Structuring Physician Group Practices: Key Legal Considerations
Evaluating Compensation Models, Forming Practice Management Arrangements, and Navigating Corporate Practice of Medicine Issues

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Structuring Physician Group Practices: Key Legal Considerations

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Strafford Webinars
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Providers are facing unprecedented reimbursement pressures, taking on risk vis-à-vis accountable care organizations and related vehicles and are being asked to do more for less and to migrate from a fee for service system to one that is driven by benchmarks (quality, patient satisfaction, cost efficiency, etc.).


“It’s time for a fundamentally new strategy. At its core is maximizing value for patients: that is, achieving the best outcomes at the lowest cost. We must move away from a supply-driven health care system organized around what physicians do and toward a patient-centered system organized around what patients need.

We must shift the focus from the volume and profitability of services provided—physician visits, hospitalizations, procedures, and tests—to the patient outcomes achieved. And we must replace today’s fragmented system, in which every local provider offers a full range of services, with a system in which services for particular medical conditions are concentrated in health-delivery organizations and in the right locations to deliver high-value care.”
Health care delivery in next five years

- Delivery system comprised of shared risk between payors, hospitals and providers
- Greater focus on wellness and preventative care
- Patient-centric bundled payments
- Tiered providers based on quality, efficiency, cost comparisons, and severity adjustments
- Seamless exchange of PHI vis-à-vis electronic health records
A Transformative Healthcare Landscape

- Universal coverage and Medicaid expansion expected to cover 30 million new insured
- Numerous strategic mergers, acquisition, and consolidation activity
- Private equity salivating for high return opportunities in a fragmented, inefficient health market with revenue enhancement growth through consolidation and innovative technology
- Payors are diversifying risk and investing in providers and provider-based technology driven by ACA’s Medical Loss Ratio rules
Why form a physician-group

- Decreasing reimbursement and focus on quality and efficiency means that physicians are being asked to do more with less
- More effectively compete in the market place
- A physician group will allow physicians to reduce total cost of care through leverage and operating efficiencies
- A physician group will allow physicians to establish and participate in ancillary services in a manner that complies with the Stark Law and other applicable health care laws
- Payors and providers are seeking to better understand the cost of a patient to the health care system and not just an individual provider
- Solo practitioners and small practices are being squeezed out of the market place due to increasing costs and health system/hospital acquisitions
- “Winners” will be rewarded; “Losers” will be isolated and rendered irrelevant
What is a Physician Group – Stark Law

- Stark Law only applies to eleven categories of “Designated Health Services”
- Single legal entity
- At least two (2) physicians who are “members” (i.e., owner or employee but not independent contractors)
- Each physician “member” of the group furnishes substantially the full range of “patient care services” that the physician routinely furnishes
- At least 75% of the total “patient care services” of the group practice “members” are furnished through the group and billed under a billing number assigned to the group, and the amounts received are treated as receipts of the group
- Members of the group personally conduct no less than 75% of the physician-patient encounters of the group practice;
- The overhead expenses of, and income from, the practice are distributed according to pre-determined methods prior to the receipt of payment for the services
- The group is a “unified business”
- No physician member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician, except under certain special rules for profit shares and productivity bonuses
Group Formation – Key Considerations

- Partners versus associates
- Specialties and other caregiver participation
- Choice of Entity, Tax planning
- Identify, analyze and address each and every item, service and financial relationship
  - Sublease of existing individual medical practice office space versus assignment of space
  - Billing and collection
  - Personnel – clinical versus non-clinical
  - Provision of additional items and services
  - Employment agreements
- Governance
- Capital contributions, line of credit, advances and other funding mechanisms
- Terms of management agreement, if any
Group Formation – Items to Consider

- Physician professional services and employment agreement
  - compensation model – base salary, professional productivity, hybrid)
  - scope of services, term, termination, non-compete, etc.)
- Allocation of costs to Care Centers – pro rata share of overhead plus direct costs
- EHR system
- Ancillary Services
- Bargaining Power with Payors
- Employee Benefits Issues (i.e. 401k plans, health care benefits)
- Malpractice insurance (captive insurance plan)
Stark Law FAQs regarding structuring a physician group

