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Physician practice management arrangements: State fee-splitting prohibitions and the corporate practice of medicine

- » Physician practice management arrangements often implicate state laws on corporate practice of medicine (CPOM) 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 physician practice management arrangement.
- » 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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Physician practice management companies (PPMs) have been around only for a quarter-century or so, but they have experienced a tumultuous history in that relatively short period of time. The industry saw PPMs grow at a frenzied rate through the early to mid-1990s, only to watch a number of large PPMs file for bankruptcy protection by the end of the decade. At the same time many PPMs were experiencing financial troubles, others went through very public divorces with their associated physician groups, many of which resulted in protracted, contentious litigation.

Although PPMs never went away entirely, their numbers significantly declined. The PPM model is viable today and, when structured properly, can provide financial gain for the PPM and significant benefits to the physicians involved. As new PPMs enter the marketplace, parties on both sides of a PPM relationship (the PPM itself and the physicians it manages) need to understand the legal pitfalls that apply to PPMs which, if not handled correctly, can jeopardize the success of any PPM arrangement. This article discusses two important legal requirements that must be understood and applied correctly to the structure of any PPM: state laws



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governing the corporate practice of medicine (CPOM) and state fee-splitting prohibitions.

What is a PPM?

In general terms, a PPM is an entity that manages one or more non-clinical aspects of a physician practice's business. PPMs manage physician practices of all types and sizes, including primary care, single-specialty, multi-specialty, and hospital-based practices. A PPM can provide a physician practice with a full suite of management, administrative, financial, and operational support services, handling virtually every aspect of the practice's business other than clinical operations, or can offer a more limited set of services. PPMs are typically owned by non-physician investors, and thus do not have any involvement in patient care or clinical decision-making (and are often prohibited from doing so legally, as discussed in more detail below).

The business rationale behind the PPM model is relatively straightforward – physicians are generally focused on providing patient care, and often do not have the time, energy, or resources to effectively and efficiently manage the “business” aspects of a medical practice. In addition, a PPM, which is funded by investors, offers a physician practice access to capital that would otherwise be unavailable, which is vitally important in an era that pits decreasing reimbursement against increasing regulatory requirements. PPMs with large networks of physician practices also can negotiate better payer contracts and provide access to clinical protocols and other benefits.

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The typical “full-service” relationship between a PPM and a physician practice involves the PPM providing office space, equipment, supplies, non-professional staff, and most everything else that is necessary for the practice to operate on a day-to-day basis. A PPM-practice affiliation often begins with a PPM “acquiring” an existing physician practice by purchasing all of the practice's assets and assuming the practice's office and equipment leases, all of which the PPM then leases back to the practice. In this scenario, the practice's

physicians usually receive a significant payment as consideration for the sale of the practice's assets at the time of the affiliation with the PPM. Alternatively, some PPMs operate under a model in which they recruit individual physicians

from existing practices or from residency and arrange for office space, equipment, staff, etc. to be provided to a new or *de novo* physician practice entity that the PPM forms. In either case, the relationship between the PPM and the practice is governed by a long-term management agreement (often with a term of 10 years or more), which sets forth all of the services to be provided by the PPM and the rights and obligations of both parties during the relationship. In addition, the PPM typically requires the physicians to enter into employment agreements with the practice (or amendments to the physicians' existing employment agreements) containing restrictive covenants that prevent the physicians from leaving the practice and directly competing with the practice. The PPM also may “hand pick” the physician who is the shareholder of the practice, creating a “friendly” physician practice entity, restricting

the physician-owner's ability to sell or transfer his or her shares to others and requiring the physician to transfer his or her shares to another physician (of the PPM's choosing) if the physician for any reason is no longer associated with the PPM.

PPMs can be compensated in a number of ways. The practice and the PPM can agree upon a payment arrangement that includes a fixed fee, a percentage of the practice's revenue or profits, a share of cost savings that the PPM helps the practice realize, or some combination of these different elements. However, the most common end-result is that the PPM guarantees the practice's physicians a generous salary and benefits, but then keeps all profits generated by the operation of the practice. The model makes perfect sense from a business perspective, as discussed below, but PPMs must be wary of state law requirements that could dictate the terms under which the PPM-physician practice arrangement must be structured.

