CATHERINE I. HANSON, State Bar No. 104506
ASTRID G. MEGHRIGIAN, State Bar No. 120896
221 Main Street, Third Floor
P.O. Box 7690
San Francisco, California 94120-7690
Tel. (415) 882-5144; Facsimile (415) 882-5143

Attorneys for Amici Curiae
California Medical Association,
American Academy of Emergency Medicine
and the California State Chapter of the
American Academy of Emergency Medicine

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE CITY AND COUNTY OF SAN FRANCISCO

AFFILIATED CATHOLIC HEALTHCARE PHYSICIANS, a Nonprofit Mutual Benefit Corporation, Plaintiff, v. EMERGENCY PHYSICIANS MEDICAL GROUP, a California Corporation, MERITEN PHYSICIAN MANAGEMENT INC., a California Corporation, and Does 1 through 100, Defendants.	Case No. C993954 AMICI CURIAE BRIEF OF THE CALIFORNIA MEDICAL ASSOCIATION, AMERICAN ACADEMY OF EMERGENCY MEDICINE AND THE CALIFORNIA STATE CHAPTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE, IN SUPPORT OF AFFILIATED CATHOLIC HEALTH CARE PHYSICIANS AND IN OPPOSITION TO MOTION FOR SUMMARY JUDGMENT Date: October 14, 1999 Time: 9:30 a.m. Courtroom: 302 Trial Date: November 8, 1999 Complaint Filed: March 27, 1998

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I. INTRODUCTION

The issues raised by this case go to the heart of the provision of quality medical care in this State-the ability of physicians to practice medicine and make medical judgments without inappropriate interference from lay entities or persons.

The California Medical Association ("CMA"), American Academy of Emergency Medicine ("AAEM"), and the California State Chapter of the American Academy of Emergency Medicine ("CAL/AAEM") have high regard for the integrity and quality of care provided by Emergency Physicians Medical Group ("EPMG") physicians, and indeed applauds those aspects of the Management Services Agreement in question which appear to be designed to help protect physician autonomy, including, but not limited to the fact that all EPMG physicians are under EPMG's control, supervision and direction in connection with medical services for patients. *See* Declaration of Joshua Rubin, M.D., Exhibit "A," paragraph 2.2. However, as Defendants acknowledge, this case could be the first in California to opine specifically on the legality of a physician management services agreement in the context of laws protecting the practice of medicine. We urge that this Court consider the impact of its decision in this broader context. Further, serious structural concerns remain that compel the conclusion that the Agreement as a whole has the potential for inappropriate lay control over the practice of medicine.

As is discussed in more detail below, California law contains numerous protections against the possibility that a physician's judgment in the provision of medical care will be compromised by a lay entity, either directly or indirectly. *See* Business & Professions Code §§650, 2052, and 2400. Because increased competition, as well as cost consciousness on the part of both public and private payors have created an environment rife with the potential for jeopardy to quality patient care, the California legislature, courts, the Attorney General's Office, and the Medical Board of California have scrupulously safeguarded and enforced these laws to protect against patient harm. Indeed, as late as 1997, California's legislature reaffirmed that the "Business & Professions Code provides an important protection for patients and physicians from inappropriate intrusions into the practice of medicine." Section 1, Stats. 1997, Ch. 673.

This protection comes in the form of structural safeguards which ensure that a physician's medical decisions are not based on financial considerations, but rather, on professional, medical judgment. California law presumes that certain business arrangements can result in the lay control of the practice of medicine and thus prohibits lay entities from, among other things, (1) contracting with physicians on an employment basis (or any basis which is characteristic of employment), and (2) sharing profits with physicians. In both of these situations, the lay entity has too much control over the manner or means by which medical care is provided. This is true as a matter of definition in the employment context and as an economic reality in the context of profit sharing. Put another way, if a lay entity has a financial interest in a physician's "bottom line" or "profit," then the entity has a direct interest in and ability to control the medical side of the business, such as how many hours the physician will work, what medications the physician may purchase, what type of medical technology should be utilized, etc. This is illegal.

Actual "medical" control need not occur for a violation of these Californian laws to be shown; rather, the law recognizes that many "business" decisions have direct and

indirect medical implications and condemns arrangements that provide for the potential of inappropriate lay control. California laws have, at their root, the goal of preservation of the physician-patient relationship for the betterment of patient care. Unfortunately, Amici are concerned that in the quest to control costs and make profits, lay organizations throughout California have, and will continue to control physicians and treat health care as merely a commercial business.

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II.

THE ARRANGEMENT AS A WHOLE SHOULD BE ASSESSED WHEN CONSIDERING THE POTENTIAL FOR LAY CONTROL, DIRECT OR INDIRECT, OVER THE PRACTICE OF MEDICINE.

Amici have reviewed the Memorandum and Declarations supporting the Defendants' Motion for Summary Judgment, and would like to bring their concerns to the Court's attention in this case.

Encumbrances of medical practices can take many forms and the fact that many aspects of the arrangement at issue appear designed to protect physician autonomy does not allow the objectionable aspects to escape scrutiny. As the Attorney General stated:

> Although the foregoing recital purports to classify the relationship of the doctor to the hospital as that of an independent contractor, it is clear that the actual relationship is a question of legal interpretation of the substantive provisions of the agreement (Albaugh v. Moss Const. Co. (1954) 125 Cal.App.2d 126, 132) and whether the hospital does exercise or has retained the right to exercise control or direction over the physician's practice must be determined not by the exculpatory declarations of paragraph X but upon objective examination of the contract as a whole. 55 Ops.Cal.Atty.Gen. 103, 106 (1972).

While we will not address each and every one of the details of the business arrangement at issue, Amici at the outset would like to highlight a few aspects of the arrangement, which, particularly when considered together, could result in inappropriate lay control by Meriten.