1) Ownership of a physician group by an individual, trust, or legal entity
2) Exclusive contracting arrangements
3) Federal anti-kickback statute group practice investment safe harbor
4) State Law self referral and medical practice considerations
1) Stark Law exceptions include in-office ancillary services exception, space rental exception, equipment rental exception, personal services exception, bona-fide employment exception, and fair market value exception

2) AKS safe harbors include group practice investment, space rental, employment, and personal services and management contracts
Operating a Physician Group Structure

- Physician Partners
- Care Center One
- Care Center Two
- Care Center Three
- Physician Group
- Ancillary Mgmt. Services, Sublease, Items and Services
- Management Company
- Investors
- Parent
- Physician Equity Participation

Dashed lines indicate financial relationships and services provided to and from each entity.
Stark Law special rules and flexibility with profit distributions and productivity bonuses

- Stark Law prohibits a group practice physician from being compensated directly or indirectly based on the volume or value of the member’s referrals for DHS.

- Stark Law governs how a group practice may pay physicians a share of “overall profits”.

- “Overall profits” with respect to DHSs is defined as either: (A) all of the group’s profits derived from DHSs; or (B) the profits derived from DHSs of any component of the group consisting of at least five (5) physicians.

- A group practice may segregate its DHS revenues or profits from its other revenues or profits for purposes of compensating physicians but all DHS must be pooled together.

- Inapplicable to profits not derived from DHS.
Physician group ancillary services

- In Office Ancillary Services Exception
  - Stark Law key exception for ancillary services within a group
  - Billing test, physician supervision test, and location test
  - Recent guidance on IOAS exception

- Pathology arrangements
  - Solo practitioners
  - Technical component, professional component, global
  - Shared lab arrangements and OIG guidance re AKS statute

- Anesthesia arrangements
  - Opinion 12-06 and subsequent OIG opinions
  - Maryland House Bill 441
  - Critical to incorporate appropriate safeguards into arrangement
  - Not simply an opportunity to profit from passive referrals
  - Structure to comply with state corporate practice of medicine and fee splitting laws

- State law considerations
How To Participate?

- Sign Confidentiality Agreement
- Execute an Expression of Interest
- Complete application
- Meaningful deliberation and discussions
- Transaction Documents
Case Study – Sale of a Group Practice

- **Physician Group**
  - 60 physician member group comprised of multiple physician care centers
  - Diagnostic imaging, clinical laboratory and other in-office ancillary services generating $2.5-5 million in EBITDA
  - Ownership in multiple ambulatory surgery centers

- **Health System**
  - Leading hospital developing centers of excellence
  - Growing footprint with desires to continue to capture greater market share through hospital/physician alignment strategies

- **Result**
  - Sale of physician practice assets including ancillaries (but not ASCs) for 3-4x -- Stark Law Isolated Sales Transaction Exception
  - Physician group exclusive provider of professional services through professional services agreement
  - Physician group and hospital participating in ICO with payment benchmarks and shared savings component
Case Study

Physicians

Physician Practice

Health System Parent

Hospital

Physicians

Physician Practice

Payor(s)

ICO
Shared Risk
Quality and Efficiency
Benchmarks
EHR Platform

Care Centers

Assets and Non-Clinical Personnel

Sublease, Items and Services

Rent and Fees

Purchase Price (3-4x)

FMV Fee

Professional Services
Innovation needs to be balanced with regulatory considerations

- Increased anti-trust scrutiny
- Increased whistleblower activity
  - Halifax
  - Davita
  - OIG Guidance
- Patient Privacy enforcement
  - Meaningful expansion of HIPAA’s web commencing in September 2013
  - Increased enforcement activity
“Your Honor, my client pleads guilty to an overzealous but well-intentioned pursuit of the profit motive.”
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Physician Practice Management Companies (PPMs)

- Typically owned by non-physician investors
- Prohibited from involvement in patient care and clinical decision-making
- Manage physician practices of all types and sizes, including primary care, single-specialty, multi-specialty, and hospital-based practices
- When structured properly can result in financial gain for PPMs and provide significant benefits to physicians
Benefits of PPMs

- Ability to make capital investments (sophisticated software, equipment, and process-management systems)

- Administrative efficiency, clinical effectiveness, and cost-efficient management of the “business” of practicing medicine

- Advanced patient-acquisition methods, population health and risk management (Actuarial support to identify the patient populations and trends that drive medical-cost inflation)

- Negotiate Higher Reimbursement Rates
Ordinarily a “full service relationship” begins with the PPM “acquiring” an existing physician practice. This includes purchasing all of the practice’s assets, (office and equipment leases) all of which are leased back to the practice.

