payments from the EMS funds to the state for the prior fiscal year from January 1 to April 15.

- *Allow counties and the Medi-Cal program to adopt fee schedules that provide higher reimbursement for services performed after hours or on weekends.

- Require EMS fund balances, beyond a reasonable reserve level, to be directed to an equalization fund and redistributed to counties that have expended the balance of their funds.

- Require counties to make reasonable efforts to notify physicians of the availability of the EMS funds.

- Allow Medi-Cal managed care plans to pay rates above the Medi-Cal fee-for-service level for on-call services to non-contracting providers.

*In the longer term, the state should commit sufficient resources to Medi-Cal physician payments and to local EMS funds to enable

physicians to receive payments that are commensurate with Medicare payments for comparable services.

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

As discussed in the report, a lack of willingness by many physicians to provide on-call services stems in part from contracting and payment problems involving commercial and Medi-Cal managed care plans. Those problems include medical group insolvencies; lack of sufficient contracts between health plans and physician specialists that cover on-call services; dissatisfaction among medical groups and their members with the terms of contracts with heath plans; dissatisfaction of non-contracting providers with the payment rates offered by health plans for on-call services; inconsistent procedural, coding and documentation requirements used for handling claims by health plans; regulatory limits on reimbursement of on-call services by Medi-Cal managed care plans; and delays in adjudication of provider claim disputes with Medi-Cal managed care plans.

In addition, physicians cite other reasons for being unwilling to provide on-call services to patients of commercial and Medi-Cal managed care plans, including the frequent use by health plans of what physicians view as inappropriate claims downcoding and bundling (combining of claims) practices. They also cite difficulties in identifying the health care plan or delegated plan subcontractor responsible for claims payment.

Recommendations

As discussed earlier, the Legislature has enacted a number of reforms since 1999 to address payment and contracting problems between health plans and physicians, including payment and contracting disputes dealing with on-call services. These include:

- Requiring plans and medical groups to exchange information in order for the groups to be fully informed of the financial risks

they are assuming and for plans to evaluate the financial stability of the groups.

- Requiring plans to administer internal dispute-resolution programs for providers, including non-contracting providers.

- Increasing the interest penalties on plans and medical groups for untimely payment of claims.

- Providing a mechanism for providers to log complaints about the payment practices of health plans with the DMHC and for DMHC to identify patterns of unfair payment practices.

- Providing DMHC with greater authority to fine and penalize health plans that demonstrate patterns of unfair payment practices.

- Requiring DMHC to adopt standards for accessibility and timeliness of care by health plans, which may encourage plans to make contractual and payment changes to ensure greater accessibility of specialists' services, including on-call services.

Pending regulations from DMHC to implement prompt-payment reforms passed by the Legislature in 2000 could, if adopted, ensure greater consistency and accountability in the processing and handling of claims by plans and medical groups by requiring plans to disclose billing information, fee schedules, policies and rules used to adjudicate claims; by standardizing the coding procedures used by plans to evaluate and pay claims; and by standardizing plans' and medical groups' procedural requirements for submitting and handling claims.

The pending regulations also attempt to establish a presumptive payment standard for situations in which non-contracting physicians provide on-call services. The standard proposed by the pending regulations would be **"**customary and reasonable**"** charges for the procedure or service, taking into consideration prevailing non-contracting provider rates in the community, the rates paid by Medicare and Medicaid, and the fees paid for similar services as reported by nationally recognized provider-fee survey publications. On-call and emergency physicians generally oppose allowing plans to take into consideration rates paid by Medicare and Medicaid, as well as fees paid by plans for similar services, in determining customary and reasonable charges for their services.

If adopted, these reforms, including many of those contained in pending regulations, are likely to go a long way toward addressing payment and contracting problems between health plans and physicians that affect the willingness of physicians to provide on-call services. Nonetheless, SOR's conclusion from its research and the working group discussions is that several additional contracting and payment reforms are necessary to ensure the effectiveness of prompt-payment reforms enacted to date.

The first is the need for a clearer and fairer presumptive payment standard for on-call services provided by non-contracting physicians. As noted above, in many cases, the responsibility for providing on-call services defaults to non-contracting providers. While one can read the intent of the Knox-Keene Act and emergency care access statutes as requiring reimbursement in these situations to be the physician's usual charges or payment consistent with customary and usual charges by other providers in the region – and while some courts have upheld the right of non-contracting providers to receive their usual charges or payment consistent with customary and reasonable charges – it is far from a settled issue. The result is that providers frequently must seek redress in the courts if they believe they have received unfair payments. SOR believes that having a clearer and fairer presumptive standard for payments to non-contracting providers will encourage greater numbers of physicians to agree to provide on-call services while simultaneously encouraging health plans and medical groups to have more extensive contracts with physicians for on-call services.