(1)

Catholic Healthcare West Owns Hospitals that Contract with EPMG to Provide Staffing for the Hospitals' Emergency Departments on an Exclusive Basis.

Declaration of Norman Label, paragraph 2; Declaration of Art B. Wong, M.D., paragraph 2.

Hospital arrangements with hospital based physicians such as emergency physicians have been subjected to increasing scrutiny due to concerns that such arrangements may compromise a physician's judgment. With exclusive contracts, by definition the contracting medical group is bound to the hospital; without the contract, neither the group nor its physicians may practice at that hospital. In addition, exclusive contracts between hospitals and physicians impact a number of matters, including

the quality of care, accessibility of care, maintenance of existing physician-patient relationships, and the property interests of physicians in maintaining staff privileges at the hospital.

(2)

Catholic Healthcare West Purchased the "Non-clinical" Assets of EPMG in Return For, among Other Things, All of the Medical Group's Profitability.

Declaration of Art B. Wong, M.D., paragraph 9.

As lay entities may not have direct or indirect control over medical matters, they may not lawfully share in profits from a medical practice. Business & Professions Code §§650, 2400.

(3)

Meriten is a Wholly Owned Subsidiary of a Hospital System, Catholic Healthcare West.

Declaration of B. Joshua Rubin, Exhibit "A" Recitals.

Meriten is not a licensed physician or professional medical corporation in compliance with the Moscone-Knox Professional Corporations Act. *See* Corporations Code §§13400 et seq. As such, it enjoys no rights or privileges under the Medical Practice Act and may not directly or indirectly control the practice of medicine. Business & Professions Code §2400.

(4)

Even Though CHW Purchased Only the "Non-clinical" Assets of EPMG, CHW Payments to EPMG Shareholders Are Subject to Reduction in the Event the Medical Group's Revenue Falls below "Shortfall Targets" or When the Group's Actual "Encounters per Hour" Decrease More than Fifteen (15%) Percent of What They Were Prior to CHW's Purchase of EPMG's "Non-clinical" Assets.

Declaration of Art B. Wong, M.D., paragraph 11.

Determining how many patients a physician must see in a given period of time, or how many hours a physician must work, is a medical decision which may only be made by a physician. *See, Medical Board of California's Perspective to Provide Guidance on the Prohibition Against the Corporate Practice of Medicine,* attached as Exhibit "A" to the Declaration of Frank Lee. *See also* authorities cited below. Reducing a physician's installment payment for the sale of "non-clinical" assets because less patients are seen in effect unlawfully grants lay entity control over this issue.

(5)

Even Though CHW Purchased Only EPMG's "Non-clinical" Assets, EPMG Shareholders Were Required to Enter into Non-competition Agreements with Meriten Prohibiting These Physicians from Engaging in "Emergency-related Services," Including Professional Medical Services.

Declaration of Art B. Wong, M.D., paragraph 13.

As they are a restraint on trade and the ability to provide services, non-competition clauses are generally unenforceable in California. Business & Professions Code §16600. While there is an exception to that rule for shareholders who sold their

"shares," *see* Business & Professions Code §16601, the shareholders here purportedly sold only the "non-clinical assets," not their ability to practice medicine. Thus, the restrictive covenant here is not only unenforceable, but yet another structural way in which the arrangement as a whole seeks to "control" the practice of medicine.

(6)

Meriten's Management Services Agreement with EPMG Specifically Authorizes Meriten to Engage in Medical Activities As It:

(a)

Enables Meriten to share in the net profits of EPMG, *see* Wong Declaration, Exhibit "A," Section 4;

(b)

Requires That Meriten, Not the Physicians, Provide or Arrange for All Medical Supplies, Medication, and Medical Equipment, *see* Wong Declaration, Exhibit "A," paragraph 1.3;

(c)

Provides Meriten with Veto Power over All Contract Negotiations with Third Party Payors, *see* Wong Declaration, Exhibit "A," paragraph 1.7; and

(d)

Provides Meriten with the Authority to Engage in All Billing Services for All Billable Medical Services, *see* Wong Declaration, Exhibit "A," paragraph 1.8.

Again, the sharing of net profits with a lay entity is illegal. Business & Professions Code §§650, 2400. Further, by law, physicians must be responsible for determining what medical equipment/supplies should be purchased, and under what circumstances they should enter into contracts with third party payors. *See* Exhibit "A" attached to the Declaration of Frank Lee. *See also* Business & Professions Code §2400. Finally, while a lay entity may perform billing activities on behalf of physicians, at least the federal government has expressed concern that management companies that perform these services on a percentage basis are at increased risk in engaging in abusive billing practices in order to maximize revenue. *See* Advisory Opinion of the United States Department of Health and Human Services Office of the Inspector General, Opinion No. 98-4, April 15, 1998.

(7)

The Agreement Binds EPMG to Thirty (30) Years of Management Control by Meriten, Restricts EPMG's Right to Terminate the Contract to Narrow Circumstances, and Leaves EPMG with No Ability to Terminate the Contract Without Cause.

Declaration of B. Joshua Rubin, M.D., Exhibit "A," section 6.

Because of the public policy supporting the practical need and opportunity to change employers, in the employment context, personal service agreements for more than a seven year period are illegal. Labor Code §2855. In a health care context, a lengthy contractual obligation between a practice management organization and physician group presumes to empower the lay party to the contract with control. *See*

"Application of FASB (Financial Accounting Standards Board) Statement No. 94, and APB Opinion No. 16 to Physician Practice Management Entities and Certain Other Entities with Contractual Management Arrangements," Emerging Issues Task Force Abstracts, Issue No. 97-2. This control is exacerbated by the fact that Meriten is entitled to net revenue (profit) under the agreement making it at least difficult, is not impossible, for EPMG to contract with other hospitals. See Declaration of Art B. Wong, M.D., paragraph 8. It is further exacerbated by the fact that Meriten's parent company, Catholic Healthcare West, has broad discretion in determining whether to award or continue exclusive contracts to EPMG to provide emergency physician services in the emergency departments of its hospitals. *See, e.g.,* Major et al. v. Memorial Hospital (1999) 71 Cal.App.4th 1380, 84 Cal.Rptr.2d 510. Because this management services agreement involves hospital-based physicians, who by definition can only practice in hospitals and a hospital-controlled MSO, this arrangement raises an additional concern. CHW now has a direct financial interest in having the emergency departments in its hospitals staffed by EPMG physicians, rather than by emergency physicians who do not contract with Meriten. The potential that such a financial interest will improperly influence CHW's future exclusive contracting decisions should not be countenanced.

