

CLE Resources: Texas Health Law Conference 1998

PPM's: For Better or Worse, For Richer or Poorer

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I. SNAPSHOT OF THE PPM INDUSTRY

A. Healthcare Marketplace

The Health Care Financing Administration (HCFA) has estimated that national healthcare spending increased to approximately \$1.0 trillion, or approximately 14% of GDP, in 1995 from \$247 billion, or approximately 9% of GDP, in 1980. HCFA projects that annual health care spending will increase at a compounded annual growth rate of over 8% to \$1.5 trillion and approximately 16% of the GDP by the year 2000. HCFA also has estimated that \$200 billion, or approximately 20%, of total health care expenditures, in 1995 were directly attributable to physician services, and an additional amount of approximately \$515 billion or 52% of such expenditures were under physician direction, by deciding in which hospitals to admit patients, or which drugs to prescribe. Thus, physicians control, directly or indirectly, over \$700 billion in healthcare expenditures annually.

As a result of escalating health care expenditures, governmental and other payors have adopted cost containment initiatives in an effort to control spending. These initiatives have resulted in a shift from traditional fee-for-service provider reimbursement to an evolving array of managed care arrangements, varying from discounted fee-for-service to fully capitated plans in which providers assume the financial risks related to service utilization for a defined group of covered members and services. The industry also has experienced a decrease in inpatient occupancies as payors have implemented incentives for providing care in a more cost-effective setting, which is often an outpatient surgery center, in-office laboratory or similar outpatient location.

Cost-containment initiatives, including outright reduced reimbursement, have hindered physician practice profitability while demands for increased clinical documentation, cost, quality and utilization data have increased physicians' administrative duties. Small and mid-sized practices generally do not have the market presence, expertise or sophisticated cost accounting and quality management systems required, and may not have the time necessary, to evaluate and enter into informed capitated risk-sharing arrangements or to continue practicing profitably under reduced reimbursement. Also, smaller practices often lack the capital required to purchase new medical equipment and information systems to enhance the efficiency and quality of their practices.

If those market forces were not enough to put pressure on small and medium size practices, state and federal governments have increased their scrutiny of healthcare "fraud and abuse" in government funded programs. Physician anti-referral and anti-kickback statutes are being enforced by state and federal authorities against all healthcare providers, and billing and payment errors or inadvertent overpayments now carry the potential for criminal sanctions or significant civil monetary penalties. Newly published proposed regulations by the Office of Inspector General (OIG) of the Department of Health and Human Services, for example, provide for sanction of suppliers who do not bill the Medicare program directly,

exclusion of entities controlled or owned by a family member of an excluded individual, mandatory permanent exclusion from Medicare/Medicaid for a third conviction of program related crimes, and civil penalties against companies who contract with or employ an individual previously excluded from the program. 63 Federal Register 46736 (September 2, 1998). Further, since the increased expenditures authorized under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), combined federal agencies have dedicated hundreds of new enforcement personnel to combat healthcare fraud. As a result of all these forces, individual physicians and small group practices during the 1990's were increasingly consolidating, either by affiliating with larger group practices and physician practice management companies (PPM's) or by forming networks or independent practice associations. By consolidating into larger organizations, physicians hoped to achieve lower administrative costs, gain leverage in negotiating with managed care organizations and position themselves to attract needed capital resources. The growth trend of group practices is highlighted below.

B. Growth of the PPM Industry

It was against that marketplace backdrop that the PPM industry has grown and -- until recently-- flourished. In 1992, only a handful of practice management companies sold their stock to the public. Today, some 44 general or specialty PPM's are traded on the public exchanges, in addition to over 150 private PPM's. Many of the newer PPM's emerged as simultaneous "roll-ups" of 10-50 separate practices, financing their acquisitions with the proceeds of the IPO. Without significant venture capital, and lacking any operating history or historical performance indices, the roll-up PPM's nonetheless hit the ground running with an immediate market share and earnings stream which typically reflected a percentage of the historical profits of the consolidated practices. And at least initially, the perception of a valuation difference between a private medical practice and a public management company allowed the roll-up PPM's to arbitrage that difference into P/E multiples of 20 to 30 times the earnings of the combined practices, creating a high value for the PPM stock, allowing the company to acquire more practice assets for less cash.

Other PPM's started as small management services organizations (MSO's) or private PPM's. Fueled by private venture capital, they gradually acquired additional practices until the company could demonstrate management capabilities as well as growth potential. Private PPM's continue to evolve. In Texas alone, some 11 privately held PPM's are headquartered.

The most dramatic growth has been in the area of specialty PPM's. Although early industry leaders such as PhyCor and MedPartners developed a multiple specialty formula that many early competitors copied, single specialty PPM's such as American Oncology Resources (AOR) (oncology), Physicians Resource Group (eye care) and Pediatrix (pediatric/neo-natal intensive care) have dominated the recent growth phase of the industry.

