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Structuring Physician Group Practices: Formation; Compensation; Hospital, Private Equity and Non-Physician Participation

Entity Selection, Tax Issues, Ancillary Services, Corporate Practice of Medicine, Fee-Splitting, Management Agreements

THURSDAY, JANUARY 3, 2019

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Today's faculty features:

Kerry Hunt Foster, Associate, **DLA Piper**, Miami

Joshua Kaye, Partner, **DLA Piper**, Miami

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Structuring Physician Group Practices: Key Legal Considerations

DLA PIPER

Structuring Physician Group Practices:
Key Legal Considerations

January 3, 2019
1:00pm – 2:30pm EST

Joshua M. Kaye
Managing Partner, Miami Office
Chair, Health Care Sector
DLA Piper (US) LLP
joshua.kaye@dlapiper.com
305.423.8521

Kerry H. Foster
Senior Associate
DLA Piper (US) LLP
kerry.foster@dlapiper.com
305.702.8847

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Overview

- **Group Formation**
  - Benefits of forming/joining and other key considerations
  - Selecting appropriate legal entity
  - Tax considerations
- **Physician Compensation in Group Practices**
  - Personally performed services
  - Ancillary services
- **Mergers and Acquisitions**
  - Common transaction types
  - Key deal terms
- **Hospital, Private Equity and Other Non-Physician Participation**
  - Corporate practice of medicine and fee splitting
  - Management Model
  - Partnering with a Hospital or Health System
- **Q&A**

Group Formation

Group Formation Considerations

- Reasons for Forming or Joining a Physician Group Practice:
  - Patient engagement and continuum of services
  - Ancillary services
  - Economies of scale and access to better infrastructure
  - Increased leverage in negotiating contracts
  - Ensure patient coverage, sharing call responsibilities

Group Formation Considerations

- Preliminary Considerations
  - Partners, Specialties, Level of Integration
- Choice of Entity
- Tax Issues
  - Initial Election
  - Transaction Considerations
- Governing Documents
- Benefits Issues
- EHR

Physician Compensation in Group Practices

Personally Performed Services

- Common compensation arrangements:
  - "Eat what you treat" – revenue from personally performed services less overhead. Methodologies for allocating overhead expenses are key:
    - Pro rata
    - Direct expenses plus share of fixed costs
  - Base salary or draw with productivity bonuses (or downward adjustments for low productivity)
  - Guaranteed salaries (typically only found in recruitment arrangements or hospital affiliated groups)

Personally Performed Services

- How to calculate:
  - Percentage of collections, minus overhead (i.e. “eat what you treat” or some portion thereof)
  - Based on survey or market information for physician’s specialty in the locality and anticipated productivity (wRVU’s)
    - Base compensation is often set by the physician’s historic production and supplemented by bonus for meeting personal productivity targets
    - Group should also retain right to adjust compensation for productivity that falls significantly below expectations
- Other factors:
  - “Incident to” services and supervision of MLPs
  - Quality measures
  - Patient satisfaction

Ancillary Services and the Stark Law

- Physician may not make a referral to an entity for the furnishing of *designated health services* ("DHS") that may be covered by Medicare if the physician (or an immediate family member of the physician) has a *direct or indirect financial relationship* with the entity
- Categories of DHS (e.g., clinical laboratory, radiology, outpatient prescription drugs)
- Strict liability statute – if financial relationship exists, then must meet an exception
- Exceptions most relevant to group practices:
  - In-Office Ancillary Services Exception
  - Bona Fide Employment Relationships
  - Personal Services Arrangements
- Potential sanctions: recoupment, civil monetary fines, federal program exclusion, False Claims Act liability
- State "baby Stark" laws

Stark Law's In-Office Ancillary Services Exception – Elements

- Performance/Supervision

- Location
  - Same Building
  - Centralized Building

- Billing

Stark Law's In-Office Ancillary Services Exception – Group Practice Defined

- Meeting Stark's "Group Practice" definition is critical for group practices to qualify for the In-Office Ancillary Services Exception and pay physicians productivity bonuses that include DHS profits

- A group of physicians practicing together does not necessarily qualify as a "Group Practice" under Stark:
  - Single legal entity operating a unified business
  - 2 or more "members"
  - "Members" furnish substantially all services through group (HPSA exceptions)
  - Income and expense allocation determined prospectively
  - Others (range of services, patient encounters, volume/value)
  - Productivity Bonuses and Profit Shares paid in accordance with 42 CFR § 411.352(i)