These structural factors, particularly when taken together, appear to give Meriten (Catholic Healthcare West) inappropriate control over the practice of medicine. While we recognize that there are many aspects of the arrangement in question which are protective of physician autonomy, CMA is concerned that the arrangement as a whole is injurious to the public welfare. Quality of care, not corporate growth, must come first. Quality of care depends on vigorous and strict enforcement of laws protecting against unlawful intrusions into the practice of medicine.

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III. CALIFORNIA'S LAW UNEQUIVOCALLY PROTECTS PHYSICIAN MEDICAL DECISIONMAKING FROM EXPLOITATION IN THE COMMERCIAL MARKETPLACE.

Recognizing the potential for improper invasions into the physician-patient relationship and the need for deference to the physician's professional judgment, the California courts and Legislature have protected physicians from the pressures of the commercial marketplace for many years.

Both federal and California law reflect the strong public policy that business agreements between physicians and lay entities should be closely scrutinized to ensure that the arrangement does not result in corporate abuse-that is, either lay entities exercising medical control or otherwise engaging in unlawful kickback schemes designed to produce income as a result of referring, and in the case of federal Medicare and Medi-Cal law, recommending or arranging, for the purchase of medical services. *See* Business & Professions Code §§650, 2400; 42 U.S.C. §1320a-7b. Both the corporate practice of medicine doctrine and the state and federal fee-splitting prohibitions reflect the fundamental recognition that any agreement between physicians and lay entities should (1) protect the physician's freedom of

action, (2) ensure that payments to the lay entity are commensurate with the expenses incurred by that entity in connection with the furnishing of services to the medical entity, and (3) be limited to issues which do not concern, directly or indirectly, medical decision-making. Agreements which fail to meet these requirements are injurious to the public welfare, and as such, illegal.

A.

California's Corporate Practice of Medicine Bar.

California law prohibits lay individuals, organizations, and corporations from practicing medicine. (Business & Professions Code §§2052 and 2400.) This prohibition generally prohibits lay entities from hiring or employing physicians or other health care practitioners, or from otherwise interfering with a physician or other health care practitioner's practice of medicine. It also prohibits most lay individuals, organizations, and corporations from engaging in the business of providing health care services indirectly by contracting with health care professionals to render such services. As they are not controlled by lay people, the corporate practice ban does not apply to physician partnerships or professional medical corporations. (*See, e.g.,* Corporations Code §§13400 et seq.)

The proscription against the corporate practice of medicine provides a fundamental protection against the potential that the provision of medical care and treatment will be subject to commercial exploitation. As the Attorney General's office has repeatedly noted, the reasons underlying this proscription are two-fold:

> [F]irst, that the presence of a corporate entity is incongruous in the workings of a professional regulatory licensing scheme which is based on *personal* qualification, responsibility and sanction, and second that the interposition of a lay commercial entity between the professional and his/her patients would give rise to divided loyalties on the part of the professional and would destroy the professional relationship into which it was cast.

See 65 Ops.Cal.Atty.Gen. 223, 225 (1982).

The corporate practice bar ensures that those who make decisions which affect, generally or indirectly, the provisions of medical services (1) understand the quality of care implications of those decisions; (2) have a professional ethical obligation to place the patient's interest foremost; and (3) are subject to the full panoply of the enforcement powers of the Medical Board of California, the state agency charged with the administration of the Medical Practice Act.[1]

No dispute exists that these goals remain valid today, particularly given the increasing lay interference in medical decisionmaking in today's increasingly competitive and cost conscious health delivery system. The consensus is that "changes in the marketplace are raising legitimate concerns about whether control over clinical care are being usurped by non-physicians or lay entities." *See* "PATIENT CARE AND PROFESSIONAL RESPONSIBILITY: Impact of the Corporate Practice of Medicine Doctrine and Related Laws and Regulations," NHLA/AAHA 1997. In fact, the heavy and escalating commercialization of the health care market necessitates robust enforcement of an ever-stronger corporate practice of medicine bar.

The courts, Attorney General's office, and Medical Board of California have been strong defenders of the corporate practice bar and have interpreted it broadly, consistent with its protective purposes to encompass "business" and "administrative" decisions which have medical implications. In Marik v. Superior Court (1987) 191 Cal.App.3d 1136; 236 Cal.Rptr. 751, for example, the Court recognized that it is difficult if not impossible in the health care area to isolate "purely business" decisions from those affecting the quality of care. Notably, in holding that a provisional director of a medical corporation was required either to be a physician or other qualified licensed person, the Marik court recognized the interrelated nature of these concerns and correctly observed:

> For example, the prospective purchase of a piece of radiological equipment could be implicated by business considerations (cost, gross billings to be generated, space and employee needs), medical considerations (type of equipment needed, scope of practice, skilled levels required by operators of the equipment, medical ethics) or an amalgam of factors emanating from both business and medical areas. The interfacing of these variables may also require medical training, experience, and judgment.

Marik, *supra*, fn. 4 at 1140.

