



Battleground New Jersey

Is an "Anti-ASC Pandemic" Possible?

By Lorin E. Patterson and Lisa S. Albright

ON MARCH 23, 2009, revisions were made to the New Jersey anti-self-referral statute (the "Codey Law"), which prohibits New Jersey physicians from referring patients to healthcare services in which the physicians have a significant beneficial interest unless an exception exists. Although heralded as a victory in the wake of *Garcia v. Health Net*, in which a New Jersey Superior Court held that referrals to ASCs were prohibited by the then-current version of the Codey Law, the so-called "Codey Amendment" contains, among other provisions, a moratorium on the development of new physician-owned ASCs.

A question arises in the amendment's adoption — will other states in the country follow? The answer to that question may lie in the degree of vigilance exercised by state ASC associations in proactively examining the anti-referral language of their states' statutes and the ability of those in the ASC industry to capitalize on positive recent events which have occurred with regard to relationships with third-party payors.

As originally enacted, the Codey Law contained a broad prohibition on physician referrals to healthcare services in which such physicians held a significant beneficial interest. Exceptions were permitted for referrals for specific services which did not include referrals for services performed within an ambulatory surgical center. Despite the lack of an express exception applicable to ASCs, physician ownership in New Jersey ASCs proliferated as investors relied upon unpublished and informal guidance given by the Board of Medical Examiners (BME) to a couple of separate projects. This informal guidance indicated that physician owned ASCs would be viewed by the BME as extensions of the physicians' medical practices. Relying upon such informal guidance certainly involved taking the path of least resistance, as opposed to attempting to effect an amendment to the Codey Law or secure more formal guidance from the BME. Unfortunately, such reliance seems to have been misplaced.

New Jersey has traditionally been an out-of-network (OON) state with ASC providers receiving on average three times the reimbursement for being out-of-network than in-network. Not surprisingly, payors have used various tactics to fight against having to pay the higher OON reimbursement, including (i) filing suit against OON providers asserting claims of insurance fraud under the New Jersey Insurance Fraud Protection Act and tortious interference with contract; (ii) threatening in-network physicians who refer to OON facilities with termination of network provider agreements, (iii) ignoring assignments of benefits and making payment directly to health plan beneficiaries, and (iv) attempting to require OON facilities to provide additional disclosure statements to patients who schedule services there.

In *Garcia v. Health Net of New Jersey, Inc.*, 2007 WL 5253484 (Ch. Div. 2007), a New Jersey ASC and its individual surgeon-owners filed suit against Health Net of New Jersey, charging that Health Net had improperly declined to renew individual surgeon-owner's provider contracts. Although the surgeons had been in-network with Health Net, the center itself was OON. Health Net counterclaimed that the center and its owners had committed insurance fraud in submitting claims for reimbursement for services which were provided in violation of the Codey Law.

Although the court held that the requisite intent to commit insurance fraud was not present, the judge called into question the physicians' reliance on the informal guidance issued by the BME finding that a plain reading of the Codey Law did not support the BME's position that ownership in an ASC was excepted from the referral prohibition.¹

As a result of the court's non-binding statements in the *Garcia* decision, the approximately 40 physician-owned ASCs operating within New Jersey suddenly found themselves "skating on thin ice." Frantic efforts to address the situation began immediately.

After several iterations, a final version of the Codey Amendment was adopted which unequivocally legitimized physician ownership in ASCs in New Jersey, provided certain conditions are met. Specifically, P.L. 2009, c.24 requires ASCs to be or become accredited by the Centers for Medicare and Medicaid Services (CMS) as an ASC in order to qualify for exception under the anti-self-referral provisions.

In addition, under the Codey Amendment physicians may continue to refer to ASCs in which they have a beneficial interest if (1) the referring physician personally performs the services, (2) income received from the ASC is directly proportional to the physicians' ownership interest, (3) all clinical decisions at a facility owned in part by non-physicians are made by physicians and (4) the referring physician discloses his or her interest in the ASC to the patient, in writing, including whether the services provided at the ASC will be reimbursed at an OON rate, and posts a sign prominently in his or her office indicating the ownership interest.

The Codey Amendment also imposes a moratorium on the issuance of new licenses to ASCs by the New Jersey Department of Health and Senior Services (DHSS), except in the case of a change of ownership of an existing center; relocation of an ASC to within 20 miles or to a "Health Enterprise Zone" with the DHSS commissioner's approval and with no expansion in the scope of services provided; ASCs for which architectural plans were filed with the municipality in which the center will be located or with the Health Care Plan Review Unit of the New Jersey Department of Community Affairs by Sept. 23, 2009 (six months within the effective date of the Codey Amendment); entities owned in whole or in part by a New Jersey hospital; and entities owned in whole or in part by a New Jersey medical school.

