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The Corporate Practice of Medicine in a Changing Healthcare Environment

April 2016

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TABLE OF CONTENTS

EXECUTIVE SUMMARY **1**

THE CORPORATE PRACTICE OF MEDICINE BAN IN CALIFORNIA **2**

BACKGROUND 2
INITIAL IMPACT OF THE BAN ON HEALTHCARE 3
CALIFORNIA PHYSICIANS 3
EXEMPTIONS TO THE BAN 4
HOW CONSISTENT ARE CALIFORNIA'S EXEMPTIONS? 7
CALIFORNIA IN CONTEXT: EXEMPTIONS TO THE EMPLOYMENT BAN IN OTHER STATES 10

NON-PHYSICIAN MEDICAL PROFESSIONALS AND THE CORPORATE PRACTICE OF MEDICINE **11**

ADVANCED PRACTICE REGISTERED NURSES 11
OPTICAL MEDICINE 12

HEALTHCARE INTEGRATION AND THE CORPORATE PRACTICE OF MEDICINE **14**

HOSPITAL-PHYSICIAN ALIGNMENT STRATEGIES 14
ACCOUNTABLE CARE ORGANIZATIONS: FROM ALIGNMENT TO INTEGRATION 16
RETAIL MEDICINE AND THE CORPORATE PRACTICE OF MEDICINE 17
MEDI-SPAS AND THE CORPORATE PRACTICE OF MEDICINE 18

PREVENTING CONFLICT OF INTEREST IN PATIENT PROTECTION – BEYOND THE CORPORATE PRACTICE OF MEDICINE **19**

CONSUMER PROTECTION: ENSURING THE BEST INTEREST OF THE PATIENT 20
CURRENT RESEARCH: CONFLICT OF INTEREST WITHIN THE HEALTHCARE SYSTEM 20
OWNERSHIP, EMPLOYMENT AND AUTONOMY 21

POLICY OPTIONS **23**

APPENDIX A: CORPORATE PRACTICE OF MEDICINE BAN AND DISTRICT HOSPITALS **26**

ENDNOTES **28**

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Requested by

The Senate Committee on Business, Professions and Economic Development

Acknowledgements

The authors wish to thank the agencies and organizations that gave their time to provide information for this report: the Office of the Attorney General, the Association of California Hospital Districts, the California Association of Physician Groups, the California HealthCare Foundation, the California Hospital Association, the California Medical Association, the California Optometric Association, Covered California, the Kern County District Attorney's Office, the Medical Board of California, the University of California, Irvine and the University of California, San Francisco.

Recommended Citation:
Martin, Pamela and Neville, Anne. "The Corporate Practice of Medicine in a Changing Healthcare Environment." California Research Bureau, Apr. 2016.

ISBN 1-58703-271-6

Executive Summary

The ban on the corporate practice of medicine has historically prevented corporations from practicing medicine, which includes the employment of physicians. From the late 1920s, California courts have staunchly protected the right of physicians to practice without being subject to potential interference by corporate employers. Since that time, California has created a number of exemptions to the ban on the corporate practice of medicine. Where exemptions do not exist, physicians and hospitals work together without creating employment relationships.

In 2007, when the California Research Bureau published a report examining the status of the ban, it argued that exemptions had created a doctrine whose "power and meaning are now inconsistent." It also raised the idea that the many exemptions to the ban may "signal a change in public opinion." As a result of these findings, the Research Bureau provided several policy options for the legislature to consider. These focused on clarifying which organizations were exempt and also on increasing the number of exemptions. The report also included an option to eliminate the ban entirely, provided some employment safeguards were in place. This paper reviews the current status of the ban in California and key policy issues associated with it.

Since 2007, the provision of healthcare has undergone changes in California. The Affordable Care Act is responsible for an increase in insured patients across the state. In 2016-2017, 13.5 million Californians are expected to have enrolled in Medi-Cal, up from 7.9 million in 2012-2013, and 1.5 million people will be enrolled in Covered California at the end of 2015-2016. As a result, more insured patients than ever are accessing healthcare services without a commensurate increase in healthcare practitioners. California has also made changes to the way optometrists and opticians work together. The legislature has begun to consider increasing the autonomy of nurse-midwives and nurse practitioners, leading to questions about whether they would be subject to the corporate ban. Policymakers hope that innovations such as Accountable Care Organizations will increase consumer health outcomes and efficiencies. In addition, retail clinics and medi-spas, which were relatively new in 2007, have expanded significantly across California and the United States.

The first Research Bureau paper on this topic included four policy options:

- Determine which organizations are subject to the corporate practice of medicine ban;
- Determine hospital employment permissibility;
- Expand retail clinics; and
- Eliminate the ban.

This paper reviews these options and suggests additional options for policymakers to consider:

- Assess changing financial incentives;
- Consider whether other methods of protecting physician autonomy are sufficient;
- Increase patient access to data about physician-hospital relationships and hospital metrics;
- Determine whether the current alignment strategies used by physicians and hospitals are more costly than direct employment models; and
- Collect additional data to better understand the impact of the ban.

The Corporate Practice of Medicine Ban in California

Background

The corporate practice of medicine ban has historically prevented a corporation from practicing medicine, which includes the employment of physicians. The ban has been enshrined in California law since the early twentieth century in order to prevent the "conflict between the professional standards and obligations" of medical professionals "and the profit motive of the corporate employer."[1] The policy underlying the corporate practice of medicine ban can be traced to the distinction between professions and occupations. Professions are unique in their "social contract with the state … the promise of providing complex and esoteric scientifically-supported knowledge to clients in exchange for state protections. Professions are legally protected against competitors…. In return, professionals should put their clients' interests above their own financial and bureaucratic interests."[2]

California's ban on the corporate practice of medicine was well established by 1928, but the clearest policy rationale was not established until 1932. That year, the state Supreme Court heard the case of Painless Parker. Born Edgar Randolph Parker, he was a licensed dentist and consummate marketer who had legally changed his first name to "Painless." His dental corporation hired dentists and opened practices across the United States and Canada. In considering Parker's commercial dental enterprise, the court argued that "the underlying theory upon which the whole system of dental is framed is that the state's licensee shall possess consciousness, learning, skill and good moral character, all of which are individual characteristics, and none of which is an attribute of an artificial entity."[3] Over 65 years later, another court put it even more clearly: "The rationale behind the doctrine is that a corporation cannot be licensed to practice medicine because only a human being can sustain the education, training, and character-screening which are prerequisites to receiving a professional license."[4]

The California Research Bureau's 2007 report on this topic focused on the history of the corporate practice of medicine ban and its relevance to current healthcare practices.[5] At the request of the Assembly Committee on Health, it looked at these issues through the lens of hospital employment of physicians in California. The report explored the idea that exceptions to the ban created at the state and federal levels could be interpreted as a shift in how society viewed the risks associated with physician employment by non-physicians. While the Research Bureau agreed that the policy rationale for the ban was still relevant, it also put forward the idea that the ban had been "eroded" by the number of exemptions placed in law. As a result, the Research Bureau deliberated whether the corporate practice of medicine ban was still necessary, particularly as it related to employment.

This updated report examines the status of the ban in California and in other states. It discusses the different entities that are exempted from the ban and the changes to the healthcare system since the Research Bureau last examined the subject. While continuing to focus most on physicians, this report also covers other medical professions and their relationship to the corporate bar. In addition, the report reviews research that examines the influences on physician behavior in the modern healthcare environment.

Initial Impact of the Ban on Healthcare

As states banned the corporate practice of medicine, the initial practical impact was to create distance between the person holding a professional license, such as a physician or dentist, and the corporate entity, thus reducing the ability of the corporation to control or coerce the licensee. For example, the ban eliminated clear conflicts that one railroad surgeon discussed in 1903. "We must bear in mind that as railway surgeons we occupy a different position toward the patients we are called upon to treat in that capacity from the one we assume in private practice. We owe a duty to the corporation that employs us as well as the patient...."[6]

Employment, both direct and contract, of doctors by corporations also caused serious issues for employees. Workers objected to these arrangements for the same reason described by the railroad surgeon above: it created a divided loyalty between the needs of the doctor's employer and that of his employees. Direct and contract employment of doctors also eliminated choice for the employee. The combined effect of these two issues was limited trust by employees of doctors affiliated with their employer. The evidence for this distrust was clear in a federal report from 1947. It demonstrated that mining companies were employing doctors based on friendships and financial arrangements and not professional expertise. This resulted in "minimal public health and sanitary facilities in mining areas and inordinately high rates of infant mortality." Company doctors also approved workers' compensation claims in only 21 percent of cases, compared to 89 percent by non-company doctors. Once the miners' union took control of healthcare through a medical fund to which the employees and mine owners contributed, it "brought about a dramatic change in miners' health and medical care." One reason for this was that the fund could "refuse payment to private doctors whom its staff physicians judged to be incompetent or excessive in their charges."[7] This new structure supported physician autonomy and, to some extent, an ability to self-regulate by doctors. The fund was also a form of insurance, which by itself introduced a new set of incentives into the market, particularly over-hospitalization and an increase in cost for medical services.[8]

