Structuring Private Equity Healthcare Management Service Organizations
Navigating Corporate Practice of Medicine and Fee-Splitting Rules, Ensuring Regulatory Compliance

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MSO Transactions

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Favorable Capital Markets

As healthcare becomes an ever larger component of the American economy, transactions in the healthcare space continue to increase as a percentage of overall market transaction activity.

- In the fourth quarter, provider services acquisitions increased over 15% from third quarter activity and 29% higher than the fourth quarter of the prior year.
- Scarcity of quality assets to meet demand for acquisitions.

Sources: Capital IQ, Thomson Reuters, Pitchbook

Aggressive Private Equity Investors

- Aggressive private equity investors with dry powder
- Ample financing available for high quality companies
- Large amount of capital that needs to be deployed in the next six to eighteen months
- Excess investable capital being drawn down

Private Capital Availability Remains Robust

Sources: Capital IQ, Thomson Reuters, Pitchbook
Leverage Markets Holding

- Increased competition from non-traditional sources, paired with a lack of demand for loans, has created a highly competitive dynamic in the marketplace.

- Issuances directed strictly to leverage buyouts have returned to pre-crisis levels, at 10.4% of total issuance over the last twelve months.

- Debt multiples for middle market LBOs continue to be stable at 5.3x in 2015, reaching the highest level since 2007 when debt multiples averaged 6.2x.

- 2015 experienced continued momentum from 2014 and favorable leverage ratios remain prevalent.

- Increasing number of loans are coming due in 2016, which will compete for new debt used for M&A and growth initiatives.
Valuations Above 5-Year Average

Average Enterprise Value to Revenue

Average Forward Looking Enterprise Value to Revenue

Average Enterprise Value to EBITDA (Proxy for Cash Flow)

Average Forward Looking Enterprise Value to EBITDA

Median NTM EV/Revenue

Median LTM EV/Revenue

Median NTM EV/EBITDA

Median LTM EV/EBITDA

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Valuations Above 5-Year Average

Comparable Public Companies Historical Median LTM EV / Revenue

Comparable Public Companies Historical Median LTM EV / EBITDA
Physician Practice Landscape

Four sectors with significant activity

- Facility-based specialties (e.g. anesthesia, radiology, ED, hospitalists)
- Retail medicine (e.g. dental, dermatology, IVF)
- Disease-state specialties (e.g. gastro, orthopedics)
- Primary care strategies
Physician Practice Landscape

Core Drivers of Consolidation

– Benefits of scale
  ▪ Leverage IT, scheduling, revenue cycle
  ▪ Access and optimize ancillaries
  ▪ Deploy physician extenders and specialize
  ▪ Manage care strategies

– Capital availability
  ▪ Investors increasingly understand potential in clinical services
Physician Practice Landscape

Core Drivers of Consolidation

- Secular trends
  - Healthcare reform
  - Employer and payer strategies

- Physicians increasingly interested in a transaction
  - Desire to establish long-term practice continuity
  - Aging physician base in ownership
  - Capital requirements
  - Wealth diversification
Transaction Considerations

■ “Platform” vs. “Bolt-Ons”
  – Platform attributes
  – Valuation differences

■ Compensation and Value
  – Trading compensation for liquidity
  – Tax considerations

■ Ownership Dynamics
  – Broadly held vs. consolidated ownership
Structuring Private Equity Healthcare Management Services Organizations
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Overview of Corporate Practice and Fee-Splitting Prohibitions, Generally

- **Broad Overview**
  - Originated in 1847 – American Medical Association issued Principles of Medical Ethics
    - Sought to distinguish between educated and trained physicians and others who claimed to be able treat and cure various ailments
    - Increasing employment of physicians by lay corporations for care of employees in late 19th century
    - Concern about potential or actual tension between profit motive and professional medical judgment of physicians
    - Much support by late 1800s and early 1900s for various forms of corporate practice of medicine prohibition
    - Doctrine to protect professional medical judgment from non-physician control
Overview of Corporate Practice and Fee-Splitting Prohibitions, Generally

- Sources of corporate practice and fee-splitting prohibitions
  - Some are relatively clear expressions in statute and regulation
  - Some derive from common law
  - Others may derive primarily through agency interpretation or state Attorney General opinion
  - Although fee-splitting may arise from separate law, usually bound closely to corporate practice restrictions
Overview of Corporate Practice and Fee-Splitting Prohibitions, Generally