The corporate practice of medicine doctrine

The PPM model involves an arrangement between licensed physicians on one hand and a business entity owned by non-licensed persons on the other. It would be easy and straightforward if the PPM could simply employ the physicians, allowing the PPM to pay the physicians' salaries and benefits and all other expenses of the practice while keeping the profits generated by the physicians' services. What may seem to be a very simple and straightforward arrangement can become exceedingly complex, however, because of a legal doctrine known as the prohibition against the CPOM, and any PPM arrangement should be carefully examined for compliance with the CPOM doctrine in each state in which a PPM-affiliated physician practice renders services. Generally speaking, the CPOM doctrine prohibits a lay corporation (i.e., one that is owned by non-professionals) from practicing medicine, either

through the corporation itself or by employing licensed physicians, under the theory that the medical profession may be practiced only by professionals that have been duly licensed by the state's medical board or other licensing agency. A majority of states maintain some form of the CPOM prohibition on the books today.

Depending on the state, the CPOM prohibition may be based upon a statute, case law, or an attorney general opinion. Most states have statutes allowing for physicians to form a professional corporation, professional limited liability company, or other form of entity to provide professional medical services. This affords the physician-owners the benefits of a traditional corporation or limited liability company (e.g., liability protection) while allowing them to avoid the state's CPOM prohibitions. However, most of these statutes restrict the ownership of such physician services entities to only those individuals who are licensed physicians. Thus, in states with CPOM restrictions, it is generally illegal for a PPM to directly employ physicians, and a separate physician-owned entity must be used.

PPM arrangements can also implicate the CPOM doctrine in other ways. First, if the form of entity of the physician practice (e.g., corporation, limited liability company, professional corporation) is not one that can lawfully employ physicians, the practice can be deemed to have violated the state's CPOM prohibition. This issue can arise when the PPM forms a series of *de novo* physician practice entities in various states and then recruits physicians to join the PPM's practice. Often, the PPM relies upon the law of one state that allows, for example, limited liability companies to render professional services and then erroneously assumes that other states similarly allow LLCs to employ physicians.

Second, the PPM can exercise too much control over the practice, which could lead to the conclusion that the PPM is effectively engaged in the practice of medicine in violation

of the CPOM doctrine. This was the conclusion reached by the Texas Court of Appeals in finding that the CPOM doctrine had been violated by a PPM that, through a management agreement, had the right to 66.67% of the practice's profits, frequently commingled the practice's and PPM's funds, pledged the practice's assets as collateral for the PPM's debt, and had the right to hire staff for the practice to use in hospitals where the practice contracted to provide services.¹ 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, a business corporation, and that the arrangement allowed the PPM to indirectly practice medicine, something that it could not do directly under the Texas Medical Practices Act.

When structuring a PPM arrangement, it is important to review the CPOM prohibitions and exceptions that exist in each state in which the PPM plans to provide services, to verify that the entity type chosen for the practice may in fact provide professional medical services or employ physicians to practice medicine. In addition, in states with strong CPOM prohibitions, the PPM and affiliated practice should be careful in structuring the arrangement so that the PPM will not be viewed as indirectly practicing medicine through its control over the physician practice entity. Further, a number of states' statutes contain requirements that the owners of a physician practice entity must be professionals licensed to practice the profession in that particular state. For PPMs using a "friendly" physician (i.e., one that is an officer, director, or employee of the PPM) to be the sole

or majority owner in each physician practice that is affiliated with the PPM, these laws may require the "friendly" physician to be licensed in each state where the PPM provides services.