California physicians

Today, over 100,000 licensed physicians and more than 71,000 active physicians practice medicine in California.[9] The California Research Bureau found that no agency tabulates the exact number of physicians working within each type of healthcare organization. However, in 2015, the University of California, San Francisco completed a survey of physicians who are in active practice in California, have completed training and provide patient care at least 20 hours per week. The results of the survey indicate a quarter of California's physicians (25.1 percent) operate solo practices. Nearly half (49.9 percent) indicate they work in group practices ranging from small partnerships (defined as partnerships of 2 to 9 physicians) to large group practices employing 50 or more. (Table 1)

Table 1. Active California Physicians by Practice Type

Practice Type	Percentage	Confidence Interval
Solo Practice	25.1%	23.0% to 27.1%
Small Partnership (2 to 9 physicians)	19.4%	17.4% to 21.4%
Mid-sized Group Practice (10 to 49 physicians)	13.0%	11.2% to 14.7%
Large Group Practice including academia (50 or more physicians)	17.5%	15.6% to 19.4%
Kaiser Permanente	13.5%	11.7% to 15.3%
Community or public clinic	5.0%	3.9% to 6.2%
VA or military	1.7%	1.1% to 2.4%
Other	3.2%	2.4% to 4.1%
Unknown/Not reported	1.5%	0.9% to 2.1%

Source: Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco, 2015. N = 1,884. Estimates are weighted to reflect the age and gender of the population of patient care physicians in California and their distribution across regions. There is a 95% confidence interval indicating that, for example, the percentage of California physicians in small partnerships (2 to 9 physicians) is between 17.4% and 21.4%.

Exemptions to the Ban

The extent and history of bans on the corporate practice of medicine have varied by state. At one time nearly all states had laws or court decisions that banned the practice, and up until the 1950s, the corporate practice of medicine ban continued to gain strength in most states.[10] However, this changed as some courts began to coalesce around the legitimacy of certain exemptions, particularly in nonprofit hospital settings. In fact, as the Research Bureau's 2007 report stated, "many courts found that employment of physicians at not-for-profit hospitals was not illegal CPM, but rather an independent contractor arrangement as long as hospitals did not attempt to control medical policy."[11]

California maintains one of the most comprehensive bans in the country. Nonetheless, the ban now looks different than it did in the middle of the twentieth century. Beginning in 1968, the state introduced a number of exceptions to the ban in response to specific policy needs, court decisions or federal requirements.

Professional Corporations

Corporations Code, Section 13400-13410

With the passage of the Moscone-Knox Professional Corporation Act in 1968, California allowed physicians, dentists and lawyers to create professional corporations. California adopted this law to meet Internal Revenue Service requirements for professional corporations.[12] The Moscone-Knox Act specifically allowed physicians to create professional medical corporations, for-profit enterprises within which physicians and other licensed professionals could serve as shareholders, officers, directors, or professional employees. Professional corporations must, in general, be engaged in rendering professional services in a single profession. For example, physicians and lawyers cannot serve as shareholders, officers, directors, or professional employees of each other's corporations. However, the Moscone-Knox Act exempted medical professions.

Today, as a result of additions to the Moscone-Knox Act, license holders in a variety of other health professions can also serve as shareholders, officers, directors, or employees of professional medical corporations. These include: podiatrists, psychologists, nurses, optometrists, marriage and family counselors, clinical social workers, physician assistants,

chiropractors, acupuncturists, naturopathic doctors, professional clinical counselors and physical therapists. Corporations Code, Section 13400-13410 specifies that physicians and surgeons can also serve in these capacities in other professional healthcare corporations, including corporations of the following types: podiatric, psychological, nursing, marriage and family therapist, clinical social worker, physician assistants, optometric, chiropractic, acupuncture, naturopathic doctors, dental, professional clinical counselor and physical therapy. While California enacted most of these exemptions between 1970 and 1980, the most recent change came in 2013 when physical therapy professional corporations were created and physical therapists were granted the explicit authority to serve as shareholders, officers, director or professional employees of professional medical corporations. Unlike discussions surrounding previous changes to Moscone-Knox, the legislative record for AB 1000 (Wieckowski, Chapter 620, Statutes of 2013) demonstrates the legislature's clear intent to allow physical therapists to serve as professional employees of a medical corporation, regardless of whether they were also serving as shareholders, officers or directors.[13]

Clinics and Hospitals Operated for the Purpose of Medical Education

Business & Professions Code, Section 2401(a)

Initially codified in 1980, an appellate court's decision in 2000 further clarified that medical schools are not subject to the corporate ban even if they are in competition with nonexempt organizations. In the court's decision, it agreed with the university that "every patient is potentially a teaching case, notwithstanding that some patients may not be seen by an intern, resident or other trainee." Additionally, "to provide a full range of medical problems and procedures for the training of its interns, residents and other students, it must admit a large and diverse patient population." The court stated that "concerns about for-profit corporations have nothing to do with non-profit teaching hospitals."[14] Today, approximately 6,000 physicians are employed through academic appointments across the five University of California campus health systems and California's three private medical schools.

Nonprofit Community Clinics

Health & Safety Code, Section 1204(a)

A "community clinic" is a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained by donations, grants, and government funds. Charges to a patient are based on a sliding scale, based on a patient's ability to pay. The California HealthCare Foundation notes that community clinics have been variously referred to in statute as primary care clinics and charitable clinics.[15] Community clinics currently employ approximately 1,839 full-time physicians.[16]

County Hospitals

Though not delineated in statute, county hospitals may also employ physicians. In 1996, the Superior Court of Ventura County in *Community Memorial Hospital of San Buena Ventura v. County of Ventura* (1996), citing a 1936 estate case, stated that "laws prohibiting the corporate practice of law or medicine do not apply to counties."[17] The California Medical Association has also concluded that counties are exempt from the ban on the corporate practice of medicine, citing "the broad 'police powers' granted to them."[18] There are 12 county-owned hospital systems in California. The Research Bureau was unable to gather a definitive number of employed physicians because each county has its own classification system for their employed and contracted physicians.

State Agencies

Government Code, Section 18500

The State of California has the authority to create a state civil service, including healthcare

professionals. For example, the California Department of Corrections and Rehabilitation employs physicians, surgeons, psychiatrists, and dentists, among other types of medical professionals. As of December 2015, there were 534 physicians and surgeons, 631 psychiatrists and 284 dentists employed by the state.[19]

Nonprofit Research Clinics

Business & Professions Code, Section 2401(b)
Health & Safety Code, Section 1206(p)

Nonprofit research clinics are licensed by the California Department of Public Health. These clinics conduct research in such areas as prostatic cancer and cardiovascular disease, and provide healthcare services to patients only in conjunction with the research being conducted. Clinics may employ physicians and charge for their professional services. However, the law states that a clinic "shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law." The Research Bureau was unable to determine the number of physicians employed by nonprofit research clinics.

Narcotic Treatment Programs

Business & Professions Code, Section 2401(c)
Health & Safety Code, Section 11839, et seq.

Narcotic treatment programs, which are operated under Section 11876 of the Health & Safety Code and regulated by the Department of Health Care Services, may employ physicians and charge for professional services rendered. Health & Safety Code, Section 11839.5 requires all narcotic treatment programs to be licensed in order to use narcotic replacement therapy. The Legislature included language in the enabling legislation prohibiting treatment programs from interfering with or controlling the judgment of employed physicians. Narcotic treatment programs currently employ 108 physicians throughout the state.[20]

Specialty Pediatric Hospitals

Business & Professions Code, Section 2401(e)

Specialty pediatric hospitals are owned and operated by a licensed charitable organization that offers only pediatric subspecialty care. As noted above, charitable institutions may employ physicians. Business & Professions Code, Section 2401(e), added to statute in 2012, allows specialty pediatric hospitals to charge for professional services rendered to patients. The hospitals must accept every patient in need of services, regardless of ability to pay. There are eight hospitals in this category. The Research Bureau confirmed with three of the eight hospitals that they do not hire physicians, but instead contract with physician groups. It was unable to attain employment data for the other five hospitals.

Health Maintenance Organizations (HMOs)

42 U.S.C., Section 300e
Health & Safety Code, Section 1340, et seq.

HMOs have been exempt from California's ban on physician employment since Congress required the state to do so when it enacted the Health Maintenance Organization Act of 1973. The purpose of the HMO Act was to reduce healthcare costs by increasing managed care. As the Research Bureau's 2007 report describes, California's Knox-Keene Act addressed the concerns of the corporate practice of medicine ban directly while allowing employment and contract relationships between physicians and HMOs. There are three types of HMO models: staff, group, and independent practice association. The only model that directly employs physicians is the staff model, and there are few, if any, HMOs of this type today in California.[21][22] While many think of Kaiser Permanente as a staff model, it is actually a group model, defined as when one physician group "provides, on an exclusive basis, virtually all of the care for plan members in an area."[23] Independent practice associations, also known as IPAs, are different from the staff or group models in that they are made up of "private

physicians in their own offices." These physicians "belong to an association for contracting purposes," and the association negotiates reimbursements on their behalf with managed care organizations or other insurers.[24] Independent practice associations vary in size. For example, as of 2013, Hill Physicians counted 3,800 physicians and Sutter Independent Physicians' IPA included 548 members.[25]

Certain Charitable Institutions, Foundations, or Clinics

Business & Professions Code, Section 2400
16 California Code of Regulation, Section 1340

California law allows a particular exemption from its declaration that corporations have no professional rights, privileges, or powers. Business & Professions Code, Section 2400 states:

> … the Division of Licensing [of the medical Board of California] may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.