SOR believes the presumptive standard for payments to non-contracting physicians should be the physician's usual charges, or a payment consistent with customary and reasonable charges for the service in the geographic area based on published surveys or databases endorsed by or identified by DMHC. Failure to pay non-contracting providers according to this standard – for example, only paying customary and reasonable charges to providers who refuse to accept discounted payments – would constitute an unfair payment pattern.

Second, while it appears that the majority of complaints related to payments filed by physicians with health plans' internal dispute resolution programs are resolved in favor of physicians, SOR believes the statute should be clarified to allow non-contracting physicians who are dissatisfied with the plans' dispute resolution process to have the ability to take billing disputes to court.

Third, since many complaints from physicians about payments for on-call services concern Medi-Cal managed care plans, SOR believes the prompt-payment statutes should be modified to make clear that complaints from physicians about Medi-Cal managed care plans should be considered by DMHC as part of the database used to determine whether plans or medical groups have engaged in patterns of unfair payment practices.

Finally, SOR believes there is a need for improved disclosure among health plans and medical groups and between health plans and hospitals concerning on-call services. SOR also believes there should be limits on the ability of health plans to delegate risks for emergency and on-call services, reductions in the backlog of physician or health plan requests for administrative hearings concerning payments involving Medi-Cal managed care plans, and adoption of specific accessibility standards for on-call services.

SOR's specific recommendations are as follows:

- Ensure greater consistency and accountability in the processing and handling of claims by plans and medical groups by requiring plans to disclose to physicians billing information, fee schedules, policies and rules used to adjudicate claims; by standardizing the coding procedures used by plans to evaluate and pay claims; and by standardizing plans' and medical groups' procedural requirements for submitting and handling claims, including for submission of medical records in justification of claims. These reforms are addressed for the most part by DMHC's pending regulations.

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

- Allow physicians who file complaints with health plans' internal dispute-resolution processes concerning the payments they receive for providing emergency and on-call services, and who are unhappy with the resolution of those complaints, to take

those complaints to court, unless they have a contract with the health plan that provides otherwise.

- Allow physicians to file complaints concerning payment issues involving Medi-Cal managed care plans with DMHC and require DMHC to evaluate such complaints as part of its overall assessment and identification of patterns of unfair payment practices.

- Require health care service plans and medical groups to provide hospitals within their service areas with updated lists of physicians who are on call for particular services or provide a 24-hour staffed telephone line. Allow hospitals to determine the health plans and medical groups that ER patients belong to, and to contact physicians on the plans' or medical groups' lists, if it would mean no delay in the provision of emergency services.

- *Require better disclosure in commercial and Medi-Cal managed care contracts with providers concerning who is responsible for on-call services and the payment terms and conditions for on-call services.

- Prohibit commercial and Medi-Cal managed care plans from delegating risks for emergency room and on-call services to medical groups or IPAs if they or their contracting groups are found to be in violation of prompt-payment provisions, including engaging in an unfair payment pattern.

- Devote additional resources to administrative hearings by the DHS Office of Administrative Hearings and Appeals of complaints by providers.

- Require DMHC and DHS to develop specific accessibility standards for on-call services that take into account the timeliness of care, based on national standards and standards in other states, as part of the mandate imposed by AB 2179 of 2002.

*Finally, SOR concludes that, aside from responding to billing disputes from individual physicians regarding on-call services, DHS and DMHC must do more to facilitate informal, regional problem-solving approaches among hospitals, physicians, health plans, and physician groups to address local problems with payment and contracting for on-call services.

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

As discussed above, most physicians who provide emergency and on-call services as non-contracting providers take the step of billing the patient's plan and only bill patients after some period of time or after the plan has made some payment, and then only for the difference between what the plan pays and their billed charges. Nonetheless, there is evidence that some physicians who provide on-call services bill the patient their full charges for the services, either in lieu of billing the patient's plan or at the same time they bill the plan, including, in limited cases, where they have contracts with the patient's health plan. The latter practice is prohibited under existing law except for collection of applicable copayments, deductibles, or coinsurance, unless the patient's plan denies payment for the services, in which case physicians are entitled to bill the patient their customary and reasonable charges.

