Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 242 (Wood) – As Introduced January 13, 2023

SUBJECT: Critical access hospitals: employment.

SUMMARY: Deletes the prohibition on the corporate practice of medicine (CPM) for federally certified critical access hospitals (CAHs) and the reporting requirements related to CAHs employing physicians.

EXISTING LAW:

1) Establishes an exemption, until January 1, 2024, from the prohibition on the CPM in order to allow federally certified CAHs to employ physicians and charge for those services. [Business and Professions Code (BPC) § 2401]

2) Prohibits, within the Medical Practice Act, corporations and other artificial legal entities from having any professional rights, privileges, or powers. Gives the Medical Board of California (MBC), discretion, to grant approval of the employment of physicians on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered to patients is made by any such institution, foundation, or clinic. This is known as the ban on the CPM. [BPC § 2400]

3) Establishes certain exemptions from the ban on the CPM, including the following:

    a) Clinics and hospitals operated primarily for the purpose of medical education by a public or private nonprofit university medical school, are permitted to charge for professional services rendered to teaching patients by licensed physicians who hold academic appointments on the faculty of the university, if the charges are approved by the physician in whose name the charges are made;
    b) Certain nonprofit clinics organized and operated exclusively for scientific and charitable purposes, that have been conducting research since before 1982, and that meet other specified requirements, are permitted to employ physicians and charge for professional services, but are prohibited from interfering with or directing a physician's professional judgment;
    c) A narcotic treatment program regulated by the Department of Alcohol and Drug Programs is permitted to employ physicians and charge for professional services rendered by those physicians, but is prohibited from interfering with or directing a physician's professional judgment;
    d) A hospital that is owned and operated by a licensed charitable organization that offers only pediatric subspecialty care, and that employed physicians prior to January 1, 2013, is permitted to charge for professional services, under certain specified conditions; and, [BPC § 2401]
    e) Establishes in case law, an exemption from the ban on the CPM for county hospitals to employ physicians. [*Wickline v. State of California* (192 Cal. App. 3d 1630)]

4) Permits, under the Knox-Keene Health Care Service Plan Act of 1975, licensed health plans to employ or contract with health care professionals, including physicians, to deliver professional services, and requires health plans to demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management. Provides in regulation that the organization of a health plan must include separation of medical services from fiscal and administrative management. (HSC § 1340 *et seq.*]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, while he is sympathetic to the concerns about interference with the clinical judgment of any health care provider, the ban on the CPM is not necessarily the best or only tool to assure physician autonomy in clinical decision-making. The number of exceptions allowed, combined with the growth of medical groups, independent practice associations and medical foundations, all represent the larger medical communities' response to pressures within the delivery system to reduce costs, improve patient outcomes and increase access. The author states that the private practice of medicine is a valuable component in our communities and should be preserved but preserving it to the exclusion of other modes of practice seems shortsighted. If younger physicians prefer or are comfortable in an employment setting, California should not limit it as an option for them. By doing so, California law may also be inadvertently limiting access in rural communities when it may not be financially viable to maintain a private practice. Rural hospitals struggle with many health care challenges, particularly as they relate to workforce and financial payer mix, which tends to be disproportionately Medi-Cal and Medicare. The author concludes that this bill provides an additional tool to rural, CAHs by providing them some workforce flexibility.

2) **BACKGROUND.**

   a) **Health Professional Shortage Areas (HPSAs)**. Of the more than 7,200 federally designated HPSAs, which is defined as a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services), three out of five are in rural regions. According to the National Rural Health Association, more than 25% of the U.S. population lives in rural areas, yet less than 10% of the country's physicians practice there. This could be because of the many obstacles they face in a rural setting, including a lack of access to resources and medical technology, the absence of a defined work schedule, a lower salary than their urban counterparts and the challenges of owning and operating a financially viable sole private practice in smaller communities.

   b) **Physician employment preferences**. A 2020 American Medical Association survey found that fewer physicians are opting to own and operate a private practice, with more seeking a career as an employee of a hospital or larger medical group. The survey also noted that many recent graduates of medical schools have significant debt and are more likely to choose employment, which offers financial stability and better work-life balance**.**

c) CAHs. CAHs are licensed general acute care hospitals that are certified to receive cost-based reimbursement from Medicare, which is intended to reduce hospital closures in rural areas. To be certified as a CAH, a hospital can have no more than 25 beds and must be located in a rural area and: i) more than 35 miles from another hospital; or, ii) 15 miles from another hospital in mountainous terrain or an area with only secondary roads. Other requirements include operating an emergency department, and having an annual average length of stay of 96 hours or less per patient.