In its regulations (16 California Code of Regulations, Section 1340), the Medical Board of California permits any licensed charitable institution, foundation or clinic to employ physicians and surgeons so long as it does not charge for professional medical services. In such a case, the physician or surgeon would directly bill the patient or the insurance company. To date, the Medical Board has made no exemptions under this section.[26]

How Consistent are California's Exemptions?

Excluding professional medical corporations, the organizations covered under the exceptions are either nonprofit or government organizations. The exceptions are not based solely on nonprofit or government status, however, and certain nonprofit and government organizations are not exempted. For example, both nonprofit hospitals and hospitals owned by healthcare districts are subject to the ban. Conversely, medical school health systems, which sometimes compete with nonprofit and for-profit hospitals, are not subject to the ban. Below, we review three types of organizations, two that are not exempt (nonprofit hospitals and hospital districts) and one that is (medical school health systems).

Nonprofit Hospitals

It could be argued that the nonprofit status of these hospitals eliminates profit-seeking motives that could lead to the need to protect physicians. Over the last decade, there has been considerable debate as to the merit of such an argument. A 2005 study observed that, "[w]hile for-profit hospitals were only somewhat more likely than nonprofits to offer relatively profitable services, both for-profit and nonprofit hospitals were considerably more likely than government hospitals to offer relatively profitable services." The author concluded, "[a]lthough all hospitals must earn sufficient profits to operate, the evidence here suggests that for-profits are more likely to respond to profitability than the other types are when making supply decisions.… Nonprofit hospitals are often the intermediate type in terms of balancing profit seeking and serving the poor through service choices."[27] A more recent study, published by a professor at the Harvard School of Public Health, found that "[h]ospital conversion to for-profit status was associated with improvements in financial margins but not associated with differences in quality or mortality rates or with the proportion

of poor or minority patients receiving care."[28] It is important to note that, while both of these studies were rigorous, their measures ended before the implementation of the Affordable Care Act, which is changing how healthcare organizations are measuring quality.

A more recent report from a team of researchers at the University of California, San Francisco found that non- and for-profit hospitals in California between 2011 and 2013 were providing the same level of uncompensated care – 4.4 percent. (There are 263 nonprofit hospitals and 145 investor-owned hospitals in California.[29]) Uncompensated care, which is a combination of charity care and bad debt, is the traditional measure by which nonprofit tax status is evaluated. Nonprofit hospitals did provide more charity care (1.9 percent) than did for-profit hospitals (1.4 percent), but there was considerable variation among hospitals. The report found that 50 percent of nonprofit hospitals used between 0.8 percent and 2.6 percent of their operating budget for charity care, while 50 percent of for-profit hospitals used between 0.5 and 2.1 percent. No nonprofit hospital spent more than 11 percent of their operating budget on charity care, and no for-profit hospital spent more than 4.9 percent of their operating budget on charity care. There was at least one nonprofit hospital and one for-profit hospital that provided no charity care.[30]

In contrast to these figures, the 21 public healthcare systems in California, which include county owned and operated hospitals and the University of California medical centers, provide 40 percent of all care to California's uninsured population.[31] A number of factors in addition to tax status also determine a hospital's behavior, including location and insurance payment rates, which result from an institution's bargaining power.[32] This research implies that while some nonprofit hospital systems act significantly different from for-profit hospitals, nonprofit hospital systems as a group are still subject to profit-seeking behavior that could result in undue influence on a physician's medical decisions.

Medical School Health Systems

Medical school health systems, which can employ physicians, serve a wide variety of patients and so by their nature compete for patients and insurance dollars with other hospitals in an area. The University of California notes that if it "is to fulfill its public mission of providing care to underserved patients, then the reimbursement received from patients with commercial insurance is critically important in helping to subsidize the public mission."[33] The current reimbursement mix helps them do that as they "receive roughly $1.40 from commercial insurers for every $1 of expense. Medicare reimburses 90 cents for every $1 spent." The excess that they receive from commercial insurers helps to underwrite the actual costs of Medicare and university research.[34]

As the medical school health systems expand, they align with existing physician groups and in some cases employ them directly. In other cases, they use alternative methods, like contracting, to affiliate with physicians. The University of California, for example, extends some faculty employment contracts for physicians to primarily serve patients rather than conduct research or teach classes.[35] In a 2013 report, the California State Auditor found that the medical centers at the University of California, Los Angeles and the University of California, San Francisco provide millions of dollars in salary support to their faculty physicians by transferring revenues from the medical centers to other departments on their campuses. The report noted that the purposes for the monetary transfers appeared valid and complied with university policy, though the universities' financial reports lacked specificity about the reasons for the transfers.[36]

California's teaching hospitals occupy a unique position in the state, providing significant uncompensated care, teaching new physicians

and conducting medical research. This unique position can be sizeable. (In the University of California medical system, for example, the largest of the four systems had revenue of $8.6 billion in FY2014.[37]) However, simply because a teaching hospital is large does not mean that it is circumventing the principles of the ban. In fact, in the 2000 appellate court case (California Medical Association, Inc. v. Regents of University of California), the court did not find evidence that the teaching hospital was interfering with relationships between physicians and their patients.[38]

Hospital Districts

Hospital districts were created in California in 1945 "to give rural, low income areas without ready access to hospital facilities a source of tax dollars that could be used to construct and operate community hospitals and healthcare institutions, and, in medically underserved areas, to recruit physicians and support their practices."[39] There are currently 78 hospital districts located in 40 counties.[40] Though counties and the state may employ physicians, hospital districts may not.

A pilot project in place from 2003 to 2011 attempted to determine whether lifting the corporate practice of medicine ban for certain hospital districts would increase the number of physicians in rural communities. As in 2003, today there is still a shortage of physicians in California's rural counties. American Medical Association figures show that, on average, California has 80 primary care physicians and 138 specialty physicians per 100,000 residents. This is in the upper range for primary care physicians (60-80) and above the range for specialty care physicians (85-105) recommended by the Department of Health and Human Services. However, when disaggregated by region, there is a coverage disparity. California's rural regions have lower numbers of physicians than its urban areas. For instance, the San Joaquin Valley has only 45 primary care physicians and 74 specialty physicians per 100,000 residents, compared with the Bay Area's 78 primary care physicians and 155 specialists per 100,000 residents. The number of healthcare providers, including primary care physicians, in California is not anticipated to dramatically increase soon.[41]

One reason for the coverage disparity may be that physicians have a disincentive to practice in rural or remote areas, which inherently pose significant economic risks because rural areas are often economically disadvantaged. In addition, the California Hospital Association says that the foundation model, used by many other hospitals, can be hard for hospitals of 200 beds or fewer, which can be the case for "smaller community hospitals."[42]

Attempting to address the rural healthcare gap, Senate Bill 376 (Chesbro, Ch. 411, Statutes of 2003) established a pilot project to allow qualified hospital districts to directly employ physicians. The project 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 percent 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.[43] 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.[44]
The California Medical Association opposed SB 376, noting the legislation would create a broad exception to the ban against the corporate practice of medicine and arguing the ban intended to preserve the integrity of the medical decision-making process. Though the bill was written in response to "growing fiscal deficits of individual district hospitals," the Association maintained the ban is even more necessary in such situations, as it deflects economic pressure from physician-patient relationships.[45]

During the pilot project, five participating hospital districts recruited and hired six physicians, whose employment contract periods ran three to four years. The Medical Board of California 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.[46]

The Medical Board of California, 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.[47]
The Medical Board of California 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. Hospital administrators view the prohibition of the corporate practice of medicine as complicating their ability to ensure adequate staffing."[48]

Though legislators initiated a number of bills to continue the pilot project or allow hospital districts to employ physicians, none became law and the pilot expired on January 1, 2011. A summary of those bills is in Appendix A.

California in Context: Exemptions to the Employment Ban in Other States

There is considerable variation in how states approach the ban with regard to the employment of physicians. Nearly all states allow for some type of employment of physicians by certain specified government, nonprofit or corporate entities.[49] In fact, the one similarity across all states is that each allows physician employment by professional corporations or similar entities as long as physicians own the corporation.[50] However, unlike California:

- 28 states (55%) allow hospitals to employ physicians;
- 30 states (59%) allow physicians to operate a medical practice as a limited liability company; and
- 9 states (17%) allow physicians to operate a medical practice as a limited liability partnership.

Three of the five states noted in the Research Bureau's original report as maintaining the most robust laws and enforcement — California, Colorado, and Iowa — continue to do so. In the other two states — Ohio and Texas — state legislatures have made changes to the ban:[51]

- Ohio's corporate practice of medicine ban now "appears to be all but extinct."[52]
- Texas modified its ban in 2011 to allow direct employment of physicians by (1) certain rural hospitals, (2) certain

hospital districts and (3) certain counties for inmate care. Employers are required to have written policies to ensure that physician employees may exercise independent medical judgment when providing care.

