TO: ARIZONA ASSOCIATION OF HEALTH CARE LAWYERS

FROM: Jerry Gaffaney, President, Secretary/Treasurer

DATE: March 22, 2016

APRIL 20, 2016 PROGRAM ANNOUNCEMENT

"Is There (Going to Be) A Doctor in the House?"

Date: April 20, 2016
Time: 12:00 noon to 1:00 pm
Place: Lewis Roca Rothgerber Christie at Collier Center
201 East Washington Street, 3rd Floor

This program will address recent developments regarding emergency and trauma call coverage. According to the 2014 Report Card prepared by the American College of Emergency Physicians, Arizona ranked 48th out of the fifty states in providing access to emergency care. The physicians who currently provide call coverage for emergency and trauma care are facing a perfect storm of statutory, regulatory, licensing and business factors, which make the provision of call coverage services even more daunting. This presentation will outline the challenges facing those physicians, without whom, there might not be a doctor in the house.

Our speaker is Robert J. Milligan, a shareholder with Milligan Lawless, P.C. Bob has extensive experience in representing all types of health care providers, including emergency physicians and other physicians who provide call coverage for hospitals.

This program will be held on April 20, 2016 at 12:00 noon at Lewis Roca Rothgerber Christie's office in Phoenix. Lunch will be served - $10 for AAHCL members/$15 for non-members.

Please RSVP in advance by e-mail to CLovejoy@dickinsonwright.com. You may pay at the door or send your check in advance (payable to AAHCL) to Jerry Gaffaney, Dickinson Wright 1850 North Central Avenue, Suite 1400, Phoenix, Arizona 85004. Whether or not you pay in advance, you must RSVP prior to the program.

This program will count for one (1) credit hour of continuing legal education.

CALL IN INFORMATION: To access the teleconference, use any of these dial-in numbers: 1-866-496-2887, 602-262-5301 or 602-385-0230. Enter this Bridge number: 5218. Enter this Participant PIN number: 95218

For CLE credits and materials for this program, please contact Cyrie Lovejoy.

OFFICE DIRECTIONS – www.lrrc.com/phoenix#directions

Take I-10W to Washington Street. Exit and turn left at Washington Street for 2 miles and follow it to Collier Center (Bank of America building, including Kincaid's and Hard Rock Café), located on the south side of Washington Street. Turn left into the parking garage just before 2nd Street. Collier Center is on the southeast corner of 2nd Street and Washington.

Take the garage elevators up to the 2nd floor (Collier Center Lobby), then take the second bank of elevators to Lewis Roca Rothgerber Christie's 3rd floor for the AAHCL Meeting.

MILLIGAN LAWLESS

Is there (going to be) a doctor in the house?

Arizona Association of Health Care Lawyers, d/b/a Arizona Society of Healthcare Attorneys

April 20, 2016

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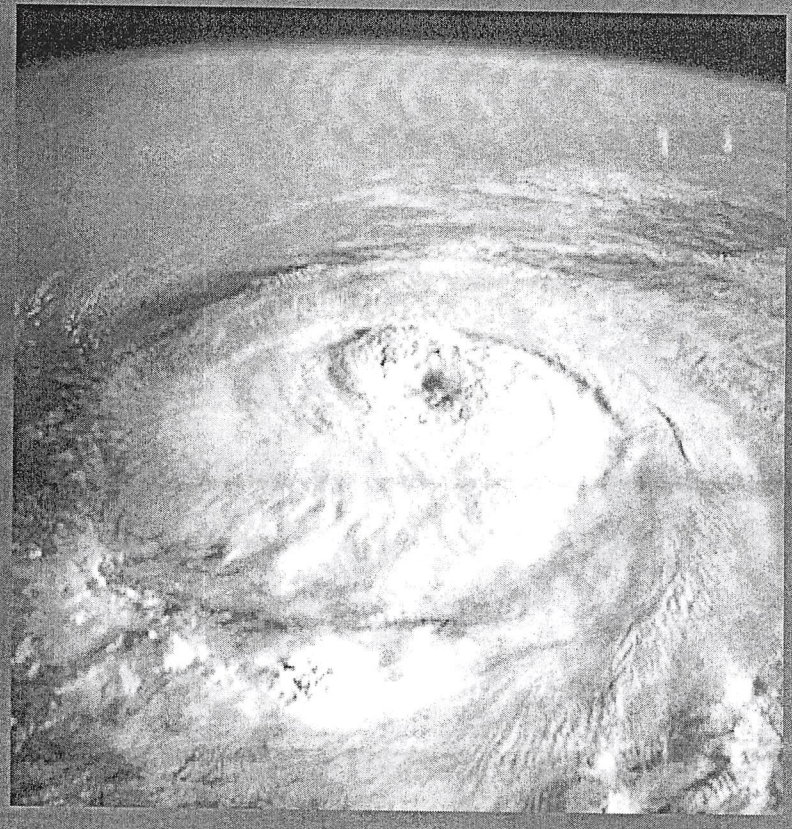
Overview