It is not known, but it is assumed that most patients who receive bills for on-call services directly from providers refer them to their health plans. In many cases, the plan then pays the provider, the provider accepts the payment from plan, and the patient has no further payment responsibility. However, patients can be the victims of unfair billing or payment practices if any of the following occur:

- The provider bills the patient but does not bill the plan, and the patient pays for the services because he or she does not know that the services may be covered by his or her health plan.

- The patient refers the bill to his or her health plan, the health plan makes an unreasonably low payment to the provider – for example, not consistent with customary and reasonable charges for similar services – and the provider bills the patient for the difference between the plan's payment and the provider's fee. The patient, under the threat of collection or legal action from the provider, pays the remaining portion of the fee.

- The patient refers the bill to his or her health plan, the plan makes a reasonable payment to the provider, but the provider insists on an unreasonable fee and bills the patient for the difference between the plan's payment and the fee. The plan

refuses to increase its payment and the patient, under threat of collection or legal action, pays the remaining portion of the fee.

Recommendations

It is difficult to legislate a solution to this problem that is fair to all parties – providers, patients, and plans. It seems reasonable that non-contracting providers should not be treated as "de facto" contracting providers by requiring them to adhere to the same prohibitions on patient billing that contracting providers are subject to. At the same time, it also seems reasonable that patients who are health plan enrollees should be protected from having to pay for services that are covered under their health plans and from paying portions of providers' fees that their health plans will not pay, either because a plan's payment is unreasonable or the physician's fee is unreasonable.

SOR's conclusion is that the best solution is a combination of better disclosure to patients of their rights and responsibilities, in particular their right to complain to DMHC if they believe they are unfairly being billed for services, and of greater regulatory oversight of these billing situations. In particular, encouraging patients to file complaints to DMHC would enable DMHC to determine on a case-by-case basis if plans or physicians are engaging in actions that could be construed to be part of an unfair payment pattern or unfair billing practice on the part of the provider.

SOR's specific recommendations are as follows:

- Require health plan disclosures to enrollees to include information about how and under what circumstances they may be liable for costs of emergency and on-call services, the extent to which the plan relies on contracted versus non-contracted providers for emergency and on-call services, and the recourse enrollees have if they believe they are unfairly billed for services.

- Require physicians who provide emergency and on-call services to include a standard disclosure in any billing statements sent to patients to whom they have provided emergency or on-call services. The disclosure would state that the services may be covered by the patient's health plan, in which case the patient's payment obligation is limited to any applicable deductibles, copayments, or coinsurance, unless the plan denies payment on the grounds that the services are either not covered or are

not medically necessary. The disclosure would also advise patients that they can contact the DMHC consumer hotline if they have questions about their payment obligations. Finally, physicians would be required to inform patients of whether the patient's health plan has been billed and whether any payments have been received from the plan.

- Clarify that a pattern of billing or receiving from patients fees clearly in excess of customary and reasonable charges for emergency or on-call services is grounds for disciplinary action by the Medical Board of California. Require the Medical Board to develop guidelines or regulations to implement this standard. Require DMHC to refer complaints regarding physician billing practices to the Medical Board.

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

***Principle 7: The state should remove legal and regulatory barriers to sharing on-call resources among hospitals.**

As noted previously, local delivery of emergency and on-call services is currently fragmented due to a number of legal and regulatory barriers, including anti-trust barriers to collaboration among hospitals, outdated hospital emergency room licensing regulations, and barriers to use of some payment arrangements between hospitals and physicians. The sense of the working group was that the state should take steps to promote regional coordination to make the most efficient and effective use of on-call resources.

Recommendations

*Federal guidelines outlining hospitals' flexibilities in how they arrange and provide on-call services, particularly guidelines issued in June 2002, make it clear that hospitals are not expected to individually provide 24/7 coverage in all specialties and may rely on other arrangements with other hospitals to share on-call

resources. However, working group members expressed concern that state licensing guidelines do not allow hospitals the same flexibility as federal EMTALA guidelines. To avoid any actual or perceived conflicts between federal and state policy, SOR recommends that the federal guidelines be codified in California.