The Court in California Association of Dispensing Opticians v. Pearle Vision Center, Inc. (1983) 143 Cal.App.3d 419, 191 Cal.Rptr. 762 was even more solicitous of the bar. In that case, the Court held that the controls exercised by the franchiser over the business aspects of optometry practice were in violation of the state's corporate practice doctrine. The provisions in the franchise agreement which were cited in reaching this conclusion were (i) control over office location and specifications, (ii) control over inventory and supplies, (iii) required use of the corporation's name and business and advertising, (iv) required submission to periodic reports, and (v) payment to the corporation of a percentage of gross revenue. The Court stated that by exerting these types of control over licensed professionals, the corporation itself was engaging in the profession and was in violation of the corporate practice laws. Similarly, the Attorney General's office found it difficult in the health care arena to isolate "purely business" decisions from those affecting quality of care. In 65 Ops.Cal.Atty.Gen. 366 (1982), the Attorney General looked at the legality of an optometric franchise. In the case before it, the franchisee was required to use the business, accounting and marketing systems of the franchiser and, with respect to medical issues, only use ophthalmologic materials that would be obtained through the franchiser or his approved suppliers. The franchiser's interest in the optometrist's provision of services was substantial, since he was to share in the "gross profit" generated as part of the franchise fee.[2] The Attorney General concluded that this type of fee-sharing arrangement violated the corporate practice of medicine bar. As was stated in the opinion:

> Under such an arrangement, there can be no doubt that the franchisor would have a substantial interest in, and control over, the business side as well as the professional side, of the franchisee-optometrist's practice. Indeed, even if limited to the former aspects, such exercise of control of the business side of an optometric practice would be tantamount to effective control of its professional side; as our Supreme Court has stated, '[t]he law does not presume to divide the practice...into [clinical and business] departments. Either one may extend the domain of the other in respects that would make such a division impractical, if not impossible.' (Painless Parker v. Board of Dental Examiners (1932) 216 Cal. 285, 296.) Without question then, the control over the optometrist's practice given the franchisor by the franchise agreement would see the franchisor engage in the "practice of optometry" and thus require him to be registered pursuant to section 3040." *Id.* at 368.

Finally, the Medical Board of California will not tolerate arrangements between lay entities and physicians which vest the former with responsibilities concerning the medical aspects of the practice. As can be seen in the legal opinion of the Department of Consumer Affairs, dated November 19, 1985 (a true and correct copy of which is attached to the Declaration of Astrid Meghrigian), a clause in a contract which expressly stated that the lay entity would not interfere with the professional judgment of physicians would not "cure" the other aspects of the contract authorizing the lay entity to engage in the practice of medicine by, for example, providing the medical equipment, stipulating the location and hours the physicians will perform services and sharing in the revenue.

B.

Laws Prohibiting "Kickbacks" to Lay Entities

The offering or acceptance of anything of value for the referral, and in the case of federal Medicare law, the arranging or recommending, of patients by physicians and others is prohibited. *See* 42 U.S.C. §1320a-7b, Business & Professions Code §650, Insurance Code §750, Labor Code §325. These laws, more commonly known as "antikickback," "fraud and abuse" or "fee-splitting" statutes, reflect the Legislature's recognition that payments made or accepted in return for the referral of patients could result in actual or threatened patient harm, overutilization, and increased health care costs, and therefore should be forbidden. These law apply to **all** goods and services. Liability may be imposed under either statute (all payors) or federal law (Medicare and Medi-Cal) whenever a physician receives or pays **any consideration from any source for any services as a result of the referral (or recommendation or arranging) to any person or entity.**

To comply with these laws, the courts and the regulators insist that any financial agreement between physicians and others must be directly related to the fair market value of the services, or at least, commensurate to the expenses incurred. Thus, for example, California's all-payor fee-splitting prohibition, Business & Professions Code §650, provides in part that "any payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue

or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of services furnished or the fair rental value of any premises or equipment leased or provided by the recipient to the payor."[3] See also, for example, 42 C.F.R. §1001.952 (providing safe harbor protection for, among other things, personal services and management contracts where the compensation is set at fair market value without considering referrals or business generated).

Net, as opposed to gross, revenue-sharing agreements are by definition based on profit, and thus not necessarily commensurate with expenses incurred. For this reason, they are illegal under Business & Professions Code §650 just as they are illegal under the corporate practice doctrine. A 1972 California Attorney General's opinion discussed an agreement between a medical director of an electroencephalography department and a hospital pursuant to which the hospital was paid a percentage of the physician's *net* income. In that opinion the Attorney General stated that a hospital's payment to a physician is legal to the extent that the payment reasonably approximates the true rental value of space being rented and any services provided by the hospital to the physician. However, the payments would constitute fee-splitting in violation of Business & Professions Code §650 to the extent that the payments exceeded the actual value of services rendered by the hospital. The Attorney General contrasted payment based on a percentage of net revenue, with payment paid on a percentage of gross revenue, with the latter being considered generally legal where the portion of fees received by the hospital is commensurate with its expenses for the cost of services rendered. However, this is not the case under a percentage of net arrangement. As the Attorney General states,

> There is nothing whatsoever in such an arrangement which would indicate the portion of fees received by the hospital would be commensurate with its own expenses incurred in connection with the furnishing of diagnostic facilities. On the contrary, the hospital's receipts are directly proportionate to the physician's profit factor, bearing no necessary relationship to its expenses. Such a plan constitutes in effect a partnership or joint venture and plainly violates the proscription against unearned rebates. (*See* 55 Ops.Cal.Atty.Gen. 103 (1972).)

Some have suggested that the antikickback laws do not come into play in some arrangements because the lay entity has no contact with the patient and therefore is not making a "referral." This notion is incorrect. Courts have condemned financial sharing agreements even where patients are not being solicited directly. For example, in Mason v. Hosta (1984) 152 Cal.App.3d 980, 199 Cal.Rptr. 859, a California court reviewed a contract entered into by a defendant physician with a lay hospital administrator, under which the administrator was to contact fellow administrators in order to persuade them to contract for emergency services with the defendant physician. The physician paid the administrator $250 per month for each client referred by the administrator. Further, the contract provided for renegotiation of the referral fees to be paid to the administrator based upon increases in **net**

receipts to the physician pursuant to these hospital contracts. Under these facts, the court found that the arrangement violated California's fee-splitting statute.