Group Practice Productivity Bonuses and Profit Shares

- A physician may be paid:
  - a share of the practice's overall profits; and
  - a productivity bonus for services personally performed or for services incident to personally performed services.
- Neither profit share nor productivity bonus can be determined in any manner that is directly related to the volume or value of the physician's referrals for DHS (other than certain DHS referrals "incident to" a physician's personally performed services)

Profit Shares

- Most common methodologies:
  - The group's entire profits derived from DHS payable by Medicare or Medicaid; or
  - The profits from DHS from any component of the group that consists of at least 5 physicians
- 3 enumerated methodologies for profit shares:
  - Per capita
  - Based on allocation of physician's compensation attributable to non-DHS services
  - 5% tests
- Must be a verifiable and reasonable methodology for the division that is not related to the volume or value of DHS referrals
- Be prepared to show your math (to the Secretary)

Productivity Bonuses

- 3 enumerated methodologies for productivity bonuses:
  - Based on patient encounters or wRVUs
  - Based on allocation of physician's compensation attributable to non-DHS services
  - Revenues from DHS are less than 5% of Group's total revenues and each physician's allocation is less than 5% of total compensation
- Calculated using a reasonable and verifiable methodology unrelated to the volume or value of the physician's DHS referrals

Stark Law's Employment Relationships and Personal Services Arrangements Exceptions

- Employment Exception:
  - bona fide employment for identifiable services compensated at FMV
  - does not take into account (directly or indirectly) the volume/value of any referrals by the employed physician (productivity bonus excepted)
  - compensation provided pursuant to agreement that would be commercially reasonable in the absence of referrals

- Personal Services Arrangement Exception:
  - signed writing specifying the services required (and all services between parties)
  - term of at least 1 year
  - compensation set in advance at FMV, not taking into account the volume/value of referrals by the contracted physician or other business generated between the parties
  - aggregate services contracted for do not exceed what is reasonable and necessary for the legitimate business purposes of the arrangement and do not involve the promotion of a business that violates any law

Physician Compensation: One-Size Does Not Fit All

- Group preferences for methodologies and structure of compensation vary
- Business objectives and legal compliance often at odds
- As reimbursement and regulation continues to change and evolve, compensation should be reviewed frequently

Mergers & Acquisitions

Common Transactions

- Group Practice Consolidation
  - Typically FMV consideration paid to physicians/practices that join the group
  - Might be reimbursed at book value
  - Goodwill payment (or sign-on bonus)

- Strategic or Financial Investor (private equity, strategic, or hospital buyer)
  - EBITDA multiple or other market valuation

Key Deal Terms: Initial Transaction Documents

- NDA/Confidentiality Agreement

- Letter of Intent/Term Sheet
  - Non-binding
  - Exclusivity/“No shop” clause

Key Deal Terms: Purchase Agreement

- Consideration
  - Cash
  - Cash + rollover equity
  - Earnouts and other holdbacks
- Representations & Warranties and Corresponding Due Diligence
  - Condition of practice
  - Corporate and regulatory housekeeping
  - RWI
- Indemnity Package
- Conditions to Closing
  - Regulatory consents & approvals
  - Notice to third party payors

Key Deal Terms: Physician Employment Agreements

- Term and renewal period
- Termination events and effect of termination
- Compensation package
- Duties (e.g., on-call terms, supervision or administrative tasks)
- Vacation/sick/CME time
- Professional liability insurance
- Patient records

Key Deal Terms: Restrictive Covenants

- Restrictive covenants
  - Non-compete
  - Non-solicit
  - Non-disparagement

- Parallel non-competes
  - Purchase Agreement
  - Employment Agreement

- Enforcement of physician non-competes

Hospital, Private Equity and Other Non-Physician Participation

Hospital, Private Equity and Other Non-Physician Participation

- Confluence of events have led to a surge in healthcare investments and M&A generally
- Group practices can position themselves well as the landscape of healthcare changes
  - State of the (U.S. Healthcare) Union:
    - In 2017, U.S. health care spending increased 3.9 percent to reach $3.5 trillion
    - The overall share of the Gross Domestic Product in 2017 related to health care spending remained steady at 17.9 percent (similar to 18.0 percent in 2016)
  - Providers being asked to “do more with less”
  - Group practices and their investors can benefit from shift toward greater clinical integration

*https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf

Hospital, Private Equity and Other Non-Physician Participation

- Hospitals
  - Typically an active player in physician practice mergers, acquisitions and affiliations/investments
  - Not limited to for profit hospitals/systems
  - Potential antitrust issues

- Private Equity
  - Physician practice investments have generally been focused on hospital (or facility)-based physicians (e.g., anesthesia, radiology, hospitalists)
  - Focus on healthcare increasing