In a “full service relationship” the PPM provides the physician practice with a full suite of management, administrative, financial, and operational support services necessary for the practice to operate on a day-to-day basis.

**Note:** Ordinarily, physicians receive payment as consideration for the sale of the practice’s assets at the time of the affiliation.
De novo or “New” Physician Entity

- PPMs recruit individual physicians from an existing practice or residency and arrange for office space, equipment, staff, etc.... to be provided to a new physician practice entity formed by the PPM.

- In a “New” or “De novo” Entity – The newly formed physician practice is governed by a long-term management agreement (usually 10 years or more).
Legal Pitfalls of PPMs

Legal Considerations to Take Into Account:

1. Corporate Practice of Medicine (CPOM) Doctrine

2. State Law Fee-Splitting Prohibition
Corporate Practice of Medicine Doctrine

Overview:
Prohibits a business corporation from practicing medicine or employing a physician to provide professional medical services.

Some states, including New York, New Jersey, Colorado, and Illinois, have carved out certain corporate employers as exceptions to the CPOM prohibition, such as hospitals, health maintenance organizations, and of course, professional corporations.
Corporate Practice of Medicine Doctrine

Public Policy:

The CPOM prohibition manifests itself in a variety of state laws, regulations, and court opinions addressing ownership or control of healthcare providers by individuals or corporations that cannot directly provide healthcare services.

Some states merely prohibit the practice of medicine without a license or the sharing of fees between licensed and unlicensed individuals, while other states flatly prohibit the ownership of medical practices or employment of professionals by nonprofessionals.
Corporate Practice of Medicine Doctrine

**Authority:**

- Corporate employment of a licensed professional has been prohibited on the grounds that such a relationship “tends to the commercialization and debasement of those professions” (Barton v. Codington Country, 2 N.W. 2d 337, 343 (S.D. 1942))


- Causes the general intrusion into the practice of medicine by corporate entities that are not licensed and therefore not subject to the same professional standards or regulatory control as licensed entities. See, e.g., State v. Boren, 219 P.2d 566, 568-69 (Wash. 1950); Funk Jewelry Co. v. State ex rel. La Prade, 50 P.2d 945, 945-47 (Ariz. 1935)
Texas Court of Appeals found that the CPOM doctrine had been violated under the Texas Medical Practices Act, holding that a PPM through a practice management agreement, retained the right to a majority of the practice’s profits, commingled the practice’s and funds with the PPM and pledged the practice’s assets as collateral for the PPM’s debt. Furthermore, under the management agreement retained the right to hire staff for the practice to use in hospitals where the practice contracted to provide services.

In this case, the court looked beyond the form of the arrangement and found that the practical effect was that the physician was an “employee” of the PPM, and allowed the PPM to indirectly practice medicine, both impermissible under the Texas Medical Practices Act.
Fee-Splitting

- AMA Opinion 6.02 - Any payment by or to a physician solely for the referral of a patient is “fee splitting” and is “unethical.”

- State Statutes - The prohibition of “Fee-splitting” is commonly included in state statutes relating: (i) licensure of medical professionals; (ii) unethical; or (iii) professional misconduct. *(New York State: BOTH Statute and Regulation)*

- The legislative intent behind fee-splitting prohibition was to remove any improper financial incentive from a physician’s consideration when diagnosing and treating patients.
NY Education Law § 6530 & N.Y.C.R.R. § 29.1(b)

Definitions of Professional Misconduct:

- Directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or in connection with the performance of professional services;

- Permitting any person to *share in the fees for professional services*, other than: a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice medicine, or a legally authorized trainee practicing under the supervision of a licensee....