It appears that a larger number of states than were noted in the 2007 report may also have robust bans on the corporate practice of medicine. For example, both Minnesota[53] and Massachusetts[54] have recently reaffirmed their bans. The idea that only five states had a particularly robust ban stemmed from a survey of hospital emergency room administrators in 1991, and the report acknowledged that even in those five states, the prohibition did not apply in all situations.[55] Today, more than half of the states clearly prohibit the corporate practice of medicine, though enforcement varies and no organization is tracking the practical application systematically.

Many states, including California, have also historically engaged in policy debates about how the corporate practice of medicine applies to dentistry. In California's 1932 *Painless Parker* case, the Supreme Court of California ruled that the law could not be interpreted as separating the "business side" of dentistry from the professional practice itself, and that by forming corporations, and employing licensed dentists, Painless Parker was unlawfully engaged in the corporate practice of dentistry.[56] Today, professional corporations in California (including dental corporations), tax-exempt charity or "free" clinics, clinics owned by a public hospital or health system, and county hospitals may employ dentists.[57] Across the country, 39 states and the District of Columbia prohibit the corporate practice of dentistry. Six states clearly permit the employment of dentists by corporations or non-licensees; one state may allow employment in clearly defined circumstances and four states have no guiding statutes or case laws, or have unclear statutory or case law guidance. In these 11 states, corporations and non-licensees that employ dentists are clearly prohibited from interfering with the professional judgment of dentists.[58]

Non-Physician Medical Professionals and the Corporate Practice of Medicine

In addition to physicians and surgeons, the state has extended or considered extending the corporate practice of medicine ban on other healthcare professions.

Advanced Practice Registered Nurses

An advanced practice registered nurse has a graduate or doctoral degree in a nursing specialty in addition to undergraduate nursing education and practice experience. They are trained and certified to assess, diagnose and manage a broad range of healthcare issues, including acute and chronic treatment. Most advanced practice registered nurses are engaged in primary care services.[59]

Nationally, there are four categories of advanced practice registered nurses: certified nurse-midwife, clinical nurse specialist, certified nurse practitioner and certified registered nurse anesthetist. These nurses, depending on state regulations, often diagnose and prescribe treatments and medications. In some states, this is under the supervision of, or in collaboration with, a physician. In other states, these nurses practice independently.[60]

Advanced practice registered nurses are certified to perform a wide variety of primary care services. Nurse practitioners may order medical equipment, place orders for medication, certify disability claims, and approve treatment for patients in home health services, under the supervision of a licensed physician or surgeon. Due to their advanced training and focus on general practice, a nurse practitioner is sometimes the only health professional to see a patient during a visit.[61] A certified nurse-midwife is a registered nurse

who is also a graduate of a nurse-midwifery program. Nurse-midwives provide primary healthcare service to women and newborns. Under the supervision of a licensed physician and surgeon, a certified nurse-midwife is authorized to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care. Services include providing basic gynecological care, ordering laboratory tests, providing immediate care of newborns, prescribing medications including birth control, and signing birth certificates.[62] Nurse anesthetists are registered nurses who administer anesthesia ordered by physicians and other healthcare specialists. A nurse anesthesia practice may include performing a comprehensive physical, developing and initiating a patient-centered plan of care, ordering and administering drugs, and providing pain management services.[63]

One approach some states are taking to meet the increased demand for healthcare services is to redefine, and often expand, the scope and standards of practice for non-physician practitioners. As of February 2013, there were 42 nurse-related scope-of-practice bills proposed across 17 states, including Alabama, Florida, Hawaii, Illinois, Indiana, Iowa, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, New York, North Dakota, Oklahoma, Oregon, and Virginia.[64] The bills did not include a prohibition against the corporate practice of medicine.[65]

In California, two bills were introduced in 2015 to expand the scope of practice and allow these medical professionals to perform their duties without physician supervision. Senate Bill 323 (Hernandez), introduced in 2015, sought to permit licensed nurse practitioners permission to practice, without being supervised by a physician and surgeon. Assembly Bill 1306 (Burke) would have granted an extended, independent scope of practice – procedures, actions, and administrative processes – to certified nurse-midwives, eliminating the need for supervision of a licensed physician or surgeon. The nurse practitioner bill did not include a corporate practice of medicine ban, but the nurse-midwife bill did – meaning that nurse-midwives would not be allowed to be employed by non-exempted corporations (such as hospitals). Both bills included language prohibiting an employer from interfering with the professional's care of a patient, and both bills would require these professionals to obtain malpractice insurance.

In the discussion around these bills, some stakeholders opposed a corporate practice of medicine ban, arguing other non-physician professionals already enjoy autonomy in their practice without being subject to the ban. Nurse anesthetists, for instance, practice independently and may be employed by corporations. In addition, no other state with expanded scope of practice laws for nurse practitioners bans hospital employment, or employment by corporations.[66] [67] Proponents of the ban argued that the expanded duties and responsibilities would be similar to those of physicians and surgeons, so nurse practitioners and nurse-midwives should be subject to the same ban.[68] [69] If the legislature expands the scope of practice for these professions, it could lead to an increase in the number of retail clinics (such as one might find in a Target or Rite-Aid) and medi-spas, both of which are primarily staffed by nurse practitioners today.

Optical Medicine

Recent court decisions and legislation have changed the way retail optical corporations can do business in California while reinforcing the ban on the corporate practice of medicine.

Retail opticians, such as Walmart, Costco, Pearle Vision and LensCrafters, have operated in California for decades. A *registered dispensing optician* is defined in Business & Professions Code, Section 2550 as an individual, corporation or firm engaged in the business of filling prescriptions for prescription lenses or related products. They fill prescriptions on

behalf of physicians licensed by the Medical Board of California, or optometrists licensed by the State Board of Optometry, and may also take facial measurements and adjust the fit of glasses.

The business model offered by these retail opticians is a "one-stop shopping" experience: customers may have eye exams in the store, conducted by an optometrist, and then have glasses made for them on site. When Pearle Vision entered the California market, they created a business model where optometrists were employed by Pearle's sister company, a health plan called VisionCare, within Pearle Vision stores. The company defended this practice as similar to the way HMOs work. In 2006, the California Supreme Court ruled unanimously against Pearle Vision and its business model, saying the Knox-Keene Act does allow optometrists to work for HMOs, but that Business & Professions Code, Section 655 prohibits opticians from entering into agreements with each other that might create a financial conflict of interest for the optometrist or constrain the physician-patient relationship.[70] [71]

In 2003, the National Association of Optometrists and Opticians, representing registered dispensing opticians such as LensCrafters and Eye Care Centers of America, sued the State of California, arguing that several sections in California law violated the dormant Commerce Clause of the constitution. The plaintiff argued that licensed optometrists were permitted to employ or contract with opticians, giving consumers a value-added one-stop shopping experience, but opticians such as LensCrafters, which also wanted to offer the one-stop experience, could not hire or align with optometrists. After a district court loss in 2006, the state appealed, and the U.S. Court of Appeals for the Ninth Circuit found for the state in 2009 and 2012. In its 2009 decision, the 9th Circuit found that the state was not discriminating against similarly situated entities, noting that opticians "are not bound by the same ethical and professional responsibilities" as optometrists and ophthalmologists.[72] The U.S. Supreme Court denied review of an appeal in 2013, upholding the Ninth Circuit's opinion.[73]

Though the constitutionality of California's law was now settled, "the law did not anticipate the myriad leasing, co-locating, and employment relationships that rose during its debated legality."[74] In addition, there was an interest in ensuring that multiple business models could operate in the state and "that consumers' interests are protected and an optometrist's clinical judgment is preserved."[75] To meet these goals, the state passed Assembly Bill 684 (Alejo, Ch. 405, Stat. of 2015).

As a result, California law (Business & Professions Code, Section 655) now permits a "direct or indirect landlord-tenant relationship with an optometrist" by "an optometrist, a registered dispensing optician, an optical company, or a health plan." The lease arrangement, however, must include certain protections for optometrists such as independence in scheduling, control over staff and fees, and ability to contract with multiple insurers. Lease payments cannot be based on the number of eye exams performed, prescriptions written, patient referrals or the promotion of a particular health plan. Statute now also includes an additional provision stating that "[t]he registered dispensing optician or optical company shall not interfere with the professional judgment of the optometrist." The allowability of a landlord-tenant relationship is new, as this relationship was previously illegal. Notably, however, the state did not change the ability of opticians to employ optometrists – they were not allowed to before AB 655, and are not able to now. (As mentioned above, however, a number of optometrists were illegally employed during the period the statute was in litigation.)

AB 684 delineated strict boundaries between an optometrist's practice and the corporation from which it leases space. The law went into effect

on January 1, 2016, and the long-term effects are not yet known, but elements of the law could be considered as a model for other business relationships in the medical industry. Retail clinics, for instance, operate under a model in which medical corporations or groups contract with retail stores. If California chose to decrease potential conflicts of interest in these retail care clinics, it could consider prescribing specific prohibitions related to business practices and autonomy protections, as the state has now done between optometrists and opticians.

Healthcare Integration and the Corporate Practice of Medicine

Hospital-Physician Alignment Strategies

As the Research Bureau noted in its 2007 report, the corporate practice of medicine ban "now most commonly refers to the employment of physicians by hospitals, but is also still used to refer to employment of physicians by for-profit and non-profit corporate entities and government." This section provides an overview of strategies that California physicians and hospitals use to align services without creating employment relationships.