- **Scope of Restriction (if any) Varies by State**
  - Some states maintain a strict corporate practice prohibition and permit physician employment of physicians only in limited circumstances
  - Some states maintain a the corporate practice prohibition but are more liberal in granting exceptions
  - Others take a more permissive approach, generally allowing lay corporations to employ physicians, so long as the corporation does not control professional medical judgment
  - Some states have no specific prohibitions on the corporate practice of medicine
California Corporate Practice of Medicine Prohibition

- CORPORATE PRACTICE OF MEDICINE (CPOM)

- General Business Entities May Not Practice Medicine Defined As:
  - “Any person who practices or attempts to practice, or who advertises or hold himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person.” California Business and Professions Code § 2502.
  - “Corporations and other artificial entities shall have no professional rights, privileges, or powers.” California Business and Professions Code §2400 (pertinent excerpt)
  - Similar Provisions in Other States.
California CPOM Prohibition

- Practical Aspects of the CPOM Prohibition
  - Ownership of a Medical Practice is limited to Physicians (and certain other health professionals)
  - Ownership of a physician’s practice by lay persons is prohibited
  - Ownership of a physician’s practice by a general business corporation is prohibited
  - General prohibition on employment of physicians for provision of professional medical services
    - Certain exceptions apply for ownership by hospitals and HMOs, certain governmental entities, academic medical centers, certain nonprofit entities, certain licensed clinics, depending upon the state
California CPOM Prohibition

- Violation of the Prohibition on CPOM
  - Fines
  - Prison
  - Licensure Action taken against physician
  - Can also pursue anyone who aids and abets the violation
  - Alleged violations sometimes arise in connection with civil litigation, arguments seeking to void a contract for illegality or payors seeking to recoup payment due to allegation that a given provider business structure violates CPOM
The “Friendly PC” Model

- A professional corporation is formed by a physician associated with the management company
- A Stock Transfer Agreement is entered into between the management company and the physician
- The Stock Transfer Agreement allows the management company to designate the owner of the stock of the professional corporation
CPOM and the “Friendly” PC Model Alternative (Cont.)

- Can set up a PC in each state in which management company will operate
- Can set up one PC and qualify it as a foreign corporation in other states
- Not all states allow foreign PCs
Common MSO Services to Friendly PC (CA and Other CPOM States)

- **Management Agreements**
  - May involve purchase and assignment of certain assets from the medical group to be managed
- **Billing and Collection Services**
  - Equipment
  - Office Space
  - Certain clinical and non-clinical personnel
  - Procurement of vendor services
  - Assistance with contracting
  - Business and strategic direction
  - Budgeting
  - Accounting
Aspects to Avoid in MSO Arrangements in CPOM States

• Medical decision making must be left to physicians and not lay corporation
• Advertising of medical services can only be done by physician
  o Unclear – CA Medical Board does not like, but many such arrangements exist unchallenged – See also Epic Decision discussed below
• Determination of how many patients to see in a given period of time cannot be decided by an unlicensed person
Aspects to Avoid in MSO Arrangements in CPOM States (Cont.)

• Determination of what tests are appropriate for a particular condition can only be made by physician
• Determinations of need for referrals to, or consultation with, another physician should be made by the physician, not the lay corporation
• Overall responsibility for patient care and treatment options should reside with licensed professionals, not lay corporations
• Should not give ultimate decision making power to MSO regarding hiring and firing of physicians, criteria for entering into contracts with payors, determinations about proper coding and billing for patient care services, determinations about medical equipment and supplies
  o But the MSO can often assist the managed physician practice with these matters
CPOM and Fee-Splitting

- Permissible compensation structures in CA
  - Fixed Compensation
  - Cost plus reasonable profit margin
  - Formula based on percentage of gross revenue
  - All permissible approaches must result in compensation amounts for the services provided that are consistent with what is within the range of fair market value

- Compare with NY – Compensation based on a percentage of physician revenues generally constitutes prohibited fee-splitting, with certain limited exceptions

- Compare with TX - May be permissible depending upon circumstances and relationship to legitimate services provided
CPOM Parameters – Epic Decision

- Recent California Court Decision Provides Useful Guidance for MSOs
  - Decision most directly relevant in California, but offers helpful guidance and could be of persuasive value in other jurisdictions
  - Court stated that the arrangement involved would not violate California’s anti-kickback statute, fee-splitting or CPOM rules
MSO Ownership, Arrangement and Services

- MSO partially owned by physicians
- MSO arrangement to manage a medical practice
- Comprehensive Management Services
  - Office Space
  - Equipment
  - Non-Physician Personnel
  - Establishment of Marketing Plan
  - Provision of Marketing Services
  - Billing and Collection Services
  - Accounting and other Services
CPOM Parameters – Epic Decision Cont.