- A brief history
- Legal challenges
- Economic challenges
- Societal challenges
- Licensing challenges
- "Why would anyone…"
- Questions, suggestions, etc.



A brief history

- In ancient times, hospitals needed doctors, and doctors also needed hospitals.
- For many surgeons, call coverage was a good way to build a practice.
- For others, call coverage was a medical staff obligation, and medical staff privileges were essential.
- For others, call coverage was a relatively minor burden, undertaken as a perceived moral obligation.

A brief history

- More recently, an increasing number of procedures can be performed on an outpatient basis, at ASCs owned by surgeons.
- Call coverage is not viewed as an important part of building a practice.
- Medical staff privileges are not essential.
- As fewer physicians provide coverage, the burden on those who might be willing to do so increases.

The current state of affairs

- "Problems with on-call specialist coverage have been identified as a significant issue for our nation's health system." Rao, *et al.*
- "Grade F…. Arizona continues to struggle with Access to Emergency Care and ranks close to last in the nation in this category. The state ranks among the bottom 10 for access to several essential medical professionals…" ACEP 2014 State-by-State Report Card
- ACEP recommendation: The state needs to cultivate an environment that attracts and retains specialists."

Legal challenges - EMTALA

EMTALA in a small nutshell

- Hospitals that have an emergency department must:
  - Provide an appropriate screening exam, to
  - Determine if an emergency condition exists, and
  - Stabilize the patient's condition or transfer.

- Hospitals may not delay screening to inquire about payment or insurance.

- Physicians who are "responsible" for examining, etc. and fail to do so are subject to $50,000 CMPs, per violation.
- How can physicians avoid being deemed "responsible"?

Legal challenges – the AKS

Anti-Kickback Statute

- OIG Advisory Opinion No. 12-15
  - Nonprofit hospital with an ED
  - 19% of ED patients have no payor source
  - Written ED call coverage agreement
    - Phone consultation
    - In person at the facility
    - Follow-up care
  - Consultant opines per diem is fmv.

Legal challenges – the AKS

OIG Advisory Opinion No. 12-15

- Physician concerns:
  - Time commitment
  - Lifestyle disruption
  - Uncompensated care
  - Obligation to provide follow-up
  - Malpractice premiums (?)

Legal challenges – the AKS

OIG Advisory Opinion No. 12-15

- OIG Analysis
  - The "one purpose" test
  - Personal services safe harbor?
    - Set in advance?
    - Specific schedule?
  - FMV? (OIG does not opine on FMV)
  - "The [AKS] neither compels hospitals to pay for on-call services nor compels physicians to provide on-call services without compensation."
  - "Low risk" of an AKS violation.
- See, also, Advisory Opinion No. 09-05.

Legal challenges - routine waivers

Routine waivers of patient responsibility:

- Wire fraud? (*US v Nichols)*
- Nonpayment? (*Kennedy v Conn. Gen.)*
  - 80% of zero is zero.
- Insurance fraud? (ARS 20-463)
- False Claims Act for FHCP (*US v EOOC*)
- Discipline ("Violating any federal or state laws….")