d) California Research Bureau (CRB) reports. In 2007, the CRB published a report examining the status of the ban on the CPM, and it argued that exemptions had created a doctrine whose "power and meaning are now inconsistent." The CRB also raised the idea that the many exemptions to the ban may "signal a change in public opinion." The CRB report notes that although the CPM doctrine is generally not believed to be extremely detrimental, its present utility seems limited, as the evolution and erosion of the CPM prohibition over many decades has resulted in a doctrine that is far removed from its origin and lacks coherence and relevance in today's health care landscape. Because the policy concerns that the CPM prohibition was meant to address are still important and have been raised in other contexts, California's statutes and regulations now address these concerns more directly. The existence of these more focused safeguards, and the ability to enact others if needed, raise the question of whether maintaining the CPM doctrine still makes sense.

On April 12, 2016, the CRB released a new report, "The Corporate Practice of Medicine in a Changing Healthcare Environment," which reviewed the status of the ban in California and key policy issues associated with it, one of them being the effect of the ban on rural areas.

As the 2016 CRB report notes, attempting to address the rural healthcare gap, SB 376 (Chesbro), Chapter 411, Statutes of 2003, established a pilot project to allow qualified hospital districts to directly employ physicians. The pilot allowed each hospital district to hire two physicians, for a total of 20 physicians throughout the state. To qualify for the pilot project, a hospital district was required to have: been in a county with population of 750,000 or less; reported net losses in 2000-01; and, had at least 50% of combined patient days from Medicare, Medi-Cal, and uninsured patients.

SB 376 was sponsored by the Association of California Healthcare Districts, which argued that authorizing the employment of physicians could improve the ability of district hospitals to attract the physicians required to meet the needs of the communities and ensure the continued survival of district hospitals. Proponents hoped direct employment would provide the kind of economic security that might encourage physicians to choose a rural community, just as the State of California is able to offer when it directly hires physicians and staffs its rural prisons.

During the pilot project, five participating hospital districts recruited and hired six physicians, whose employment contract periods ran three to four years. The MBC sent letters to participating physicians, participating administrators, and also administrators in nonparticipating hospital districts to get their views on the project. All six participating physicians were positive about the employment experience. Responding administrators acknowledged it would have been more difficult to recruit the physicians without the

employment opportunity, and expressed support of the project. Responding nonparticipating administrators also generally supported the project as a means of recruiting physicians into rural areas. The MBC, in its assessment, stated there was not enough evidence to draw conclusions about the effectiveness of the program, but believed there might be justification to extend the pilot so a comprehensive analysis could be made. The MBC also noted that, "[f]rom the responses received to the Board's queries about the pilot, there seems to be a universal belief that many physicians hesitate settling in California, especially rural areas of the state, because of the disincentive created by the laws governing the corporate practice of medicine – most physicians in California work as contractors, not employees."

e) **AB 2024 (Wood), Chapter 496, Statutes of 2016.** The provisions of SB 376 expired in 2011. AB 2024 established an exemption, until January 1, 2024, from the prohibition on CPM in order to allow federally certified CAHs to employ physicians and charge for those services. According to the Department of Health Care Access and Information (HCAI), of the 36 CAHs in California, half have hired physicians between 2017 and 2023, as follows:

Hospital Name	Total Physician Hires from 2017-23
Adventist Health Clearlake (St. Helena Hospital)	0
Adventist Health Mendocino Coast (Mendocino Coast District Hospital)	0
Adventist Health Howard Memorial (Willits Hospital)	1
Adventist Health Tehachapi Valley	0
Bear Valley Healthcare System	0
Banner Hospital	0
Catalina Island Medical Center	1
Colorado River Medical Center	0
Eastern Plumas District Hospital	2
Fairchild Medical Center	0
Glenn Medical Center	1
Hazel Hawkins Memorial Hospital	0
Healdsburg Hospital (North Sonoma Healthcare)	10
Jerold Phelps Community Hospital	0
John C. Fremont Healthcare District	0
Kern Valley Hospital District	0
Mammoth Hospital	0
Mark Twain St. Joseph's Hospital	16
Mayers Memorial Hospital	3
Mercy Medical Center, Mt. Shasta	4
Modoc Medical Center	4
Northern Inyo Hospital	0
Ojai Valley Community Hospital (Community Memorial Health System)	2
Orchard Hospital	5
Plumas District Hospital	0
Redwood Memorial Hospital	0
Ridgecrest Regional Hospital	6

San Bernardino Mountains Community Hospital District	1
Santa Ynez Valley Cottage Hospital	3
Seneca Healthcare District	0
Southern Inyo Healthcare District	0
Surprise Valley Community Hospital	0
Sutter Lakeside Hospital	6
Tahoe Forest Hospital District	54
Trinity Hospital (Formally Mountain Communities)	2
George L. Mee Memorial Hospital	2
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3) **SUPPORT.** The California Hospital Association (CHA) supports this bill and states that, California continues to face serious challenges meeting the physician needs of its population, particularly in primary care. This challenge is even more pronounced in parts of the state known as HPSAs, which is defined as a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services. CHA notes that it is estimated that 28% of California's population lives in an HPSA and concludes, with this in mind, the CHA strongly supports this bill.