- **Compensation Provisions**
  - Physician Practice agreed to pay MSO 120% of costs incurred in providing comprehensive management services via written contractual provisions
    - Not to exceed 50% of collected professional revenues and 25% of collected surgical revenues
  - However, actual arrangement used involved payment to the MSO of 50% of the revenue for office medical services, 25% of revenue from surgical services and 75% of pharmaceutical-related revenues
    - Notably, it was later determined that this formula actually provided the MSO less profit than if the parties had stuck with the original compensation terms, as written in the agreement!
Dispute and Arbitration

• After 3.5 years of the arrangement the relationship between the MSO and the physician practice soured
• Parties commenced arbitration
• Arbitrator concluded that physician practice breached agreement by failing to pay a portion of management fees owed under the modified compensation arrangement (modified by the conduct of the parties)
• Physicians moved to vacate award arguing that modified compensation structure violated anti-referral prohibitions in California
  o Argument based in part on small number of patient referrals made by MSO to physician practice
CPOM Parameters – Epic Decision Cont.

- Trial court denied physician practice motion to vacate
  - Court reasoned that any illegality from small number of referrals only “technical”, and not material enough to result in a violation of California anti-referral laws
Physician practice appealed the trial court decision

- Argued that California maintains an absolute public policy against making payments to anyone who makes patient referrals
- Court noted that Section 650(b) of the California Business and Professions Code expressly permits such payments under certain circumstances similar to those in the agreement at issue
- Based in part on this, concluded that there was no clear or likely contravention of public policy rendering the arbitration award reviewable under California law
BUT, the Court went further and said that if the arbitration award were reviewable, it would have found that the MSO agreement and its terms did NOT violate the law.

- Court noted express language under Section 650(b) that payment for services other than patient referrals based on a percentage of gross revenue or other similar contractual arrangements are not unlawful if the consideration is commensurate with the value of the services furnished.
- Court also reasoned that there was no demonstration or finding that the compensation paid was not commensurate with FMV of the management services rendered.
- Court stated that there was clear delineation between the medical elements of the practice controlled by the physician and non-medical elements that the MSO was engaged to handle.
  - Important given the percentage-based compensation arrangement and comprehensive nature of the services provided by the MSO.
CPOM and Fee-Splitting Parameters – Epic Decision Cont.

- Epic Court did not state any concerns about original written provision calling for “cost plus” compensation formula of 120% of management services costs.
- Epic Court was not troubled by actual use of the 50-25-75 compensation system, which apparently resulted in a 12.8% profit margin on the MSO services provided.
- There was a rough correlation between cost of the MSO services provided and the amount charged to the physician practice.
- No violation of fee-splitting and anti-kickback restrictions of California Business and Professions Code Section 650.
- Likely would have constituted prohibited fee-splitting in NY.
- Likely a better argument for compliance with fee-splitting rules in TX.
CPOM Parameters – Epic Decision Cont.

  - Lay company MSO contracted with labor union for provision of medical-related and management services
  - Labor union paid MSO fee
  - MSO selected, scheduled, secured and paid for radiology services ordered by union’s physician for its members
  - Selected radiology site with appropriate equipment
  - Selected radiologists to read the tests and prepare reports
  - CA Attorney General opined that these actions involved the exercise of professional medical judgment
  - Union paid MSO for professional services and non-clinical MSO services
  - MSO paid for the radiology and professional interpretations directly
CPOM Parameters

- Compare EPIC with *In re Oca, Inc.*, 552 F. 3d 413 (5th Cir. 2008)
- Comprehensive management services
- MSO determined how much each orthodontist had to work
- Orthodontists had no control over or access to their own bank accounts
- Orthodontists paid for overhead and MSO hourly management fee
- MSO and orthodontist practice split profits
- Texas 5th Cir. held that totality of the arrangement gave too much control over the orthodontist practice by the MSO.
CPOM Parameters

- Compare In re Oca with Gupta v. Eastern Idaho Tumor Institute, Inc., 140 S.W.3d 747 (Tex. App.—Houston (14th Dist.) 2004, pet. denied)
  - Arrangement by which Dr. Gupta provided professional, medical and administrative staffing of radiation oncology practice
  - Lay corporation provided all equipment, office space, billing and collections
  - Agreed to divide gross revenues of the practice related to value of services each party provided
  - After a later dispute, Dr. Gupta sought to invalidate the agreement based, in part on CPOM allegations
  - Court rejected the argument – Dr. Gupta retained authority to hire and fire medical staff, no exclusivity in MSO–type agreement, oversaw coding and billing, used his own judgment regarding all clinical matters.
Take Away for CPOM and Fee-Splitting