- Other Investors

Regulatory Barriers to Non-Physician Participation

- Corporate Practice of Medicine
  - Most states still have laws prohibiting, to varying degrees, the corporate practice of medicine ("CPOM")
  - CPOM states generally prevent unlicensed lay entities from employing physicians or otherwise contracting with physicians to furnish medical care
  - CPOM laws may limit the flexibility of physicians and non-physicians to structure ownership and employment arrangements

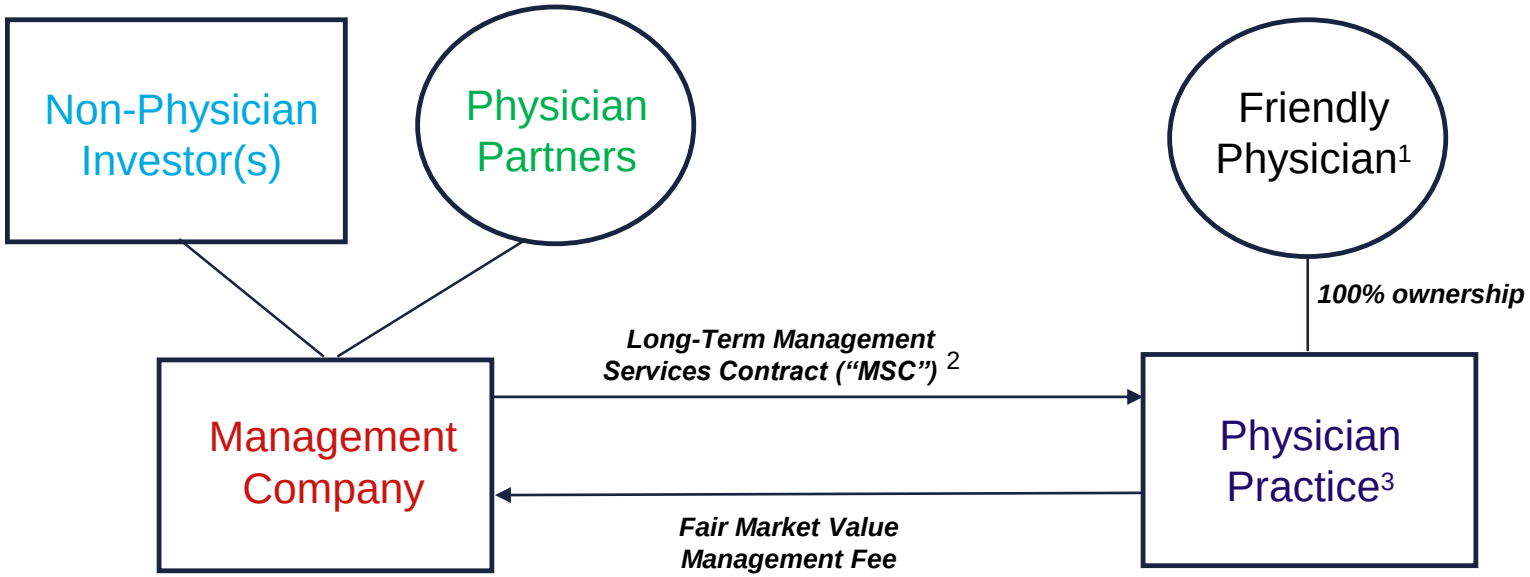
- Some states with strong CPOM laws (e.g., California and Texas) even prohibit hospitals from employing physicians, but have laws permitting nonprofit "medical foundations" to engage physicians (e.g., through their existing medical group) indirectly to provide medical care

Regulatory Barriers to Non-Physician Participation

- Fee-Splitting
  - Typically defined to include unearned division of professional medical fee with layperson/lay entity and/or payment for referrals
  - Some states without CPOM prohibition still have fee-splitting limitations that can be triggered by certain non-physician participation models (e.g., Florida)
  - Documentation of fair market value of services is key

- ***Investments and business models in states with these barriers require careful regulatory analysis to minimize regulatory risk***

Management Model



[1] *Physician licensed in applicable state, generally will enter into a stock transfer restriction agreement (or have same incorporated into MSC), but stock transfer restrictions are prohibited in some jurisdictions (e.g., New York)*

[2] *Management Company is typically either the former practice entity (and medical assets are spun out into new practice entity), which is acquired by the non-physician investor(s) or is a NEWCO that acquires the non-medical assets. It then provides the Mutlispecialty Physician Practice with use of those assets (typically including real estate – whether owner or leased) and turnkey management and administrative services*