Historically, hospitals relied on affiliated physicians to volunteer for emergency room shifts. In this model, hospitals allowed individual physicians to utilize a hospital's equipment and laboratories, and in exchange, the physician volunteers agreed to staff hospital emergency rooms. In this way, hospitals were "acting in ways that are beneficial to physicians, such as by acquiring new equipment, in exchange for physicians receiving hospital-admitting privileges that include implied responsibilities, such as participating in quality improvement activities and providing emergency call coverage."[76] With changes to the healthcare system over the last several decades, however, hospitals across the country are using the voluntary model in fewer numbers. Today, a number of hospitals outside California also employ physicians. In fact, "hospital employment of physicians remains one of the most frequently cited strategies for hospitals and physicians to meet the challenges of the post-health reform marketplace."[77] However, the percentage of doctors employed by hospitals is a debated statistic. The 2014 American Medical Association's annual survey put the percent of physicians at 7.2 percent,[78] but the American Hospital Association's 2012 statistics showed 17.3 percent.[79] When hospitals do not employ physicians, they do use other models to create service integration.

In California, where for-profit and most nonprofit hospitals may *not* employ physicians, hospitals align with physicians in various ways. In fact, California has a reputation as "a leader in innovative health care organizational practices."[80] Below are three examples that do not violate the employment ban but do create a relationship between a physician and a hospital.

Medical Foundations

Health & Safety Code, Section 1206(l)

One way non- and for-profit hospitals work with a group of physicians is by setting up a medical foundation that can contract directly with physicians. A medical foundation "conducts medical research and health education and provides healthcare to its patients through a group of 40 or more physicians and surgeons, who are independent contractors representing not less than 10 board-certified specialties, and not less than two-thirds of whom practice on a full-time basis at the clinic." To comply with the corporate practice of medicine ban, the foundation arranges for physician services through a professional services agreement with medical groups or with individual doctors.[81] As noted earlier, the requirements for medical foundations can prevent smaller hospitals from creating them. The California HealthCare Foundation notes, for example, that "the

complexity and costs of [establishing medical foundations] may preclude smaller, financially weaker, and rural hospitals from pursuing them, thus widening gaps between them and stronger, competing hospitals."[82] The Palo Alto Medical Foundation, Dignity Health, and First Choice Physician Partners (a foundation Tenet Healthcare created) are examples of medical foundations.

Hospital Outpatient Departments

Health & Safety Code, Section 1206(d)

Another strategy hospitals use to align with physicians is to form hospital outpatient departments. These facilities provide outpatient services and coordinate with their owner-hospitals to provide care for patients with chronic or complex conditions. Health & Safety Code, Section 1206(d) defines hospital outpatient departments as "clinics conducted, operated, or maintained as outpatient departments of hospitals." Using a professional services agreement or contract, the hospital agrees to provide infrastructure, administrative assistance and support services, while the physicians provide medical services. Physicians, not hospitals, generally bill third-party payers.[83]

A hospital outpatient department is exempt from clinic licensure laws because it is an extension of a hospital, which itself must be licensed by the Department of Public Health.[84] Because hospital outpatient departments are owned by hospitals, they are not exempt from the corporate practice of medicine ban.[85]

Hospitals Purchasing Medical Practices

Though hospitals in California may not employ physicians, they may purchase the physical assets (building, equipment, etc.) of physician practices. The non-physician entities manage the administrative and operational side of the practice while doctors continue to be responsible for medical decisions and direct billing of insurers. Many hospitals purchased physician practices in the 1990s. But the trend decreased as hospitals often found the cost of purchasing and maintaining physician practices was not offset by cost savings. Today, however, the trend is on the rise again, as hospitals seek to expand their referral networks and make their managed-care operations more flexible.[86]

Physicians who sell their medical practices to hospitals reduce their administrative burden, as the hospitals provide the support staff, supplies, equipment and general maintenance.[87] Another advantage to the physician who sells the practice to a hospital is the opportunity to take advantage of Medicare reimbursement rate differences. Medicare fee-for-service payments for non-emergency procedures can vary widely between in-office visits and hospital visits, because when Medicare determines an equitable rate of reimbursement, it factors in the higher overhead costs associated with hospitals.[88]

When Medicare reimbursements change, the result can be a shift in the number of physician practices that agree to sell to hospitals. In one example, Medicare lowered the reimbursement rate for a procedure commonly performed by cardiologists in private practice. The cardiologists received lower reimbursements for the procedure in their own offices than those who did the same procedure in a hospital setting. This is because there was an assumed overhead cost for the hospital-based cardiologists. The result was a rise in the number of cardiologists selling their practices to hospitals in order to qualify for the better reimbursement rate.[89]

In a 2013 report to Congress, the Medicare Payment Advisory Commission acknowledged this disparity in payment reimbursement rates and agreed that Medicare should carefully study the matter and possibly make changes to the reimbursement structure. But the report also cautioned that equalizing the rates is a complicated procedure. "[P]utting the principle of paying the same rate for the same service across sectors into practice can be complex

because it requires that the definition of the services and the characteristics of the beneficiaries across sectors be sufficiently similar."[90] Recent research also suggests that while the integration of physicians with hospitals could "improve communication and reduce waste," hospital-owned practices may also result in an increase in hospital prices as they increase their market share.[91]

Other Alignment Strategies

Hospitals and physicians are also using other types of alignment strategies, such as joint ventures, emergency call coverage arrangements, and the use of hospitalists (physicians whose practice emphasizes providing care to hospitalized patients). Hospitals may choose to use more than one alignment strategy, and may base their alignment strategies on their unique circumstances and on budgetary constraints.[92]

Accountable Care Organizations: From Alignment to Integration

An Accountable Care Organization is a type of clinical integration system in which a network of coordinated healthcare providers serves designated groups of patients. These organizations seek to improve service efficiency while remaining accountable to patients and third-party payers, including Medicaid or Medicare, for quality healthcare. Many organizations now use the term loosely to refer to integrated efforts among providers to improve efficiency and quality of care. For instance, an Accountable Care Organization might coordinate care across hospital affiliates, physician groups, individual doctors and specialty caregivers to reduce instances of duplicate tests and services while increasing cost-effective treatment. The Department of Health and Human Services has created three types of Accountable Care Organizations. The most integrated form is an employment model, as mentioned above.[93]

Accountable Care Organizations that succeed in reducing costs for the Medicare program may receive "shared savings" through the Medicare Shared Savings Program, which are distributed to participating entities in the network.[94] All providers, even individual physicians, may share in any cost savings as long as the Accountable Care Organization meets federal efficiency and health quality goals. To enable participation in the Shared Savings Program, the Department of Health and Human Services has issued waivers to the federal anti-kickback and Stark laws[95] for Accountable Care Organizations "formed in connection with the Shared Savings Program." The final rules for these waivers were originally published on Nov. 2, 2011, and then again, with minor changes, on Oct. 29, 2015.[96]

There are some who argue that Accountable Care Organizations are made inefficient by the corporate practice of medicine ban. In a 2011 report published by UC Berkeley Law, the authors noted that the state could write an anti-kickback waiver that would parallel the federal waiver for Accountable Care Organizations. By contrast, there was and is no federal equivalent to the state's corporate practice of medicine ban, nor has the Medicare Shared Savings Program pre-empted the ban. The authors argued that even the workarounds used by other healthcare organizations "obstruct the ability to coordinate care and achieve significant savings." For these reasons, they recommended that California should do away with the corporate practice of medicine ban, or at least exempt all Accountable Care Organizations.[97]

Despite these warnings, however, there are currently 67 Accountable Care Organizations operating in California.[98] Further, in states that have varying levels of regulation with respect to the corporate practice of medicine, Accountable Care Organizations have demonstrated initial success. For example, the Texas corporate practice of medicine doctrine prohibits corporations from employing physicians, but certain government-run

hospitals are exempt from the ban, including rural hospitals. The Memorial Hermann Accountable Care Organization in Texas, a shared savings program, operates a clinically integrated hospital-physician network consisting of 13 nonprofit hospitals and 5,500 affiliated physicians. In 2013, this Accountable Care Organization served 34,430 Medicare beneficiaries and earned shared savings of $28.3 million.[99] The State of Maine, with no corporate practice of medicine laws in statute, is home to MaineHealth Accountable Care, a shared savings program in Portland. It has an independent board, staffed through a physician-hospital association. It is working toward a single care plan across its 10 hospitals and 1,300 member physicians. In 2013, it served over 48,000 Medicare beneficiaries, earning shared savings of $9.4 million.[100] These early results from Texas and Maine indicate that it may be possible for an Accountable Care Organization operating under the ban to be as successful as one operating without it.