Economic challenges - insurers

- In-network physicians who provide call get in-network (elective) reimbursement.
- On call physicians have difficulty getting paid, even for in-network services.
- ACA requirement for ED insurance coverage is the lesser of:
  - median in-network;
  - UCR (?)
  - Medicare allowable.
- NY Attorney General settlements with insurers for systematically underpaying for emergency out of network care.

Economic challenges - patients

- Uninsured patients
- "Insured patients" with high deductibles and co-insurance (80%)
- Insurance payments to patients, for physician services
- Patient reactions to liens
- Social media chatter

Economic challenges - hospitals

- Decreasing stipend and subsidy amounts
- Discontinued stipends and subsidies at some hospitals
- Pressure on physicians to contract with payors
- EMTALA concerns
- Employment vs private practice models

Societal challenges – who is to blame

Are "greedy doctors" at fault?

- "To charge five times what Medicare charges, it's greedy and immoral."
- "Representatives of some hospitals say they have encouraged [practice] to accept contracts with more commercial health plans."
- "A March 2015 survey of 2,202 privately insured adults by the Consumer Reports National Research Center found that nearly one-third of adults had grappled with a surprise medical bill over the previous two years."

Arizona Republic, April 10, 2016

But, four ED physicians took the time to go to the Call to the Public to express concerns about what will happen to them, and to patients, if doctors who provide call coverage currently, decide they've had enough.

Who is to blame?

"Medicine's Top Earners Are Not the M.D.s"

- "Physicians, the most highly trained members of the industry's work force, are on average right in the middle of the compensation pack."
- Average salaries (not including stock) for
  - An insurance executive: $584,000
  - A hospital CEO: $386,000
  - A hospital administrator: $237,000
  - A surgeon: $306,000
  - A "general doctor": $185,000

  Elisabeth Rosenthal, New York Times, May 17, 2014

Who is to blame?

Are insurers at fault?

- "Insurance companies take advantage of that 'treatment requirement'…. They think, 'we'll just squeeze our ER doctors, because they can't say no.' In such a situation, the patient and the doctor are both caught in a vise." (ABA Healthsource, November 2011)
- Payments to patients, instead of providers.
- Underpayments for emergency services per New York settlements.

Who is to blame?

Insurers can be pretty easy targets.

- Who likes their health insurance company?
- Are insurers struggling under ACA?
  - Sylvia Burwell, Secretary of DHHS makes $203K a year.
  - United Healthcare CEO made $66M in 2014, and $102M in 2010 (slashed by one-third as a result of the ACA?); Aetna CEO made $36M in 2012.
- What purpose is served by the practice of paying to patients the amounts due to doctors?

Are co-pays to blame?

- Most physicians would waive co-pays, but for the legal prohibition against it.
- In the elective setting, co-payments help moderate the demand for medical services and provide incentives to hold down the cost of medical care. *Kennedy v Connecticut General Life Insurance Co.*
- Do they fulfill those goals in "true emergencies"? Would it be possible to define "true emergencies" and alter the patient responsibility structure for them?

Who is to blame?

Are hospitals at fault?

- Should hospitals pay more to "responsible" physicians?
- "[H]ospitals are knowingly complicit in a deception, since they reap large profits from unnecessary utilization of inpatient services."
- "Hospitals could easily cure this malignancy by requiring doctors to either contract…or agree to accept the insured's out of network benefit…."
- And, also, "Doctors who cannot build a referral base will prowl the emergency room for cases."

Opinions, AZCENTRAL.COM

Licensing challenges

32-1401. Definitions In this chapter, unless the context otherwise requires:

27. "Unprofessional conduct" includes the following, whether occurring in this state or elsewhere:

(w) Charging or collecting a clearly excessive fee. In determining if a fee is clearly excessive, the board shall consider the fee or range of fees customarily charged in the state for similar services in light of modifying factors such as the time required, the complexity of the service and the skill requisite to perform the service properly. This subdivision does not apply if there is a clear written contract for a fixed fee between the physician and the patient that has been entered into before the provision of service.