[3] *Has provider number(s), payor contracts, employs and/or contracts with physicians*

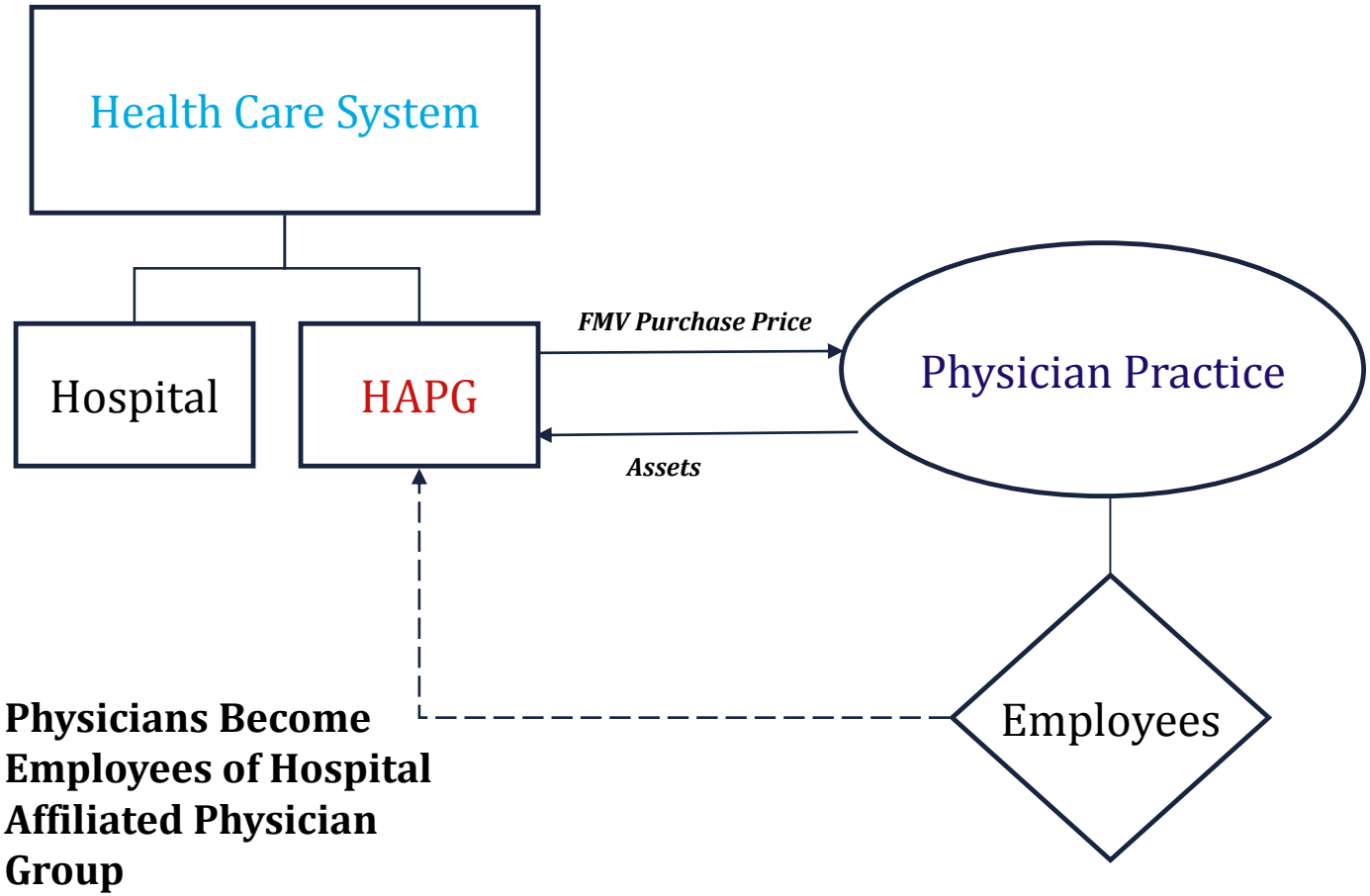
Management Model (Continued)

- Management Agreement terms are key to success of the arrangement
- Pros
  - In CPOM States, allows for non-physician “ownership” of Practice
  - Subsequent transactions at MSO level have minimal impact on practice
- Cons
  - Risks of friendly physician
  - Can be limitations on management fees
- Maintaining Clinical Independence