Payor attacks on ASCs in New Jersey have not been limited to questioning the legitimacy of such entities under state law. Blue Cross Blue Shield of New Jersey (BCBSNJ) introduced a new small business health plan that caps payment for out-of-network

ASCs services at \$2,000 per person per year. The New Jersey Association of Ambulatory Surgery Centers and the Alliance for Quality Care, a coalition of ASCs and other healthcare providers, contested the state Department of Banking and Insurance (DOBI)'s approval of the plan, arguing that the cap violated state law regulating small employer health benefit plans. DOBI denied the request to prohibit its sale and both the Appellate Division and the state Supreme Court denied stays of the sale pending litigation. The new small plans, although the subject of litigation, have been sold to employers and are affecting ASCs' ability to receive fair reimbursement for OON services. Other payors may be jumping into the fray. For example, Aetna has instituted a freeze on reimbursement for in-network ASC services and may be in the process of implementing a cap on out of network reimbursement similar to BCBSNJ's.

The situation started by the Garcia case can generally be summed up in a few simple sentences. The physician-owned ASC industry in New Jersey was content to grow in a murky regulatory environment while generally using aggressive OON tactics against powerful and hostile payors. When the "tremors" caused by the Garcia case struck, New Jersey ASCs were forced to seek hurried redress from the legislature in a national climate that is generally hostile to physician ownership of providers. This hostility is evidenced by provisions curtailing ownership by physicians in hospitals which are contained in all versions of the national healthcare reform bills circulating around Washington. In the end, existing physician-owned ASCs received what they needed but not without paying a significant price. A quasi certificate of need regime has been set in place in New Jersey largely to the benefit of hospital and payor lobbies in that state. The situation is worsened when the payors' attempts to unilaterally impose caps on OON reimbursement is considered.

Whether the situation in New Jersey will prove to be "contagious" may depend on how nimble ASC advocates in any given state can be when facing

similar challenges. For example, recent events in California have created a "foggy climate" similar to that which existed for ASCs in New Jersey before the Codey Amendment was executed. Following the decision in *Capen v. Shewry*, 155 Cal. App. 4th 378 (2007), the California Department of Public Health (DPH) issued a policy statement instructing district offices not to license, or renew licenses for, physician-owned ASCs. DPH's position is that, in accordance with *Capen*, it does not have the authority to license physician-owned ASCs as they fall under a statutory exception to the definition of "surgical clinic." As a result of the *Capen* case, ASCs in California are faced with a surreal situation in which Medicare-certified ASCs can continue to open and operate while the state cannot license such facilities.

The California Ambulatory Surgery Association (CASA) has not been content with operating in the gray area created by the *Capen* case.



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“What we learned in California was being complacent was not good,” notes Scott Leggett, the immediate past-president of CASA. Leggett states that his previous involvement with CASA taught him that the association should have been more proactive in confronting changes in the state’s worker’s compensation laws when it had the opportunity to do so several years ago. Leggett says that such experience has taught him that failing to be proactive means that “... you are on the menu rather than having a seat at the table.” According to Leggett, CASA is using the Capen case as an opportunity to educate lawmakers as it aggressively seeks to correct the uncertainty left in the Capen decision’s wake.

ASCs around the country would also be well advised to actively monitor positive developments on the OON reimbursement front if they encounter tactics such as those being implemented in New Jersey by BCBSNJ as previously described. For example, New York Attorney General Cuomo announced on Oct. 27, 2009, that a new not-for-profit company, FAIR Health, Inc. and an upstate research network headquartered at Syracuse University have been established which, collectively, will develop a new independent database of “usual and customary” rates for consumer reimbursement for OON charges to replace the widely used Ingenix, Inc. system which was earlier debunked in Cuomo’s report, “The Consumer Reimbursement System is Code Blue.” This new reimbursement system will be funded by the almost \$100 million in settlement money received by the state from insurers like United HealthGroup and CIGNA after assertions by the Attorney General that such companies had under-reimbursed consum-

ers and providers by hundreds of millions of dollars for OON services. Further, ASCs should require that their counsel track the class action lawsuits underway on OON issues in Georgia and California.

Although the battles occurring in New Jersey and California are the result of a confluence of factors unique to each state, ASCs are well-advised to be ever vigilant in removing ambiguity from their state’s anti-referral statutes at the earliest possible opportunity and in assessing the status of state-specific reimbursement plans and legislation. The lessons of New Jersey and California teach us that efforts to exert change are best made proactively, rather than reactively once laws have been passed, regulations have been promulgated and physician-owned ASCs’ rights have been eroded. ●



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Reference:

1. Health Net appealed the decision and, on Nov. 17, 2009, the Appellate Division affirmed. *Garcia v. Health-Net of New Jersey, Inc.*, No. A-2430-07T3 (N.J. Super. Ct. App. Div. Nov. 17, 2009). While the affirmation of the lower court’s holding is very positive news for ASCs operating on an OON basis it does nothing to mitigate the ramifications of the Codey Amendment.

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