C. Recent Industry Performance

- *The publicly traded practice management sector has a market capitalization of \$8 billion in April, 1998. By August that declined to \$4 billion.*
- *A specialty eyecare management company posts a second quarter loss after taking a \$51 million pretax writeoff related to physician practices seeking to disassociate from the company.*
- *A large, aggressive provider organization files for bankruptcy protection, leaving a trail of unpaid claims, and affiliated physicians left to consider their future.*
- *5 of the largest PPM's suffer a combined second quarter 1998 loss of \$147 million.*

It's no secret that in the last 12-18 months the PPM industry has fallen on hard times. An industry leader such as PhyCor, Inc., which traded at \$35.00 a share as late as June of 1997, traded at \$5.00 a share in September, 1998. In October of 1997, during discussions to merge with PhyCor, MedPartners, Inc. listed at \$26.00 per share. Scarcely a year later, the common stock was trading under \$5.00.

Others have not even fared that well. FPA Medical Management, which suffered disappointing earnings and was involved in extensive litigation with physicians and stockholders, filed for bankruptcy protection in July, 1998, leaving a trail of disappointed investors and physicians. In addition to the FPA bankruptcy filing, PhyMatrix recently announced its intention to divest itself of its practice management business, and focus more on developing clinical trial management programs at selected locations. Industry pioneer PhyCor has announced a moratorium on new acquisitions throughout 1999.

Other companies have done a better job of weathering the storm. Specialty company AOR, which dropped to \$8.00 a share from its 52 week high of \$16.00 a share a year earlier, recently has traded

above the \$10.00 range despite the general drop in the stock market, and the company has optimistic projections of earnings and further practice affiliations.

Pediatrix perhaps has flourished better than all the rest. Focusing on the operation and management of pediatric neo-natal intensive care units, since its IPO in late 1995, the company stock has consistently traded in the \$40.00 - \$45.00 range, and the company has met or exceeded earnings estimates each year.

D. Keeping the Physicians Happy

The nosedive in the PPM industry has led some to question whether the practice management industry is viable, or whether structural changes in the way PPM's do business is necessary to ensure future growth in this business sector. Investment banking firms and brokerage houses are falling all over themselves to publish updated analyses of the industry, demonstrating why they alone saw all this coming, (without completely disassociating themselves from the industry).

The challenge ultimately for each PPM is to keep its physician partners satisfied. Those companies that have been and will be successful are not those with the most onerous contractual ties to their physicians, but rather those that pay at least as much attention to providing added value services to the physicians as they do to acquiring new practices and satisfying investor expectations. Physician income and loyalty is key to any PPM meeting its goals.

Meeting physician expectations is difficult enough on a good day, but recent court and regulatory challenges have heightened the scrutiny of PPM's and their management agreements with their affiliated practices. These regulatory growing pains are likely to continue, and will impact the industry in the years ahead.

II. CURRENT STATE LAW DEVELOPMENTS

A. Corporate Practice of Medicine

PPM's seeking to operate in a given state must first examine state law regarding the corporate practice of medicine. The laws of many states prohibit non-physician entities from practicing medicine or employing physicians to practice medicine. These laws vary from state to state and are enforced by the courts and state regulatory authorities with broad discretion. Although much of the case law is relatively dated, there have been developments in recent years where courts, state attorneys general, and licensing boards have reinforced the vitality of the doctrine. Two states in particular, Texas and California, illustrate the business challenges presented by the corporate practice prohibition.

1. Texas

In Texas, the long standing prohibition against the corporate practice of medicine is contained in the Medical Practice Act, Tex. Rev. Civ. Stat. Ann. Article 4495b (MPA), Sections 3.07(e) and 3.08(12), (15). The primary restriction is in Section 3.08(15) which prohibits a physician from: "aiding or abetting, directly or indirectly, the practice of medicine by any person, partnership, association, or corporation not duly licensed to practice medicine by the board." The Texas State Board of Medical Examiners ("TSBME"), enforces the MPA.

While there is limited case law upon which to rely, the prohibition against the corporate practice of medicine has been interpreted to prohibit several specific practices. For example, a physician may not be employed by a lay person to provide medical services to patients on a salary basis, nor can he allow the lay person to make decisions about how medicine is practiced. Rockett v. Texas State Board of Medical Examiners, 287 S.W. 2d 190 (Tex. Civ. App - San Antonio 1965, writ ref=d); Watt v. Texas State Board of Medical Examiners, 303 S.W. 2d 884 (Tex. Civ. App - Dallas, writ ref=d, n.r.e.) cert. den., 356 U.S. 912 (1957). Similarly, HMO's may not hire physicians as employees. Garcia v. Texas State Board of Medical Examiners, 384 F. Supp. 434 (W.D. Tex. 1974). Finally, lay persons forming a management company to provide exclusive management services to a physician and keeping 67% of the profits of the entity while maintaining effective control over the financial and medical aspects of the practice also violated the corporate practice prohibition. Flynn Brothers, Inc. v. First Medical Associates, 715 S.W. 2d 782 (Tex. Civ. App. - Dallas 1986, writ ref=d n.r.e.).