- Clearly delineate those decisions and responsibilities that are clinical and those that involve non-clinical, business operations
- Ensure that lay corporation does not control professional medical judgment
- Ensure that parties actually operate consistent with written, compliant MSO agreement
- Compensation should bear a reasonable relationship to the cost of providing MSO services and should be consistent with FMV
- States vary as to whether a percentage-based compensation formula can be used
- Review applicable state law carefully to determine what scope of MSO services is permissible
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Common Regulatory Issues

• **Corporate practice doctrines and fee-splitting issues**
  • Need to use practice management models in many states
  • Some states have very broad definitions of what constitutes “professional practice”
  • MSO control over “clinical decisions” (interactions with non-professional clinic administrators, quotas and schedules, etc.)
  • Is the practice management model properly operationalized?
  • Political headwinds in some states; tailwinds in others

• **Fraud and abuse issues**
  • Is the practice a referral source or referral recipient?
  • Use of rollover equity and earnouts with practicing professional owners
  • Are there economic relationships tied to the volume or value of DHS referrals?
  • Does the platform growth model involve the built-out of DHS capabilities?
  • Utilizing employment agreement and in-office ancillary services exception under the Stark laws
  • Suspect contractual joint ventures
  • Gift certificate and other rewards-based patient referral initiatives
  • Contracts sales representatives and related compensation structures
Common Regulatory Issues (cont’d)

- **Billing and coding / utilization**
  - Importance of billing and coding audits and quality of coding/documentation practices
  - Outliers on services and procedures being ordered
  - US Attorney and Attorneys General investigations based on government-available data

- **Quality of care issues**
  - Use of certain clinical techniques
  - Failure and success rates in certain procedures
  - Peer comparisons (both internal and external)
  - Training and support infrastructure

- **Patient credit balances and compliance with unclaimed property laws**
  - Present both historic liability exposure and “deferred services” revenue hit to working capital
  - Some states are watching for deal announcements to trigger audits
Common Regulatory Issues (cont’d)

• **Data privacy and security**
  - Platform-appropriate policies, procedures and assessments, with real implementation
  - Training and support infrastructure
  - History of data breach / disclosure issues
  - Consistent use of business associate agreements, etc.

• **State licensure laws**
  - Limitations on advertising and signage
  - State professional board audits and inspections
  - Cross-jurisdictional licensure and tele-medicine issues

• **Compliance programs and infrastructure**
  - Expectations should be appropriately scaled to size and maturity of platform

• **Additional service offerings**
  - Discount plans
  - Patient financing operations
  - Capitated care / insurance products

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Key investment considerations:

- Corporate practice doctrines and fee-splitting laws
- Tax structuring (many S-corporations) and defined benefit plans
- Keeping key clinical professionals incentivized
- Fraud and abuse issues with rollover equity and earn outs
- Avoiding cash flow interruptions with bolt-on acquisitions
- Insulation from historic operating liabilities (esp. overpayments)
- Assignment of managed care contracts
- Related-party transactions (leases, employment, etc.)
- Restrictive covenant limitations
- Negotiating credit covenants and requirements that work for the structure
Objectives:

• Provide competitive compensation for clinical professionals
• Align clinician incentives with practice performance
• Align practice performance with corporate performance
• Maximize use of affiliated ancillary service lines
• Ensure compliance with applicable fraud and abuse laws
• Optimize tax efficiency for the platform and clinicians
Clinician Incentive Considerations

• Important to understand a target practice’s historical compensation model
  • Salary v. “eat what you kill” and points in between
  • “Associate” v. “Partner” economics
• Important to ensure there is clinician buy-in on compensation recalibrations where the founders have historically taken annual distributions of free cash flow but the acquisition is priced on an EBITDA/revenue multiple
• Post-closing clinician compensation options:
  • **W-2 employment compensation**: cash compensation based on personal productivity and quality
  • **LTIPs**: phantom equity plans linked to local / regional performance
  • **Incentive equity**: profits interests or stock options linked to overall platform performance
  • **Rollover equity**: tax-deferred equity interest providing a “second bite at the apple” for former equityholders of acquired practices