Federal law is even tougher than California law on this issue. In its comments to the safe harbor regulations, the DHHS Office of the Inspector General ("OIG") expressly refused to provide safe harbor protection to any percentage agreements between entities in a position to refer Medicare or Medicaid business, as these arrangements are "directly tied to the volume of business or amount of revenue generated" and these "contracts have been rife with abuse." 56 Fed.Reg. 35952 (July 29, 1991) Thus, the OIG stated that it would examine these arrangements on a case-by-case basis and determine whether the nature of relationship, if any, between the overall volume of use and referrals triggers the statute. According to the OIG, if the entity receiving the percentage revenue is not in a position to make referrals, the agreement would not violate the anti-kickback statute.

In OIG Advisory Opinion 98-4, dated April 15, 1998, the OIG repeated its long standing concern that percentage billing arrangements could increase the risk of upcoding and similar abusive practices. In this situation, a family practice physician requested guidance from the OIG concerning a proposed arrangement whereby a management company would provide the physician's clinic with all operating services such as accounting, billing and direct marketing. Also, the management company would set up provider networks to which the physician's practice would be required to refer its patient. In return for the management company's services, the physician would pay the management company, among other things, a percentage of its monthly revenues.

The OIG characterized the proposed medical management company arrangement as "problematic" since the proposed arrangement may include financial incentives that increase the risk of abusive billing practices. Put another way, since the management company would receive a percentage of the physician's revenue and arrange for the physician's billing, the management company would have an incentive to maximize the physician's revenue.[4]

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IV.

ASPECTS OF THE ARRANGEMENT AT ISSUE MAY IMPAIR INDEPENDENT PHYSICIAN MEDICAL DECISIONMAKING.

Viewed in the context of these fundamentally important laws protecting the provision of medical care in this state, serious and substantial concerns are raised by the arrangement at issue.

A.

By Their Very Nature, Arrangements Between Hospitals and Hospital-Based Physicians Raise Concerns Regarding Physician Autonomy in the Practice of Medicine.

Because most physicians depend on access to hospitals to treat their patients, California law has long recognized the power hospitals have over physicians. *See, e.g.,* Anton v. Board of Directors of San Antonio Community Hospital (1977) 19 Cal.3d 802, 140 Cal.Rptr. 442. That power is even greater over hospital-based physicians; these physicians cannot practice at all unless they have hospital

privileges. To compound the concern, most hospital-based specialists operate pursuant to "exclusive contracts," that is, an agreement between the hospital and the medical group that only the medical group will have the exclusive right to practice that hospital-based speciality in that hospital. While there are undoubtedly times when exclusive contracts are justified by patient care exigencies, the potential for abuse is apparent.

The federal government has recognized this problem. For example, on October 21, 1991 the Office of Inspector General issued a Final Management Advisory Report (MAR) on financial arrangements between hospitals and hospital-based physicians that may violate the Medicare and Medicaid anti-kickback statute. These arrangements were essentially an extortion with respect to physicians as they (a) required physicians to pay more than market value for services provided by the hospital or (b) compensated physicians less than the fair market value of goods and services that they provided to the hospitals.

The OIG concluded that contracts which require hospital-based physicians to split portions of their income with hospitals are suspect, although not *per se* violations of the statute. The report then listed a number of examples of contractual provisions which "appear to violate the statute," including where:

- A hospital provides no, or token, reimbursement to pathologists for Part A services in return for the opportunity to perform and bill for Part B services at that hospital.
- Radiologists must pay 50 percent of their gross receipts to a facility's endowment fund.
- Thirty-three percent of all profits above a set amount must be paid by a radiology group to a hospital for its capital improvements, equipment, and other departmental expenditures.
- A radiologist group was required to purchase radiology equipment and agreed to donate the equipment to the hospital at the termination of the contract. The hospital has an unrestricted right to terminate the contract at any time.
- When net collections for a radiology group exceed $230,000, 50 percent is paid to the hospital, and the hospital reserves the right to unilaterally adjust the distributions if it determines that the physician group has not fulfilled the terms of the contract.
- A radiologist group pays 25 percent of the profits exceeding $120,000 to the hospital for capital improvements. Fifty percent of the profits exceeding $180,000 go to this purpose.
- A radiology group pays for facilities, services, supplies, personnel, utilities, maintenance, and billing services furnished by the hospital on a fee schedule that begins at $25,000 for 1989, and rises to $100,000 by 1993. Payments are due only if the radiologist's gross revenue exceeded $1,000,000 in the previous year.

The OIG went on to state that whether a contract provision actually violates the fraud and abuse laws will require "an entire review of the contract and the relationship between the parties," and that "agreements which require physicians to

turn over a percent of their income over a threshold amount, may approximate the fair market value of the services the hospital provides," thus not raising fraud and abuse concerns.
Finally, the OIG pointed to the following problems created by illegal kickbacks between hospital-based physicians and hospitals:

- Hospitals may award the exclusive contract based on improper financial considerations instead of on traditional considerations centering on the professional qualifications of the physician.
- The kickback gives hospitals a financial incentive to develop policies and practices which encourage greater utilization of the services of hospital-based physicians payable under Medicare Part B.
- Hospital-based physicians faced with lowered incomes may be encouraged to do more procedures in order to offset the payments to hospitals.
- Illegal arrangements may also complicate the development and updating of physician fee schedules. Physician practice costs could be artificially inflated by hospitals and physicians that enter into arrangements not based on fair market values.