Fee-splitting

Although sometimes misconstrued as part of the CPOM doctrine, the prohibition against physician fee-splitting is a distinct concept and may exist in a state even if an arrangement does not implicate a particular state's CPOM prohibition. Although the fee-splitting prohibition is rooted in a proscription of physicians sharing their professional fees for the referral of patients, some states flatly prohibit any dividing of professional fees between physicians and other persons or entities (whether or not tied to referrals of patients).

Fee-splitting is commonly included in state statutes relating to licensure of medical professionals. Often, fee-splitting is identified as one of many things constituting "unethical" or "unprofessional" conduct in such statutes, which could subject an offender to disciplinary action.

The prohibition on physician fee-splitting is of great relevance to PPM arrangements, because most PPMs seek to be compensated (at least in part) based upon a percentage of the revenues or profits of their affiliated physician practices. In states that strictly prohibit any form of physician fee-splitting, such as Illinois, such percentage-based compensation physician-management arrangements are simply not allowed (although percentage-based billing and collection fees are permitted). In other states where fee-splitting proscriptions are limited to the division of professional fees when tied to patient referrals, a

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percentage-based management fee may not, on its face, violate the proscription. However, a deeper look must be given to case law and administrative interpretations of the relevant statutes to determine the exact scope of the prohibition.

For example, in Florida, the fee-splitting statute prohibits “any split-fee arrangement... for patients referred...” At first glance, this statute does not appear to prohibit a management fee that is based upon a percentage of revenues or profits, because the PPM’s management fee is typically thought of as being for management services provided by the PPM. However, the Florida courts have interpreted this statute to prohibit the payment of a percentage of income-based management fee to a PPM when the PPM provided marketing and managed care contracting services to the physician practice, because the percentage-based management fee, in essence, rewarded the PPM for increasing business or referrals to the practice.²

Structuring PPM arrangements in states with strong fee-splitting restrictions can be challenging, because the general business goal of allowing the PPM to retain the profits from the practice after paying all expenses can be hard to achieve. In strict fee-splitting jurisdictions, creative approaches to assessing the management fee must be developed to allow the PPM to achieve its desired result through a series of fixed fee payments.

Potential consequences of violating the CPOM or fee-splitting prohibitions

Violating a state’s CPOM or fee-splitting prohibitions can have serious consequences. In most jurisdictions, the courts have the authority to enjoin the unlawful practice of medicine by a PPM in violation of the state’s CPOM prohibition. In addition, a physician could be subjected to disciplinary action by the state medical board or other licensing agency, including loss of the physician’s license to practice medicine, for engaging in an improper fee-splitting

arrangement. Some states also have criminal penalties associated with their fee-splitting prohibitions, which could subject the parties involved to fines or, in a particularly egregious case, imprisonment.

Further, many PPMs may not realize that if an arrangement runs afoul of a CPOM or fee-splitting prohibition, the illegality of the arrangement could be used as a defense to enforcement of a contract between the PPM and the physician practice or physicians under the theory that the contract is void as a matter of law. For example, the Florida case described above arose out of an attempt to enforce a non-competition covenant in a physician’s employment agreement. The physician argued that the management agreement, which contained the unlawful compensation term, served as consideration for the non-competition covenant that he had agreed to, and therefore, the non-competition covenant should be found to be invalid.

Conclusion

The physician practice management model is a viable alternative to the “independent” medical practice in which physicians are responsible for all of the practice’s clinical and business operations. Successful PPM arrangements can provide sound financial returns for the PPM while allowing the physicians involved to focus on patient care and be paid a generous salary without having to deal with the administrative burdens associated with managing the day-to-day operations of the medical practice. However, when structuring a PPM arrangement, the parties should be careful to comply with the CPOM and fee-splitting prohibitions in each state that the PPM-affiliated practices will conduct business, because a failure to do so could result in serious, adverse consequences for the PPM and the physicians involved. ☐

1. *Flynn Bros, Inc. v. First Medical Assocs.*, 715 S.W.2d 782 (Tex. App. 1986).
2. *Gold, Vann & White, P.A. v. Friedenstab*, 831 So. 2d 692, 695 (Fla. Dist. Ct. App. 2002).