- This prohibition shall include any arrangement or agreement whereby the amount received in payment for furnishing space, facilities, equipment or personnel services used by a professional licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee from such practice......
In *Necula v. Glass* a physician had been excluded from New York’s Medicaid program after he was found to have entered into contracts with management companies that provided him with “facilities, supplies, equipment and non-physician staff necessary to operate his radiology practice [and paid] the companies a fixed percentage of his receipts for *billing services* and a fixed dollar amount for each procedure performed.” The court found this to be illegal fee-splitting and upheld his exclusion.
Times are Changing ..........

**THEN** - When the fee-splitting prohibitions were enacted, most physicians did their own billing using a secretary or billing clerk.

**NOW** - Today many physicians use electronic billing services and pay them based upon a percentage of billed fees or collections; thereby conflicting with statutory law.

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**Fee Splitting Exceptions (Billing Arrangements)**

**Public Act 96-0608 (Section 22.2) to the Illinois Medical Practice Act**

Exception for medical billing arrangements allows payment by a physician (or physician practice) for the performance of billing, administrative preparation, or collection of claims for professional fees, but only if three requirements are satisfied:

First, the payment of compensation must be consistent with fair market value. Second, the physician or physician practice must control the amount of fees charged and collected. Third, all collections for professional charges must either be paid directly to the physician (or physician practice) or deposited directly into an account in the name and under the sole control of the physician (or physician practice), or into a trust account by a licensed collection agency.
Physician Practice Management Arrangements (PPMAs)

- PPMAs - Are arrangements between licensed physicians and a business entity owned by non-licensed persons.

- PPMAs - Set forth the services to be provided by the PPM and the rights and obligations of the parties during the relationship.

- PPMAs - Typically require physicians enter into employment agreements with the practice (or amend the physicians’ existing employment agreement) to contain a restrictive covenant that prevents the physicians from leaving the practice and directly competing with the practice.
PPMAs – Keys Areas of Concern for Counsel

- Parties’ obligations and deliverables
- Management company costs and pass through costs
- Calculation of revenue and handling of collections
- Real estate (bricks and mortar) of the transaction
- Default provisions and balance of power
- Buy-out provisions
- Termination and Term
PPMAs – Other Issues of Interest

- HIPPA / BAAs
- Billing and Collection Services
- How the occupational licenses are titled
- Medicare Provider Number (Location)
Ownership

- **Lay Corporation / Non-Professional** - The CPOM doctrine can dictate the form of physician entity to be used in a physician practice management arrangement.

- CPOM doctrine prohibits a lay corporation (i.e., one that is owned by nonprofessionals) from practicing medicine.

- **Friendly Physician** – Many States require that a “Friendly” physician be the officer, director, or employee of the PPM. In this scenario the “Friendly” Physician assumes sole or majority ownership of the physician practice. “Friendly” physician **MUST** be licensed in each state where the PPM provides services.

Employment

- PPMAs can implicate the CPOM doctrine if the form of the physician entity (e.g., corporation, limited liability company, professional corporation) is not one that can lawfully employ physicians. *(See, state-specific exceptions)*
Check…Check & Double Check

Payments

- Payments should be structured as either a flat fee, or on a fee-for-item or fee-for-service basis. Payments based simply on a percentage of the medical practice’s gross or net revenue are prohibited as “fee-splitting” and can void the entire arrangement.

Control

- PPMs can exercise too much control over the practice, which could infer that the PPM is effectively engaged in the practice of medicine. (See, Flynn Bros, Inc. v. First Medical Assocs., 715 S.W.2d 782 (Tex. App. 1986).
Important Takeaways

- **PPMAs often implicate state laws on CPOM doctrine and fee-splitting prohibitions.**

- The CPOM doctrine can dictate the form of physician entity to be used in a physician practice management arrangement.

- Fee-splitting prohibitions may prevent certain management fee structures that are common to physician practice management arrangements.

- Laws vary from state to state, so these laws should be examined for each state in which services will be provided under a PPMA.

- Violation of CPOM or fee-splitting prohibitions can lead to serious consequences for both the physician practice management company and the physicians involved in an arrangement.
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