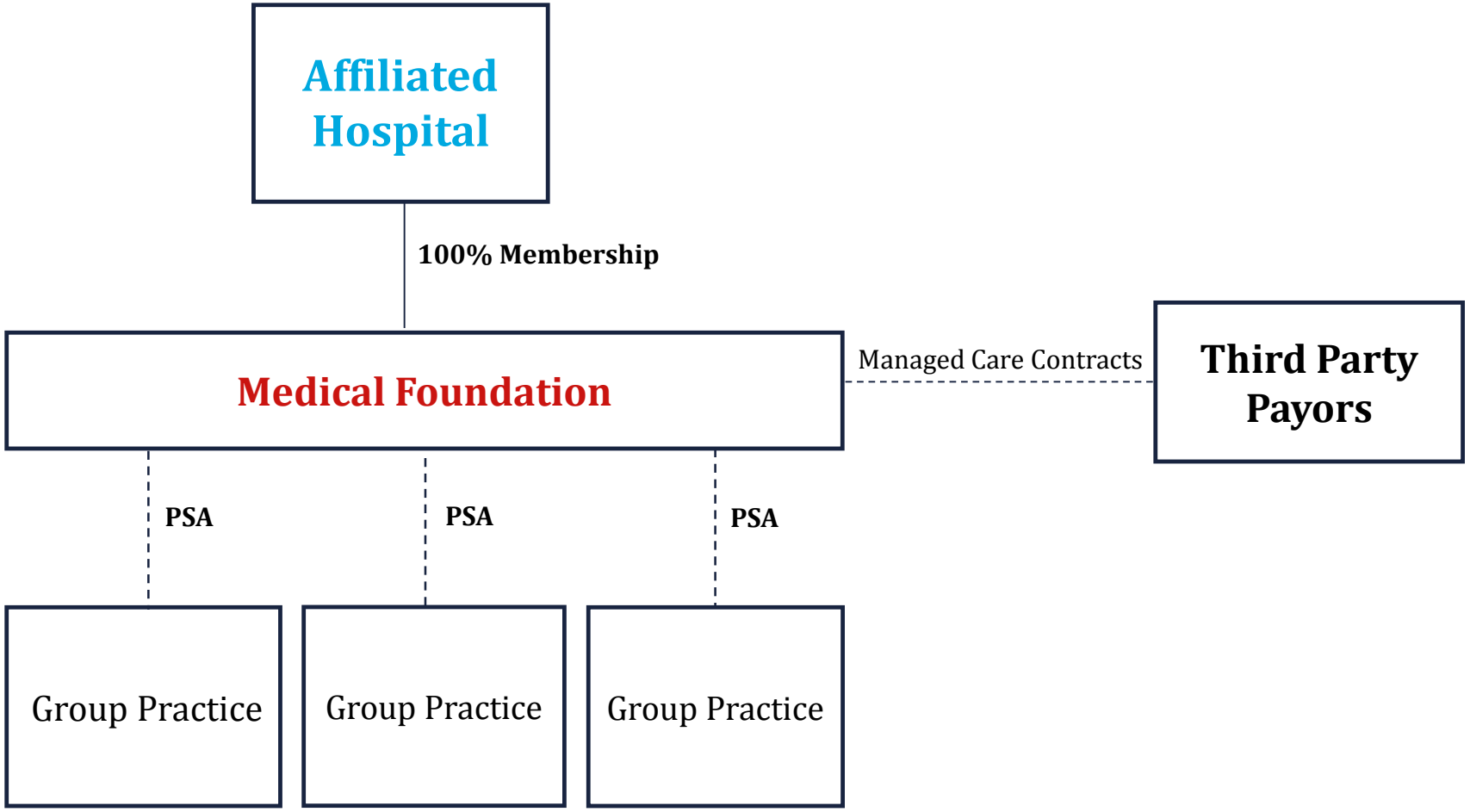
Partnering with a Hospital or Health System

- Direct Practice Acquisition/Physician Employee Model
- Foundation Model

Direct Practice Acquisition Model (Asset Deal)



Foundation Model



Foundation Model (Continued)

- **Pros**:
  - Retention of provider billing numbers & key relationships
  - Foundation handles billing for the professional services
  - Foundation pays the physician practice pursuant to an agreed compensation formula

- **Cons**:
  - May be difficult to return practice to its status quo
  - Less complete integration (compared to other JV structures or the employment model)

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Key Legal Considerations

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Joshua M. Kaye
Managing Partner, Miami Office
Chair, Health Care Sector
DLA Piper (US) LLP
joshua.kaye@dlapiper.com
305.423.8521

Kerry H. Foster
Senior Associate
DLA Piper (US) LLP
kerry.foster@dlapiper.com
305.702.8847