With respect to PPM management services agreements, since no PPM's employ physicians directly, the factors that the TSBME and a Texas court likely would examine in determining whether the corporate practice doctrine is violated would be the nature of the management fee, and the degree of control the Manager exerts over the medical aspects of the physicians' practice, both under the terms of the MSA and in practice. With those factors in mind, the Flynn Brothers case is most instructive.

The Flynn Brothers set up a corporation, FBI, Inc. which signed an exclusive management agreement with First Medical Associates, a professional association comprised of one physician, which secured a contract with a Dallas hospital to provide emergency room services. The physician later attempted to terminate the contract, and FBI sued to enforce the agreement. The Court of Appeals struck down the contract because it violated the MPA, focusing on several key factors in reaching its decision:

1. FBI retained 67% of the net profits of the practice;
2. Funds of the practice and FBI were often co-mingled and were often transferred directly to one of the Flynn brother's personal bank account;
3. FBI pledged the contract rights and other assets of FMA to secure a pre-existing FBI debt at a local bank;
4. FBI had the right to select medical staff to work in the hospitals along with the doctor.

Although the court noted that the physician was not the employee of the management company, "the practical effect was the same." The design, effect and purpose of the agreement was to do indirectly what the parties could not do directly. 715 S.W.2d at 785.

PPM's operating in Texas should scrupulously adhere to the constraints articulated by the Flynn Bros. court and its predecessors. While a percentage management fee is not prohibited in Texas, the fee must be at fair market value and should not cross the 50% of profits threshold noted by the Flynn Bros. court. All medical fees should be deposited initially into a practice account, and practice and management funds should not be commingled. PPM's of course may not employ a physician, and they must avoid any interference in clinical decision making. While the TSBME has no decisions or pending cases regarding PPM management contracts, several lawsuits filed by disgruntled physicians have alleged corporate practice violations by PPM's, and a Texas court some day could reach this issue.

2. California

California also traditionally has taken a strong position on the corporate practice of medicine. The primary statutory authority for the corporate practice of medicine prohibition is contained at Cal. Bus. and Prof. Code ' 2400. The statute provides:

Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the division of licensing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic. Also, Cal. Bus. Prof. Code ' 2052 makes it illegal for any person to practice, attempt to practice or to advertise that they are capable of practicing medicine without a valid license. Penalties for the unlawful practice of medicine include: (1) criminal prosecution; (2) injunctive relief; (3) ouster in a quo warranto proceeding; and (4) exposure to civil lawsuits.

The California corporate practice of medicine prohibition is broader than the doctrine in many other states, in that it potentially impacts certain financial arrangements which do not involve direct employment. The primary concern for California courts with arrangements between physicians and corporations stems from the potential conflict between profit motive and professional standards and obligations which could arise. The County of Los Angeles v. Ford, 121 Cal. App. 2d 407, 413, 63 P.2d 638, 641, 642 (1953). Because of this potential conflict, California courts will examine management arrangements to insure that the corporation is not exercising too much control over the physician. The corporate practice of medicine prohibition is premised upon a "strong long-standing public policy against permitting lay persons ... to exercise control over decisions by healing art practitioners." Cal. Assn. of Disp. Opticians v. Pearle Vision, 143 Cal. App. 3d 419, 427 (1983). Under the traditional PPMC model, the PPMC exercises a certain degree of control over physicians. Thus, any arrangement should be scrutinized to insure that the PPMC is not exercising a degree of control which would implicate the corporate practice of medicine prohibition.

The California Medical Association ("CMA") has published materials offering further guidance in this area. The 1994 guidelines require that practicing physicians make certain ultimate decisions and exercise exclusive control over the treatment and diagnosis of patients and recommendations for patient care. the guidelines also allow practicing physicians and a lay entity such as a MSO to jointly decide on a number of non-medical treatment related issues such as how many hours a physician should work, non-clinical decisions concerning medical records, contractual relationship with third-party payors, how much the physician group should be compensated and marketing activities.

3. Current Enforcement

Most of the caselaw interpreting these various statutes is rather dated, and the authors are not aware of any current regulatory enforcement activity asserting corporate practice violations against PPM's or PPM-managed practices, stemming from the management agreement with the PPM.