Retail Medicine and the Corporate Practice of Medicine

Retail clinics continue to grow as part of the primary care delivery system. As of 2015, over 2,000 retail clinics were operating across 41 states and Washington, D.C., primarily in urban areas.[101] They provided two percent of primary care visits in the United States.[102] These clinics typically offer extended hours and allow walk-in patients. Some are located within larger retail settings. Many retail clinics, including those in California, "are owned by medical groups operating under contract with the retail store in which they are located."[103] Nurse practitioners also own practices in the 17 states in which they can practice autonomously.[104]

When the Research Bureau published its first report on the corporate practice of medicine in 2007, it noted "one of the reasons cited for their [retail clinics'] limited growth in California is the strength of the CPM doctrine in this state."[105] In considering options, the report recommended that California consider "whether convenient care clinics, or retail clinics, should be encouraged to expand in California, in which case the legislature could allow corporations other than professional medical corporations to operate these clinics and employ physicians."[106] In 2010, the RAND Corporation, in a report for the federal Department of Health and Human Services, made a similar conclusion, observing that "[t]o the extent that retail clinics are owned by corporations, these [corporate practice of medicine] regulations may limit the clinics' ability to expand into certain states, or they may require changes in the business and operating practices of these organizations."[107] Implementing this change would require California to make an exception to the existing corporate practice of medicine ban.

The Research Bureau report also noted that the legislature could specify the scope and conditions of convenient care clinics.[108] Currently, retail clinics treat a variety of minor ailments and injuries. If retail clinics were to expand the scope of practice, and more types of patients could be treated, then the demand for physicians – or nurse practitioners and physician assistants – would be greater. As the legislature considers expansion of the scope of practice of nurse practitioners such that they could practice autonomously, it may wish to consider whether retail clinics should be allowed to employ nurse practitioners, and whether nurse practitioners themselves may own retail clinics.

The research about the effect of scope of practice on the growth of retail clinics is mixed and limited. One study found that there is no clear relationship. [109] Another report argues that state scope-of-practice laws "impede the development of retail clinics."[110] Recent research does, however, indicate that the scope of practice regulations are related to cost-effectiveness in retail clinics. In states in which nurse practitioners can practice autonomously, researchers found that the cost-per-episode in

retail clinics was less than in those states in which they could not do so.[111]
Similarly, research concerning retail clinics and the corporate practice of medicine doctrine is also limited. Though a number of factors influence a company's decision to open a retail clinic, including population density, licensing requirements, regulations related to the corporate practice of medicine and out-of-state ownership limitations, the Research Bureau found no research that assessed the impact of all of these variables. As of 2009, (which is the latest data publicly available), Florida had 152, while California and Texas had 84 and 85, respectively. These three populous states have very different corporate practice of medicine regulations. California and Texas do not allow general corporations to employ physicians, but Florida does. Though compelling on its face, this raw data does not consider other site selection elements. Merchant Medicine, an organization collecting market data on retail clinics, has instead suggested that "market demand play[s] a more significant role than state regulations in clinic operators' location decisions."[112]

If policymakers hope retail clinics will continue to grow and support the state's primary care needs, and the number of primary care physicians and nurse practitioners will not grow commensurately, the legislature may wish to further investigate why clinics decide to open in certain areas and not others, as well as the impact of scope of practice and corporate practice of medicine regulations on those decisions.

Medi-Spas and the Corporate Practice of Medicine

Medical spas, also called medi-spas, are businesses that offer elective cosmetic treatments such as Botox, laser hair removal and tattoo removal, usually in an office setting. Estimates suggest that revenues of the 2,100 medical spas in the United States reached $1.94 billion in 2012, and will increase to $3.6 billion by the end of this year. Average revenues per facility are $924,000 – with about 80 percent coming from procedures and 20 percent from retail product sales.[113]

In California, a nurse practitioner, registered nurse or physician assistant may perform the cosmetic procedures, including the use of lasers, prescriptions and prescriptive devices under the supervision of a physician. It is the physician's responsibility to examine the patient before delegating responsibility to another medical professional.[114] [115] [116] In 2006, in response to concerns surrounding medi-spas, in which unqualified or unsupervised staff were using lasers in cosmetic procedures, California enacted SB 1423 (Figueroa, Ch. 873, Stat. of 2006), directing the Medical Board of California and the Board of Registered Nursing to conduct a joint investigation. The two boards concluded that California needed to better enforce the current law to identify laypersons or nonmedical corporate entities acting as owners of medi-spas.[117] In 2012, as a result of AB 1548 (Carter, Ch. 140, Stat. 2012), California also increased the fines for medi-spas that violate the corporate ban.

As of 2015, three regulatory agencies (the Medical Board of California and the California Board of Registered Nursing, in consultation with the Physician Assistants Committee) are reviewing issues surrounding the use of laser devices in elective cosmetic procedures, paying particular attention to the appropriate level of physician supervision and level of training, as well as procedures to be followed.

While all professional medical corporations are for-profit, medi-spas are defined in Business & Professions Code, Section 2417.5(b) as providing "medical procedures or treatments that are performed to alter or reshape normal structures of the body solely in order to improve appearance." The for-profit nature of these corporations is not necessarily balanced by the particular healthcare needs of a patient, since all of the treatment is elective. The growth of medi-spas is limited by anti-kickback and

other rules, and the corporate practice of medicine ban prevents non-physicians from legally owning and operating a medi-spa. A limited number of physicians do act as absentee medical directors, which is allowed by law. To the extent that the procedures patients undergo at these facilities require physician-level training, medi-spa owners who flout the law jeopardize the health of patients.

Preventing Conflict of Interest in Patient Protection – Beyond the Corporate Practice of Medicine

Having discussed the status of the ban on the corporate practice of medicine in California, we turn to the question of how effective it is in meeting its goals. In *Physicians Service v. Aoki Diabetes Research Institute*, the court succinctly stated the end goal of the corporate practice of medicine ban, writing, "[it] is meant to protect patients."[118] Historically, public policy supporting the ban has been rooted in the belief that if a corporation were making medical decisions, then it would abide by the "fundamental premise in business law that corporations have a duty of loyalty to their shareholders."[119] In contrast, policymakers expected that licensed professionals would operate "above the market and pure commercialism … [and that they] have set higher standards of conduct for themselves than the minimal rules governing the marketplace … [such] that they can be judged under those standards only by each other, not by laymen."[120]

The assumption then was that the higher standards would manifest themselves in such a way that "licensed professionals … will always act independently in the best interests of their patients, regardless of their self-interests or the interests of others who stand to benefit from the patient-physician relationship."[121] Similar to members of other professions, some license holders will not act in this way. For example, in California, the Office of the Attorney General collects statistics on Medi-Cal fraud and elder abuse by licensed or certified individuals, including but not limited to physicians, audiologists, chiropractors, dentists, nurses, psychologists and pharmacists. Between 2010-2015, the Attorney General's office investigated 536 cases of Medi-Cal fraud and/or fiduciary abuse, ultimately filing 159 criminal cases. These 159 cases represented 42 percent of all criminal cases that the Bureau of Medi-Cal Fraud and Elder Abuse filed. In these types of cases, it is clear that license holders subverted the best interest of the patient for their own self-interests.[122]

These particular examples of criminal wrongdoing reflect the broader complexity of the healthcare environment with its many providers, payers and alignment structures. In fact, there is an ongoing debate about whether and to what extent healthcare has become corporatized. Managed care, non-negotiable reimbursement rates with the government, and the growth of third-party payers have led some to argue that physicians have lost their autonomy in this new corporatized environment.[123]

Literature on this topic points to a variety of issues that cause conflicts of interest (though not necessarily wrongdoing) within the healthcare field, and in particular for physicians. The most up-to-date findings in the field demonstrate that financial incentives lead to conflicts of interest that create bias in physician decision-making. These financial incentives include: self-referrals for office services and physician-owned centers; physician salaries, reimbursement models and bonuses, including the influence of health insurers; and pharmaceutical promotions and drug samples.[124] Patient self-advocacy and influence is an additional conflict of interest that can create bias in decision-making.[125] While it is clear that these conflicts of interest create bias, "the sociological and policy literatures have been unable to settle whether professionalism

has actually declined and whether the commercialization of health care inevitably leads to negative health effects."[126] With respect to physician autonomy, recent survey research indicates that physicians' status as salaried employees in large organizations (medical practices, medical schools, hospitals, etc.) is not associated with decreased "reports [by physicians] of freedom in making clinical decisions." However, physicians in larger organizations do experience less autonomy in logistic-based decisions, partly attributable to managed care relationships.[127] As discussions about the corporate practice of medicine continue, it is important that public policy discussions consider it within the context of conflicts of interest and autonomy in the modern healthcare environment.