Other specific recommendations are as follows:

- *DHS should be required to establish specific standards under which hospitals may operate regional call-sharing arrangements, including referral centers for specialties that lend themselves to regional centers such as orthopedics, neurosurgery, and plastic surgery, subject to the approval of DHS and local EMS agencies. In addition, hospitals should be provided with state action anti-trust immunity and protection under state emergency care access statutes to coordinate on-call schedules or sharing of on-call specialists subject to the oversight of the state attorney general.

- *Physicians, physician groups, and hospitals should be given state-action anti-trust immunity to form independent practice associations or other physician organizations devoted to providing emergency on-call services on a regional or local basis, subject to oversight by the state attorney general.

- *A task force should be convened to recommend changes to the existing emergency department classification system to more closely base ER classification on medical staff capabilities, more closely distinguish levels of care, and facilitate patient transfer arrangements.

***Principle 8: Further study should be given to the issue of whether physicians should be given additional liability protections for providing on-call services.**

Although California law provides immunity to physicians responding in many emergency situations, the scope of immunity that is afforded to on-call physicians responding to calls for assistance in hospital emergency rooms is unclear. The working group agreed that the issue required further study.

Recommendation

- *The Emergency Medical Services Authority should study the scope of liability immunities available to physicians who provide emergency on-call services and whether additional liability

protections beyond those in existing law are warranted to encourage greater provision of on-call services.

***Principle 9: The state should monitor gaps in the availability of specialists that manifest themselves in on-call shortages, including gaps in specific geographic areas and in specific specialties.**

As discussed previously, regional shortages of certain types of specialists are beginning to manifest themselves as the result of a variety of interacting factors, including reductions in medical training slots, difficulties recruiting physicians, and limits on the state's ability to monitor the availability of physicians by specialty and by geographic area. While the state has limited control over the supply of physicians, the sense of the working group was that the state could be doing more to monitor specialist availability and to improve accessibility at the local level.

Recommendations

- *To better monitor physician shortages that impact the accessibility of on-call services, the Medical Board and Office of Statewide Health Planning and Development (OSHPD) should periodically report on physician shortages in local geographic regions and among specialties using newly created data on physician practice arrangements and specialties created by AB 1586.

- *OSHPD should also be required to study and make recommendations on potential applications of telemedicine as a means of mitigating the on-call coverage problems of hospitals, particularly rural hospitals.

- *OSHPD should additionally be required to study and make recommendations concerning potentially needed changes in physician training programs at the University of California to address imbalances in the demand and supply of physician specialists.

It is difficult for the state in isolation to influence the national supply of specialists due to the influences of federal Medicare payment policies on academic medical centers and the interstate mobility of newly trained specialists. However, the state could improve the attractiveness of California as a practice location for newly trained specialists by implementing geographic accessibility standards for physician specialists governing HMOs and Medi-Cal

managed care plans as required by AB 2179 of 2002 and AB 1282 of 2002. This would be based on timeliness of access, taking into account variations in the availability of physician specialists by geographic region.

Principle 10: The state should more closely monitor problems with accessibility of on-call services.

Recommendations

- Require DHS to more frequently audit ER on-call coverage arrangements to identify areas where systematic problems are contributing to unacceptable access to on-call services and impacting the quality of patient care. Require DHS to share information on on-call access problems with the DMHC and DHS Division of Managed Care.

- *Request the University of California and/or California State University to conduct studies of the underlying causes and costs of the on-call coverage problem in California.

Appendix A

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Appendix C

AB 2611 Meeting Agendas

AB 2611 On-Call Coverage Working Group Meeting
February 2, 2001
1:00 – 4:00

Chamber of Commerce
1215 K St., 14th Floor

AGENDA

1. Introductions

2. Discussion of working group mission, goals, and make-up

3. Issue discussion: The legal and regulatory environment for on-call coverage

   - Ruth Patience
     Health Care Financing Administration

   - Steve Lipton, Attorney
     Davis, Wright, and Tremaine

   - Astrid Meghrigian, Legal Counsel
     California Medical Association

   - Reaction: Loren Johnson, MD
     Medical Director, Emergency Department
     Sutter Davis Hospital

   - Task force discussion

   - Open comment

4. Issue discussion: How hospitals and medical staffs currently arrange and provide on-call coverage and services

   - Dan Gross, DNSc
     CEO
     Sharp Healthcare

   - Richard Frankenstein, MD
     Physician, emergency and internal medicine

   - Task force discussion

   - Open Comment

5. Future meetings and task force functions

6. Open comment

7. Adjourn

AB 2611 On-Call Coverage Working Group Meeting
April 20, 2001
10:00 – 2:00

Kaiser Permanente
California Division Headquarters
Oakland, CA

AGENDA

1. Introductions

2. Recap of February 2, 2001, meeting

3. Discussion of noneconomic and economic factors impacting provision of on-call coverage and services

Lunch Break

4. Presentation of findings and recommendations from Health Care Association of Southern California (HASC) survey

   - Julia Pennbridge, Ph.D.
     Director, Research and Development
     National Health Foundation