A true and correct copy of the October 21, 1991 Financial Management Advisory Report is attached to the Declaration of Astrid Meghrigian as Exhibit "C."
More recently, the OIG recognized the control hospitals can have over physicians in the context of joint ventures. In an OIG Advisory Opinion, 97-5,[5] the OIG recognized that "like any kickback scheme, these arrangements can lead to overutilization of such [Medicare] services, increased costs for federal health care programs, **corruption of professional judgment**, and unfair competition." (Emphasis added.)
While CMA does not suggest that every arrangement between a physician and hospital is illegal per se, we note that the concerns are heightened in the context of an exclusive contracting arrangement. These contracts provide that physicians who enter into them are the only physicians authorized to provide the contracted for services in the hospital. *See* Liang, M.D., Ph.D., J.D, Bryan A., "An Overview and Analysis of Challenges to Medical Exclusive Contracts," 18 J. Legal Med. I (1997). Thus, in order to practice at that hospital, a physician must be authorized to perform services on behalf of the group that holds the exclusive contract.
Evaluating the propriety of an exclusive contract requires a careful balance of the impact the contract will have on a number of matters, including the quality of care, the accessibility of care, the maintenance of existing physician relationships, and the property interest of physicians in maintaining staff privileges at their hospital. Because of the potential for harm, exclusive contracts are justified only when they are necessary to safeguard the quality of care and protect the interests of patients, and when less drastic alternatives will not suffice.
With increased emphasis on controlling health care costs, however, CMA is concerned that hospitals enter into exclusive contracts for economic efficiency, as opposed to quality of care reasons. In fact, the use of exclusive contracts has increased "along with the current trend toward managed care." *See* Borkon, Peter E. "Exclusive Contracts: Are Constructively Terminated Incumbent Physicians Entitled to

a Fair Hearing?" 17 J. Legal Med. 143-168 (1996). Explaining the concerns of entering into contracts for efficiency reasons, Dr. Liang reasoned:

> The possible result of this trend is to 'lean toward the mean' (or less), that is, physician performance may move progressively toward bare competence rather than high quality. Excellence would not be considered an incentive in these contractual arrangements because, theoretically, physicians with the lowest cost (the lowest bid) would win the contract and perform at a minimal acceptable level in an effort to maximize their profits. Exclusive contracts can also be seen as a form of economic credentialing. (Footnote omitted.) Further disadvantages include physician discontent and insecurity in maintaining a consistent practice, lack of continuity of care, and lack of patient choice or physician or termination of an existing physician-patient relationship and service areas covered by the exclusive contract.

18 J. Legal Med. -1-3.

Exclusive contracts can, therefore, if inappropriately structured, represent a hallmark of improper lay control over a physician's practice. For that reason, the courts will only uphold exclusive contracts on corporate practice of medicine grounds, where (1) the physician's contract does not impair the physician's freedom of action and (2) the compensation received by the lay entity is commensurate with the expenses incurred by the entity in furnishing the services. *See* Blank v. Palo Alto Stanford Hospital (1965) 234 Cal.App.2d 377, 44 Cal.Rptr. 572. However if, as here, the lay entity receives a share of net income, rather than gross income, and the lay entity retains a substantial influence over a physician's practice, the Blank formula no longer applies and the agreement is unlawful. *See also* 55 Ops.Cal.Atty.Gen. 103 (1972) (agreement between medical director of electroencephalography department and hospital constitutes the unlawful practice of medicine).

The fact that CHW created a wholly owned subsidiary, Meriten, to manage the "business" side of EPMG does not cure the problem. Meriten is not licensed to practice under the Medical Practice Act, nor is it a professional medical corporation exempt pursuant to the provisions of the Medical Practice Act. *See* Business & Professions Code §2402.

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B.

In Many Respects, The Arrangement at Issue Expressly Affects Medical Decisionmaking.

In support of its position, Defendants place considerable reliance upon CMA's "The Corporate Practice of Medicine Bar Decisionmaking Authority for Integrated Entities Criteria." At the outset, CMA would like to note that this criteria is not directly relevant to agreements between physicians and lay practice management organizations. These types of arrangements do not deal with "integrated" entities, as

the criteria expressly states.[6] Even as such, the arrangement at issue violates the CMA criteria in many respects.

1.

Lay Entities May Not Share Profits with Medical Practices.

As has been discussed at length above, both corporate practice of medicine and fraud and abuse laws are violated where contracts call for payment on the basis of a percentage of net income. By definition, the value of net income depends upon physician practice economics, not the value of services provided. *See* 55 Ops.Cal.Atty.Gen. 103 (1972); *see also* California Association of Dispensing Opticians v. Perle Vision Centers, *supra; see also* Exhibit "A" to the Declaration of Astrid G. Meghrigian. Profits are not commensurate with the lay entity's expenses incurred in connection with the furnishing of "administrative" services and thus are illegal.[7] The problem would appear particularly acute in this case where 100% of the profit from the physicians' services has been transferred to the lay entity. *See* Declaration of Art B. Wong.

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2.

Lay Entities May Not Have Control over How Many Patients Are Seen by a Physician Group

In at least two respects, the arrangement as a whole provides lay entities with incentives for EPMG to maximize the number of patients seen. First, CHW payments to EPMG shareholders are subject to reduction in the event the medical group's revenue falls below "shortfall targets" or when the group's actual "encounters per hour" decrease more than 15% of what they were prior to CHW's purchase of EPMG's "non-clinical assets." *See* Declaration of Art B. Wong., M.D., paragraph 11. Second, by enabling Meriten to share in the net profits of EPMG, Meriten has an economic interest in a bottom line, including how many patients the physicians in the group see. Put another way, the more patients the physicians see, the more revenue the group derives, and the more profit Meriten realizes. This type of control is unlawful. *See* CMA Decisionmaking Authority for Integrated Entities Criteria, designating "how many patients should be seen" as a physician decision; *see also* 55 Ops.Cal.Atty.Gen. 103 (1972) (agreement with hospital and physician requiring physician, among other things, to be present in a hospital during such hours as the hospital deems necessary and proper and requiring physicians to be responsible for furnishing to members of the medical staff consultation on patients treated by the Department as may be required unlawful). *See* also Exhibit A to the Declaration of Frank Lee, "Medical Board Perspective" (stating only a licensed physician may determine "how many patients a physician must see in a given period of time or how many hours a physician must work").