   The Association of California Healthcare Districts (ACHD) supports this bill and states that there are 33 district hospitals in the state of California, 17 of which have critical access designation. Since the enactment of the pilot program under AB 2024, several of these hospitals have successfully used this tool to recruit and retain physicians to underserved areas of the state. Those that have not yet utilized this ability have long awaited its permanency to ensure they would not lose valuable providers once they were employed. ACHD notes that California is facing a severe workforce shortage, of both primary and specialty care providers. The ability to employ physicians allow CAHs to offer benefits and guaranteed salaries, making serving these areas more financially attractive. ACHD concludes that it is essential to closing provider gaps, ensuring Californians continue to receive care in rural and remote communities.

   Tahoe Forest Hospital District supports this bill and states that since the enactment of AB 2024, CAHs, including Tahoe Forest Hospital have benefited greatly from the direct hire of primary care and specialty physicians, and this bill will ensure access to high-quality health care is equitable at Tahoe Forest Hospital and hospitals across the state.

4) **OPPOSE UNLESS AMENDED.** The California Medical Association (CMA) is opposed to this bill unless it is amended. CMA notes that in 2016, the author's bill, AB 2024, established the pilot program and required a report to be created by HCAI to determine the usage and efficacy of the program and its impact on patient care. That report is due in July 2023. CMA states that until HCAI publishes its report regarding the impact the program has had on patient care, they would request that the sunset on the program be extended for five years and not made permanent.

5) **PREVIOUS LEGISLATION.**

   a) AB 2024 established an exemption, until January 1, 2024, from the prohibition on the CPM in order to allow federally certified critical access hospitals to employ physicians

and charge for those services.

b) SB 1274 (Wolk), Chapter 793, Statutes of 2012, permits a hospital that is owned and operated by a charitable organization and offers only pediatric subspecialty care to begin billing health carriers for physician services rendered, notwithstanding the prohibition in the CPM if specified conditions are met.

c) AB 824 (Chesbro) of 2012 would have established a pilot project to permit certain rural hospitals to directly employ physicians and surgeons. AB 824 was never heard in Assembly Health Committee.

d) AB 648 (Chesbro) of 2009 would have established a demonstration project to permit rural hospitals, as defined, whose service area includes a medically underserved or federally designated shortage area and which meet certain specified requirements, to directly employ physicians and surgeons. AB 648 failed passage in the Senate Business, Professions and Economic Development Committee.

e) AB 646 (Swanson) of 2009 would have permitted health care districts and certain public hospitals, independent community nonprofit hospitals, and clinics, as specified, to directly employ physicians and surgeons. AB 646 failed passage in the Senate Business, Professions and Economic Development Committee.

f) SB 726 (Ashburn) of 2009 would have revised and extended the MBC pilot project that allows qualified district hospitals, as defined, to employ a physician, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician. SB 726 failed passage in the Senate Business, Professions and Economic Development Committee.

g) AB 1944 (Swanson) of 2008 would have allowed health care districts to employ a physician. AB 1944 failed passage in the Senate Committee on Health.

h) SB 1294 (Ducheny) of 2008 would have expanded the pilot project enabling health care districts to directly employ physicians. SB 1294 failed passage in the Assembly Appropriations Committee.

i) SB 376 authorized, until January 1, 2011, a hospital owned and operated by a health care district meeting specified criteria to employ a physician, and to charge for professional services rendered by the physician if the physician approves the charges.

REGISTERED SUPPORT / OPPOSITION:

Support

Adventist Health
Association of California Healthcare Districts; the
Avalon Medical Development Corporation
Banner Lassen Medical Center
California Hospital Association
Cottage Health

Dignity Health
District Hospital Leadership Forum
Fairchild Medical Center
Kern Valley Healthcare District
Mee Memorial Healthcare System
Mountain Communities Healthcare District
Providence
Rural County Representatives of California (RCRC)
Sohum Health
Tahoe Forest Hospital District

Opposition

None on file.

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