Consumer Protection: Ensuring the Best Interest of the Patient

The corporate practice of medicine doctrine exists within a broader set of policies meant to protect patients through eliminating or reducing conflicts of interest. During the latter half of the 20th Century Congress passed two sets of laws. The federal Anti-Kickback Statute (42 U.S.C. Section 1320a-7b) became law in 1972. It prohibits "offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate Federal health care program business."[128] In 1989, Congress passed the Stark Law (42 USC Section 1395nn, with revisions in 1993 and 1994), which was focused on physician self-referrals for Medicare patients. The Stark Law: (1) "prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or immediate family member) has a financial relationship," and (2) "prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral."[129]

The Stark Law was a legislative response to a practice called "self-referral," in which a patient's medical doctor refers him/her for medical treatment or services "to an entity in which either the physician or an immediate family member of the physician has a financial interest."[130] These arrangements were most prevalent in non-hospital facilities such as clinical labs, ambulatory surgery centers, outpatient diagnostic imaging centers, and durable medical equipment companies.[131] Although the bill for this law was originally introduced in 1988, it did not gain traction in Congress until the U.S. Department of Health and Human Services' Office of the Inspector General issued a special report in 1989 stating "empirical evidence suggested physicians were abusing the referral process in order to financially benefit themselves."[132] Two findings were likely instrumental in changing Congress's attitude about passing the Stark Law: (1) patients of physicians owning or investing in independent physiological labs received 45 percent more clinical lab services than average Medicare patients; and (2) the cost of increased use of these clinical labs cost the Medicare program approximately $28 million in 1987 dollars.[133] [134] This Inspector General report was not, however, the first time some physicians' referral practices elicited concern. In 1949, the California legislature passed a law, led by both the Better Business Bureau and the California Medical Association, to regulate kickbacks.[135] Like Stark, this law was the direct result of concerns about the impact of these activities on patient care and the professionalism of medicine.[136]

Current Research: Conflict of Interest within the Healthcare System

As the healthcare ecosystem changed over the last century – adding more entities to the patient, physician and employer relationships, specifically including insurers, pharmaceutical companies and device manufacturers – research has begun to address the role of commercialism in medical care and its impact on decision-making and autonomy. The Research Bureau reviewed current literature to assess the impact of conflicts of interest on

physician decision-making – in particular, the physician's role as employee. Much of the research focuses on the field of healthcare conflicts of interest in general, in which factors related to employment are one subset within the broader array of financial incentives.

The peer-reviewed evidence supports the idea that "financial relationships bias physician decisions to different degrees [across] three areas: the payments to referrers, the incentives created by health insurers, and the largesse provided by the drug and device industries." [137] What remains unclear is the extent to which patients were harmed – or in some cases, perhaps even helped – as a result of this bias.

Even among the best research, the studies were unable to "establish a baseline of appropriate care using practice guidelines or independent care…" Without a baseline, it is not always possible to demonstrate that the "financial interest was contrary to the interests of the patient … [and] it is possible that, even if financial relationships are changing physician behaviors, they are changing them for the better in certain situations. It may be that most patients get MRIs too rarely, and that self-referring physicians are actually approximating the optimal rate of prescriptions, while other physicians are lagging." [138] Similarly, while the impact of the financial incentives was evident in a study that reviewed physicians that held capitated (fixed price per patient) contracts with insurance companies – patients were admitted to lower cost hospitals that were farther away – the researchers did not find either decreased patient health outcomes or decreased quality of care.[139] In some cases, the final health outcome for patients may still be debatable, but it does not contravene the evidence that current incentive structures create "conflicts of interest [that] contribute to bias [in decision-making.]" [140]

In California, it is notable that the state has adopted a specific public policy related to the influence of insurers on physician decision-making. Business & Professions Code, Section 510 states "that a health care practitioner be encouraged to advocate for appropriate health care for his or her patients … [by] appeal[ling] a payer's decision to deny payment for a service … or to protest a decision, policy, or practice … [that] … impairs the health care practitioner's ability to provide appropriate health care to his or her patients."

Ownership, Employment and Autonomy

Various ownership structures can also create conflicts of interest. A study specifically examining facilities in which physicians maintain a financial interest (in this case, physician-owned specialty hospitals) found clear evidence of overutilization with respect to referrals.[141] Physician-owned specialty hospitals tripled between 1990 and 2003, largely as a result of two factors: "profit motivations fueled by decreasing physician salaries… [and] community hospital administrators and corporate hospital conglomerates that frustrated physicians' efforts to exercise reasonable and legitimate controls over their clinical practices."[142] Regulators were increasingly concerned with specialty hospitals' overutilization of services that created unnecessary healthcare expenditures, "referral patterns [that] "undermine public and community hospitals" by taking more lucrative and healthier patients and "inadequate emergency care."[143] To address these concerns, the Affordable Care Act created new limitations on and oversight of these organizations. For those seeking Medicare reimbursement, the law prevented new physician-owned hospitals from opening and existing physician-owned hospitals from expanding, except in limited circumstances. The law also required physician-owned hospitals to provide more transparency about their investors. It is important to note, however, that "popular media and government reports support the view that patient satisfaction at physician-owned specialty hospitals is generally high – in some instances higher than it is in

competitor full-service, community hospitals."[144]

In the case of physician-owned specialty hospitals, it appears that physicians responded to financial interest (decreasing salaries) and a need for autonomy in decision-making by creating new organizations that they owned and to which they could refer patients. These organizations created greater costs to the overall healthcare system through overutilization of services and often sought the most profitable patients, sometimes harming community hospitals in the process.[145] Despite this, these hospitals delivered value to many patients that translated into high levels of satisfaction. However, to achieve this end, the hospitals and physicians engaged in the very practice that the Stark laws were meant to prevent. It is only because Stark allows an exception for a whole hospital that these specialty hospitals are able to self-refer. Different from traditional hospitals in that they narrowly specialize in cardiac, orthopedic or other highly profitable surgical procedures, specialty hospitals are licensed as hospitals, and thus eligible for the exception.[146]

When physicians are not partial- or full-owners, but instead a hospital owns the practice, conflicts may also arise. The most recent research on this subject (August 2015) demonstrates that when a hospital or system owns a physician's practice, the physician's patient is substantially more likely to choose the owner-hospital even when other hospitals have lower costs and higher quality.[147] Absent ownership, patients are more likely to choose the opposite: closer, less expensive and higher quality hospitals. This outcome for patients in physician-owned practices would seem to undermine the goal of healthcare integration: greater coordination and efficiency, leading to better outcomes for patients.

These questions of independence appear across all types of physician employment relationships. For example, comparing data between 1996 and 2005, a recent study based on national, longitudinal data reviewed physicians' own sense of autonomy across different practice types. The analysis examined solo/two physician practices, practices of three to ten physicians and practices greater than ten and including hospitals and medical schools. Similar to prior research, this study found that physicians in larger practices felt less autonomy in logistic-based decisions (as determined by believing they had "adequate time with patients") than physicians in smaller practices. These lower levels of perceived autonomy were partly explained by increased managed care participation and status as an employee rather than an owner.[148]

In contrast to logistic-based decisions, knowledge-based decisions are those "that require specialized knowledge imparted to the profession during a prolonged training period." The study found that the level of knowledge-based decision-making was determined by whether the physician felt s/he had "the freedom to make clinical decisions that meet my patients' needs." Importantly, the results showed that there is "no association between salaried status and reports of freedom in making clinical decisions." In addition, physicians in larger practices reported higher levels of autonomy than did physicians in solo practices. This may be because "[s]maller practices may not be able to keep financial and clinical considerations separate due to their decreasing share of the healthcare market, and thus physicians in such situations may feel limited in their choice set of clinical actions, leading to lower levels of perceived autonomy." However, the solo-practitioner result was unexpected and it would be worthwhile to conduct additional research on that topic.[149] Nonetheless, it is important to note that these two indicators (logistic- and knowledge-based decisions) are not necessarily inclusive of all types of employment constraints. For example, recent research has raised concerns about restrictive employment contracts within for-profit, physician-owned medical specialty

groups and the impact of these contracts on physician autonomy and quality of care.[150]

Doctor-patient frameworks have historically focused on the role of the physician's advocacy for the patient, the trust between the physician and the patient, and the vulnerability of the patient. In recognition of today's far more complex healthcare environment, it may be worthwhile to consider a conceptual model that reflects the "vulnerability and compromised judgment on the part of both the patient and the provider."[151] Framing conflicts of interest within this theoretical model would support a broad-based policy discussion that includes physician employment status as one of many issues that can result in biased decision-making by physicians and other medical professionals.

Policy Options

California enacted the ban on the corporate practice of medicine arguing that there was a clear difference between the "consciousness, learning, skill and good moral character"[152] of the professional license holder and the profit-seeking motives of a corporation. Nationally, removing the influence of corporations in medical decisions was important to extending quality healthcare in the first part of the twentieth century, especially in industries like mining. The Research Bureau's 2007 report demonstrated that "the legislature has clearly and repeatedly stated its intent that physicians, and not corporations, be responsible for patient care decisions." However, the report also argued that the fragmented manner in which California had extended the ban resulted in a doctrine whose "power and meaning are now inconsistent." It also considered the idea that the many exemptions to the ban may have "signal[ed] a change in public opinion."[153]

While the provision of healthcare in California has changed considerably in the nine intervening years, many of the same issues surrounding the corporate practice of medicine remain. The Research Bureau's 2007 report offered four options that the Legislature could consider to resolve these issues. Below we discuss these options:

- **Determine which organizations are subject to the corporate practice of medicine ban**: The exemptions to the corporate practice of medicine ban were created through statute, court decisions and Attorney General opinions. To clarify the status of affected organizations, the Research Bureau's report proposed to "determine and enumerate the types of entities that may (or may not) lawfully employ physicians." The Legislature did not address this issue and could still do so. The underlying question policymakers would consider under this option is whether a license holder's employer could exert influence over his or her professional decisions, presumably for financial gain. Making these determinations would result in a consistent policy rationale for applying (or not applying) the ban to professions, nonprofit organizations and governments in California.