3.

Lay Entities May Not Have Control Medical Equipment or Supplies to Be Used by Physicians.

Notwithstanding attestations to the contrary, the MSO agreement unequivocally requires that Meriten, not the physicians, provide or arrange for all medical supplies,

medication and medical equipment. See Declaration of Art B. Wong, M.D., Exhibit "A," paragraph 1.3. The purchase of medical equipment is undisputably a medical decision. *See* Marik v. Superior Court, *supra*, California Association of Dispensing Opticians, Inc., *supra; see also* "Medical Board's Perspective" attached to the Declaration of Frank Lee as Exhibit "A," (providing that "approval of the selection of medical equipment for the medical practice" must be made by the physician.)

4.

Lay Entities May Not Have Veto Power over a Physician's Contract with Third Party Payors.

Pursuant to the agreement, Meriten is able to negotiate third party contracts on behalf of EPMG. While there may be mutually agreed upon "parameters," Meriten nonetheless retains the power to agree or not agree upon a particular contract with a third party payor. *See* Declaration of Art B. Wong., M.D., Exhibit "A," paragraph 1.7. There is no question that where a lay entity sets a physician's fees, or has any control over the receipt and collection of such fees, it is practicing medicine in violation of Business & Professions Code §2400. *See, for example,* 55 Ops.Cal.Atty.Gen. 103 (1972) (an agreement between a physician and a hospital constituted the unlawful practice of medicine where, among other things, the physician neither set his own fees nor had any control over the receipt and collection of such fees). *See also* Exhibit "A" attached to the Declaration of Frank Lee "Medical Board Perspective," (providing that "parameters under which physician will enter into contractual relationships with third party payors" must be made by a physician, and not an unlicensed person or entity).

C.

Lengthy Contractual Periods, Particularly When Coupled with Non-competition Clauses, Impairs a Physician's Freedom of Action.

Contrary to the representation of Defendants, structural limitations on a physician's ability to practice medicine, such as covenants not to compete, and thirty year terms in a management agreement, have absolutely everything to do with the corporate practice of medicine doctrine. Covenants not to compete, as well as lengthy contractual terms, bind physicians to the lay entity and leave them with virtually no freedom of action to pursue their profession in the event a physician finds it is no longer acceptable to practice medicine under the contract. For this reason, Business & Professions Code §16600 expressly declares void "every contract by which anyone is restrained in engaging in a lawful profession." While there is an exception to that rule for persons who sell their shares in a particular corporation, that exception is not applicable here because all that was purportedly sold by EPMG was its "non-clinical assets." *See* Business & Professions Code §16601. Thus, because the non-competition agreement applies to the provision of medical services, not solely business support services, that exception is inapplicable.

Further, in this particular case, not only are former EPMG shareholder precluded from pursuing their profession outside of the EPMG context, but they are bound to Meriten for a thirty year term. This length of time in the context of this arrangement as a whole is inappropriate.

California's legislature has recognized the personal nature of a personal services contract, such as a management service contract, and has provided that an employment contract to render personal services may not be enforced against an employee for more than a seven year period. *See* Labor Code §2855.
Noting the public policy considerations supporting this provision, the Court in DeHaviland v. Warner Bros. Pictures, Inc. (1944) 67 Cal.App.2d 225, reasoned as follows:

> There are innumerable reasons why a change of employment may be to their advantage. Considerations relating to age or health, to the rearing and schooling of children, new economic conditions and social surroundings may all call for a change. As one grows more experienced and skillful there should be a reasonable opportunity to move upward and to employ his abilities to the best advantage and for the highest obtainable compensation. (Footnote omitted.) Legislation which is enacted with the object of promoting the welfare of large classes of workers whose personal services constitute their means of livelihood and which is calculated to confer direct or indirect benefits upon the people as a whole must be presumed to have been enacted for a public reason and as an expression of public policy in the field to which the legislation relates.

Id. at 325.
While in this particular case, the agreement between EPMG and Meriten is not an employment contract, all of the considerations discussed in the DeHaviland case hold true here. Medical services, by their very nature, are performed by individual people. Physicians should have the same opportunity as employees to make changes when circumstances warrant. Particularly given the fact that the MSO has no real performance standards against which Meriten can be judged and terminated for cause, let alone a termination without cause provision, EPMG, by binding itself to a thirty year term, has no real or practical ability to obtain management services from other management organizations that provide superior services at reduced prices. Additionally, in the health care context, one of the specific reasons that lay practice management organizations contract with physicians for a lengthy period of time is precisely to control the physician group. The length of the contract term has been expressly addressed as a control issue. For example, practice management corporations hoping to go public sought to treat all revenue from patient services as revenue of the management with payments to the physicians treated as an expense. These corporations favored using accounting methods that consolidated physician practices to their own and thus enhance their appearance in terms of size and strength. However, physician practice management corporations could not take advantage of consolidated accounting under the securities laws where state prohibitions against corporate practice of medicine prevented the company from owning an interest in the physician practices. To accommodate these problems, the Emerging Issues Task Force (EITF) of the Financial Accounting Standard Board (FASB) issued a consensus opinion in March of 1998, concluding that the

consolidation rules may be applied even where the management firm does not own a majority voting interest in the medical practice. *See* "Application of FASB Statement No. 94 and APB Opinion No. 16 to Physician Practice Management Entities and Certain Other Entities with Contractual Management Arrangements" EITF Abstracts, Issue No. 97-2. *See* Exhibit "E" to the Declaration of Astrid G. Meghrigian. The Task Force determined that the controlling financial interest may be established by contractual management agreements that meet a number of specific criteria, including the fact that:

> The contract between the physician practice management corporation and the physician practice must have a term that covers either the entire remaining life of the physician practice entity or a period of at least ten years and,
>
> The contract must restrict the physician practices' right to terminate to narrow circumstances.