5. Status report on AB 2611 study and data collection

   - Peter Hansel
     Principal Consultant
     Senate Office of Research

6. Presentation on UCLA Medical Center on-call coverage system

   - Frank Maas
     Administrative Director, Emergency Medicine Center
     UCLA Medical Center

7. Open comments

8. Adjourn

AB 2611 On-Call Coverage Working Group Meeting
July 31, 2001
9:30 – 2:00

Daniel Freeman Memorial Hospital
333 North Prairie Avenue
Inglewood

AGENDA

9:00 Continental Breakfast available

9:30 Introductions and recap of 4/20/01 meeting

9:45 Status of AB 2611 study and related studies

10:00 Presentation of results of UCLA study of trends in ER supply and utilization

- Susan Lambe, M.D.
  Emergency Physician and Research Fellow, UCLA Robert Wood Johnson Foundation Clinical Scholars Program

11:00 Department of Managed Health Care implementation of AB 1455 and SB 1177 dealing with payment disputes between health plans and providers

- Curtis Leavitt
  Supervising Staff Counsel
  Department of Managed Health Care

Lunch

12:30 Development of principles for reform of emergency room on-call system

- Peter Hansel
  Principal Consultant
  Senate Office of Research

1:20 CAL-ACEP Task Force on Hospital Emergency Department Categorization System

- Loren Johnson, MD
  President, CAL-ACEP

1:40 Results of CMA physician workforce study

- Aileen Wetzel
  Associate Director
  Managed Care & Medical Staff Issues
  California Medical Association

1:55 Closing remarks

2:00 Adjourn

AB 2611 On-Call Coverage Working Group Meeting
November 6, 2001
1:00 – 5:00

State Capitol, Room 112

AGENDA

1. Introductions

2. Recap of July 31, 2001, meeting

3. Panel discussion: Stakeholder views on how to address the on-call coverage problem in California

   - Loren Johnson, MD, President, CAL-ACEP
   - Jackie Nolen, CEO, Local Health Plans of California
   - Michael Sexton, MD, Vice Chairman, California Medical Association
   - Representative, medical groups
   - Representative, California Health Care Association
   - Representative, Blue Cross

4. Open comments

5. Plan and schedule for completion of report

   - Peter Hansel
     Senate Office of Research

6. Adjourn

AB 2611 On-Call Coverage Working Group Meeting
February 1, 2002
1:00 – 4:30

State Capitol
Room 317

AGENDA

1. Introductions and recap of last meeting
2. Discussion of AB 2611 draft report
   - Summary of comments received
   - Additional comments on report
3. Discussion of legislative proposals
4. Next steps
5. Open comments

Appendix D

AB 2611 Statute

Assembly Bill No. 2611

CHAPTER 828

An act relating to emergency health care.

[Approved by Governor September 28, 2000.
Filed with Secretary of State September 28, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2611, Gallegos. Health facilities: emergency services.

Existing law provides for the regulation of hospitals.

This bill would require the Senate Office of Research to conduct a comprehensive study of the hospital emergency room department on-call coverage issue in California, to convene a working group of affected California stakeholders, and to report to the Legislature by January 1, 2002, with recommendations to address the California hospital emergency room on-call issues.

The people of the State of California do enact as follows:

SECTION 1. (a) (1) The Senate Office of Research shall conduct a comprehensive study of the hospital emergency room department on-call coverage issue in California.

(2) The study required by paragraph (1) shall include, but not be limited to, the magnitude of the challenges facing California hospital emergency room departments, including those in underserved and rural areas, the scope of the challenges facing other states relative to these issues, and how other states have addressed these complex and challenging issues.

(b) The Senate Office of Research shall convene a working group of affected California stakeholders, including, but not limited to, hospitals, hospital organizations, physician organizations, physician representatives, including emergency room physicians and other on-call specialists, and payors, and state agencies as appropriate.

(c) The Senate Office of Research shall report to the Legislature by January 1, 2002. The report shall include recommendations to address the California hospital emergency room on-call issues.