- **Determine hospital employment permissibility:** Today, nonprofit, for-profit and district hospitals are included under the ban, while state, county, teaching and pediatric specialty hospitals are exempted. The Research Bureau's 2007 report suggested that the Legislature could determine whether hospitals should employ physicians, conditioned on the agreement that "physicians remain in control of medical decisions." If the legislature determined that it was not in the best interest of doctors and patients to allow *all* hospitals to employ doctors, it could consider whether to exempt *additional* hospitals. It could also specifically reconsider whether to exempt hospitals owned by hospital districts. To determine whether a hospital would try to usurp a physician's medical decisions, policymakers could consider a number of different

metrics that may impact a hospital's decision-making, including the amount of uncompensated care, patient outcomes, geographic service area or fiscal health.

- **Expand retail clinics:** Retail clinics have continued to expand across California since 2007. The Research Bureau's first report noted that to encourage their growth, "the legislature could allow corporations other than professional medical corporations to operate these clinics and employ physicians." Research about the factors that inhibit retail clinic growth is inconclusive. If the legislature is interested in supporting clinic expansion, a second option is to expand the scope of practice for nurse practitioners and then support professional nursing corporations owning retail clinics in addition to professional medical corporations. In a policy move similar to allowing the landlord-tenant arrangement for optometrists and opticians, the legislature could also consider requiring certain lease provisions for retail stores that wish to rent space to these clinics, whether they are owned by physicians or by nurses.

- **Eliminate the ban:** The Research Bureau's 2007 report included an option to end the corporate practice of medicine ban "and delineate lawful physician employment." Current policy bars direct employment in many circumstances, but it permits workarounds that allow hospital-physician alignment. These workarounds are intended to create distance between hospital administration and physicians while allowing coordination between the two groups. Physicians might have admitting privileges at a hospital and physician groups may contract with hospitals directly to provide services. Hospitals own practices and may also contract with medical foundations. The 2007 report did not focus on incentive structures outside the physician-employer relationship, but these are critical to the modern healthcare environment. For example, physician groups must negotiate with insurance providers to join their networks. If they are not part of a network, they cannot be reimbursed by a consumer's insurer for services they provide. If the rates at which the insurer or the government reimburses are too low, the physician may not make any profit. The Research Bureau did not find research that compared levels of physician protections across different employment structures, but we did find data about physician autonomy across differently sized practices and the myriad of potential conflicts of interests that can lead to bias in medical decision-making.

  It should also be noted that district attorneys across the state currently rely on the corporate practice of medicine ban when prosecuting certain cases in which unlicensed individuals practice medicine. If the legislature considers eliminating the ban, it would be important to ensure that the state does not lessen its ability to prosecute these types of cases.[154] [155]

Additional Policy Options

Based on the information gathered for this new report, the Research Bureau offers the following additional options that policymakers could consider:

- **Assess changing incentive structures:** Hospitals and insurers (including the government) are beginning to move away from per-procedure payment plans and toward compensation models that reward coordinated, high quality and efficient patient care. Policymakers may wish to consider whether this new common incentive structure will create shared incentives between physicians and hospitals, thus potentially removing the need for a hospital ban on the corporate practice of medicine. In addition, it is clear that threats to the quality and affordability

of care resulting from potential provider conflicts of interest can be found in any kind of healthcare office or organization. Some of these incentives may be removed through a new common incentive structure, but in other cases policymakers may consider statutory protections against such threats that exist separately from, though not necessarily in lieu of, bans on certain employment structures.

- **Consider whether other methods of protecting physician autonomy are sufficient:** Prohibitions against employer interference in physician medical decisions are currently in two of the statutes authorizing exemptions to the corporate practice of medicine ban. Similar language is included in physician-employee contracts in other states. In a few circumstances, hospital physician-employees have formed unions in order to increase their influence within their hospitals.[156] The state could determine whether these alternative protections provide physicians enough autonomy in employment situations. If they do, they could consider replacing the employment restrictions of the corporate practice of medicine ban in some or all situations.

- **Increase patient access to data about physician-hospital relationships and hospital quality/cost metrics:**

    - Research indicates that patients of physicians whose practices are owned by hospitals are more likely to choose those hospitals, even if they are higher cost and lower quality than alternatives. One way to mitigate this issue could be to advise patients of their hospital options and rank those options by a set of measures (cost, quality of care, geography, etc.)

    - The Affordable Care Act has introduced a number of pricing transparencies into the system,[157] and California could consider increasing its required disclosures as well.

- **Determine whether the current alignment strategies used by physicians and hospitals are more costly than direct employment models:** The corporate practice of medicine ban is so institutionalized in California that hospitals and other healthcare organizations have created a number of strategies to legally work around it and still meet many of their needs. These alternative structures may introduce inefficiencies in the system, but no one has conducted an analysis to determine the extent of these inefficiencies compared with the direct expenses associated with employment.

- **Collect additional data to better understand the impact of the ban:** Limited data makes it more difficult to assess how the corporate practice of medicine ban affects California's doctors. The state does not collect the specific numbers of doctors that are employed directly by nonprofit clinics, teaching hospitals, state governments, and some county governments and pediatric hospitals. The Research Bureau could not find data for some county governments or pediatric hospitals and could not find any reliable data for professional medical corporations or medical foundations. Without a full understanding of how many physicians in the state are employed through an exemption, it is difficult to know whether the exemptions are, as the original Research Bureau report argued, so broad as to dilute the meaning of the ban.[158]

Appendix A: Corporate Practice of Medicine Ban and District Hospitals

During the years the SB 376 pilot project was in effect, legislators introduced nine bills that would have extended or modified the SB 376 pilot project. A summary is below:

SB 1640 (Ashburn) Introduced Feb. 22, 2008	This bill would have extended the SB 376 pilot project to January 1, 2016, and revised it to authorize "general acute care hospitals," as defined in Health & Safety Code, Section 1250, to employ an unlimited number of physicians and surgeons, and to charge for professional services rendered by those physicians. The acute care hospitals would be limited to those in rural or underserved areas.	Failed passage in the Senate Committee on Business, Professions & Economic Development
SB 1294 (Ducheny) Introduced Feb. 19, 2008	This bill would have extended the SB 376 pilot project to January 1, 2017. It would have allowed district hospitals to hire an unlimited number of physicians and surgeons, subject to board approval. It would also have changed the definition of a qualified district hospital to a hospital that, among other things, is located in a medically underserved area or a rural hospital that had net losses in the most recent fiscal year.	Failed passage in the Assembly Appropriations Committee
AB 1944 (Swanson) Introduced Feb. 13, 2008	This bill would have eliminated the SB 376 pilot project. In its place, it would have permanently authorized healthcare districts to employ physicians to primarily treat Medi-Cal patients and bill for the physicians' services with their approval. It would have prohibited the hospital from interfering with the professional judgment of physicians and surgeons.	Failed passage in the Senate Health Committee
AB 646 (Swanson) Introduced Feb. 25, 2009	This bill would have eliminated the SB 376 pilot project. Instead, it would have authorized a healthcare district and a clinic owned or operated by a healthcare district to employ up to 10 physicians and surgeons within each healthcare district, if the healthcare district's service area included a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP), or if it had been federally designated as a Health Professional Shortage Area (HPSA). The bill would have provided that a district may extend any employee contracts up to 10 years. It also required a study of the program's effectiveness and a sunset date of January 1, 2021.	Failed passage in the Senate Committee on Business, Professions & Economic Development

SB 726 (Ashburn) Introduced Feb. 27, 2009	This bill would have extended the SB 376 pilot project to 2018. It would have revised the pilot to authorize the direct employment by qualified healthcare districts and qualified rural hospitals of an unlimited number of physicians and surgeons, and authorized such hospitals to employ up to five physicians and surgeons at a time with a term of contract not to exceed 10 years.	Failed passage in the Senate Committee on Business, Professions & Economic Development
AB 648 (Chesbro) Introduced Feb. 25, 2009	This bill, by the author of the SB 376 pilot, would have established a new pilot project that extended the scope of the first pilot. This bill would authorize a rural hospital to employ up to 10 physicians and surgeons at one time and to retain all or part of the income generated for medical services billed and collected, provided the physician and surgeon in whose name the charges are made approved the charges. The bill would require a rural hospital to develop and implement a policy regarding the independent medical judgment of the physician and surgeon. This pilot would expire January 1, 2020.	Failed passage in the Senate Committee on Business, Professions & Economic Development
AB 926 (Hayashi) Introduced Feb. 18, 2011	By 2011, the SB 376 pilot project had sunset. This bill would have reenacted the pilot project as written, but would have allowed all qualified district hospitals to employ not more than 50 physicians and surgeons. This pilot would have expired January 1, 2022.	Failed passage in the Assembly Committee on Business, Professions & Consumer Protection
AB 1360 (Swanson) Introduced Feb. 18, 2011	This bill was similar to bill language in AB 646 (2009). It would have authorized a new pilot project that allowed a healthcare district and a clinic owned or operated by a healthcare district to employ physicians and surgeons if the service area included a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP), or had been federally designated as a Health Professional Shortage Area (HPSA). The bill would have provided that a district could extend any employee contracts up to 10 years. It also required a study of the program's effectiveness and a sunset date of January 1, 2022.	Failed passage in the Assembly Committee on Health
AB 824 (Chesbro) Introduced Feb. 17, 2011	This bill was similar to bill language in AB 648 (2009). It extended the proposed pilot project to January 1, 2022.	Failed passage in the Assembly Committee on Health

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