32-1451.04 imposes a "clear and convincing" burden of proof for disciplinary matters (excluding (z), sexual contact)

Licensing challenges

- EMTALA makes a "clear written contract" impractical in the ED or trauma room.
- How does the AMB find evidence of "fees customarily charged"?
- How do physicians who want to set an fmv fee schedule find evidence of "fees customarily charged"?
- How does the Board assess "modifying factors" like 24/7 availability, uncompensated care and other issues?

Licensing challenges

September, 2014 Billing Guidelines

- Regarding subsection (w): "'Excessive' should be defined as 3 times over the Medicare Allowable Amount. This determination was made based on historical complaints received from private insurance companies to the board concerning overcharging patients."
- Regarding subsections (e), (t), (u) and (v), the guidelines recommend referrals to the Assistant US Attorney in some circumstances.
- Based on discussions at the April 6 Board meeting, the Board appears to be re-evaluating its approach to this issue.

Licensing challenges

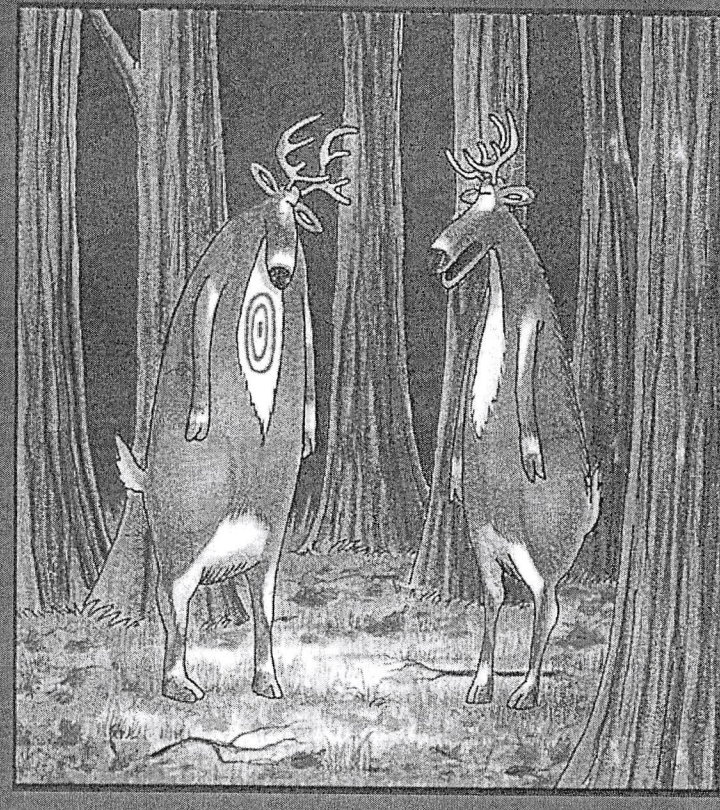
Legal issues regarding the guidelines:

- 32-1401.27(w) ("shall consider") and 1451.04 ("clear and convincing")?
- Administrative Procedure Act?
- State and federal due process?
- State and federal antitrust laws?

Are Medicare allowables an appropriate component of a "clearly excessive" calculation?

Why would anyone want to provide call coverage?

- When I go out to dinner with my family, we bring two cars in case I get a call.
- I've missed a lot of birthdays/anniversaries/sporting events.
- I've been bitten/hit/spat at by patients.
- I went to the ED knowing I would spend most of the night taking care of a patient, with absolutely no chance of getting paid anything.
- I don't have much of a social life.
- It's not easy getting OR time, an OR team, etc. in the middle of the night.
- I'd be very happy to write off the patient's co-pay.
- I'm not sure I need this anymore.



"Bummer of a birthmark, Hal."

Questions, suggestions, etc.

- Hospital collaboration?
- Physician collaboration?
- Insurer collaboration?
- Fellowship programs?