It is precisely this type of control that Meriten has achieved here. Thus, the length of the term is absolutely critical when determining whether or not a contractual arrangement inappropriately violates the laws protecting against commercial exploitation of the practice of medicine.

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V.

CONCLUSION

The concerns which gave rise to the longstanding prescription against the corporate practice of medicine apply with even greater urgency at the present time. There have been profound changes in financing of both government and private health care delivery systems in the past few years.

Particularly given the increasing cost consciousness throughout California's health delivery system, it is crucial that those involved, directly or indirectly, in the delivery of professional medical services, be licensed as a physician and surgeon and have a thorough understanding of medical practice and the implications of "business decisions" for quality patient care.

DATE:

Respectfully submitted,

CATHERINE I. HANSON
ASTRID G. MEGHRIGIAN

By:

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Astrid G. Meghrigian
Attorneys for *Amici Curiae*
California Medical Association, American Academy of Emergency Medicine and the California State Chapter of the American Academy of Emergency Medicine

1. The strength of California's policy against permitting lay persons to practice medicine or to exercise control, directly or indirectly, over medical practice cannot be questioned. (See, for example, Business & Professions Code §§2052, 2400, 2408, 2409, 2410; Corporations Code §§13400 *et seq*.; Parker v. Board of Dental Examiners (1932) 216 Cal. 285, rehg. den. September 28, 1932 (lay persons may not serve as directors of professional corporations); Pacific Employers Ins. Co. v. Carpenter (1935) 10 Cal.App.2d 592, 594-596 (holding that for-profit corporation may not engage in business of providing medical services and stating that "professions are not open to commercial exploitation as it is said to be against public policy to permit a 'middle-man' to intervene for a profit in establishing a professional relationship between members of said professions and the members of the public"); Benjamin Franklin Life Assurance Co. v. Mitchell (1936) 14 Cal.App.2d 654, 657 (same); People v. Pacific Health Corp. (1938) 12 Cal.2d 156, 158-159 (same); Complete Service Bureau v. San Diego Medical Society (1954) 43 Cal.2d 201, 211 (non-profit corporations may secure low cost medical services for their members only if they do not interfere with the medical practice of the associated physician); California Physicians Service v. Garrison (1946) 28 Cal.2d 790 (same); Blank v. Palo Alto-Stanford Hospital Center (1965) 234 Cal.App.2d 377, 390, 44 Cal.Rptr. 572 (non-profit hospital may contract with radiologist only if the hospital does not interfere with the radiologists' practice of medicine); Letsch v. Northern San Diego County Hospital District (1966) 246 Cal.App.2d 673, 677, 55 Cal.Rptr. 118 (district hospital may contract with radiologists under restriction imposed in Blank above); California Association of Dispensing Opticians v. Pearle Vision Center, Inc. (1983) 143 Cal.App.3d 419, 427, 191 Cal.Rptr. 762, 767 (Pearle Vision Center, Inc.'s franchise program violates California's prohibition against the corporate practice of medicine); Conrad v. Medical Board of California (1996) 48 Cal.App.4th 1038, 55 Cal.Rptr.2d 901 (review den.)(hospital districts may not employ physicians); 65 Ops.Cal.Atty.Gen. (1982) (general business corporation may not lawfully engage licensed physicians to treat employees even though physicians act as independent contractors and not as employees); 63 Ops.Cal.Atty.Gen. 729, 732 (1980) (for-profit corporation may not engage in the practice of medicine directly nor may it hire physicians to perform professional services); 57 Ops.Cal.Atty.Gen. 213, 234 (1974) (only professional corporations are authorized to practice medicine); 55 Ops.Cal.Atty.Gen. 103 (1972) (hospital may not control the practice of medicine).)

2. Although the opinion uses the term "gross," and not "net," it is likely that what was being referred to was the IRS definition of gross profit, which is the net amount realized from sales, minus the cost of goods. IRS Regs. §1.61-3.

3. Significantly, Business & Professions Code §650 was amended to expressly provide that compensation based on a percentage of gross revenue or similar arrangement is not necessarily unlawful. This change in the law was sought to modify a California Court of Appeals decision, Beck v. American Health Group International (1989) 211 Cal.App.3d 1555, 260 Cal.Rptr. 237, in which a psychiatrist, who served as a medical director for a hospital's psychiatric service, was to be compensated for his duties at ten percent of the monthly room and board charges for all psychiatric admissions. The Beck case ruled that the legislature intended any percentage compensation

formula to violate Section 650 because such a formula would necessarily result in an increase in compensation to the physician by his or her own referral of patients. As amended, the law makes it clear that a percentage formula may be used in appropriate circumstances.

4. A true and correct copy of OIG Advisory Opinion 98-4 is attached to the Declaration of Astrid Meghrigian as Exhibit "B."

5. A true and correct copy of this Opinion is attached to the Declaration of Astrid G. Meghrigian as Exhibit "D."

6. As can be seen by Exhibit "B" to the Declaration of Frank Lee, the document is expressly restricted to integrated entities which are defined as "an entity where there has been a consolidation of practicing physicians and lay businesses into health delivery systems."

7. Further, a physician's freedom of action is further limited in profit sharing arrangements with lay entities since competing entities would be loath to contract with the physician since it would be difficult to allow its competitor "profit" from its own contract. See Declaration of Art B. Wong, M.D., paragraph 8. Why would a hospital that competes with CHW contract with EPMG when it knows that CHW's subsidiary would garner 100% of the profit of the physicians' services provided in the competing hospital's ER?