However, the risk to management companies in recent months has manifested itself not so much in enforcement action by regulatory authorities, but rather litigation from managed practices seeking to unwind the management relationship, or disgruntled shareholders disappointed with poor PPM stock performance. Several publicly traded PPM's are involved in litigation with physician groups seeking to have their management agreements declared void. Phymatrix Corp.'s recent decision to unwind its practice management operations stemmed in part from litigation involving its predominantly Florida operations. Although no recent court decision has found a PPM "corporate practice" violation, the corporate practice doctrine remains a convenient sword by which an unhappy physician may try to sever his PPM relationship, even for a carefully structured management agreement.

B. Fee Splitting

Corporate practice of medicine and fee splitting are virtually synonymous in some states. Both doctrines are creatures of state law, typically are found in the licensing statute for physicians, and are enforced by the applicable Board of Medicine or Medical Examiners.

1. Texas

Texas does not have a true "fee splitting" statute as might be found in other states. Texas' fee splitting prohibition is contained in Section 3.07(c) of the MPA which provides that:

"A physician or surgeon may not employ or agree to employ, pay or promise to pay, or reward or promise to reward any person . . . for securing, soliciting, or drumming patients or patronage. A physician or surgeon may not accept or agree to accept any payment, fee, reward, or anything of value for securing, soliciting, or drumming for patients or patronage for any physician or surgeon. . . The preceding shall not be construed to prohibit advertising . . ."

The prohibition more accurately could be termed an anti-kickback statute, and it is seldom if ever enforced by the TSBME. The authors have found no reported cases interpreting this provision in the PPM context. In fact, much of the language of ' 3.07(c) was incorporated into Texas' anti-kickback statute, ' 161.091, Texas Health and Safety Code. Section 3.07(c) strikes at the straightforward referral fee arrangement where a physician pays or receives a referral fee in exchange for the referral of a particular patient, a practice not likely to occur.

2. Florida: Doing the Bakrania

In Florida, however, the Florida Board of Medicine recently ruled that a PhyMatrix management agreement in that state violated the "fee splitting" provisions of Florida's Medical Practice Statute in *In Re: The Petition for Declaratory Statement of Magan L. Bakrania, M.D.* 20 FALR 395 (1998). The case originally arose because the now famous Dr. Bakrania was contemplating joining a Florida medical group with an existing management contract with PhyMatrix, and his counsel recommended obtaining a protective Declaratory Statement from the Board of Medicine approving the arrangement. The Board (over the objection of their general counsel) ruled that the management agreement violated Florida's fee splitting statute. See Appendix A. That case is currently on appeal, and PhyMatrix has announced it intends to discontinue its practice management operations. Nonetheless, the decision evidences an attention by the Board of Medicine to PPM relationships, and if upheld on appeal, could cause a restructuring of PPM management agreements in Florida. Ironically, Florida has no corporate practice prohibition, and PhyMatrix probably could have employed Dr. Bakrania directly, under virtually the same economic terms disallowed by the Board.

C. Insurance Regulation

An important element of most PPM's business and strategy includes acting as an agent for Physicians and affiliated networks to negotiate with insurance companies, HMOs, employer self-funded plans, health plans and other managed care organizations (MCOs) for the provision of health care services to the subscribers or beneficiaries of the health plans operated by such parties. Under some of these contracts, the PPM or its managed practice receive capitation payments on behalf of a network and reimburses participating physicians on a fee-for-service basis. Under the laws of some states, this contracting arrangement could be determined to involve an insurance risk. Therefore, to the extent a company is deemed to be in the business of insurance in a particular state, the company and its affiliated physicians and networks could be subject to State Department of Insurance regulatory scrutiny.

1. Regulation of Risk Bearing Entities

With the bankruptcy filing of FPA Medical Management in July, 1998, thousands of physicians - many of them located in Texas - were left to seek payment from the bankrupt estate for services rendered to patients under contract through FPA or an FPA-managed medical group. Because of complaints from specialists and patients, the Texas Department of Insurance has recently indicated its intention to further scrutinize and regulate physician and other provider networks that accept financial risk for the provision of health care services. Physicians and physician organizations (such as professional associations and 5.01(a) organizations) are exempt from regulation under the HMO Act and thus can assume and share risk for healthcare services, as well as contract with other physicians for the provision of healthcare services that the medical group itself is not capable of providing. A physician group may subcontract with other physicians either under a fee-for-service arrangement, a risk sharing arrangement, or a capitated risk arrangement. The problem arises where the entity accepting the capitation payment (the medical group or the PPM manager) becomes insolvent, leaving specialists and other contracted providers unpaid for services already rendered to the group's patients. Neither the PPM nor the medical group are regulated entities; thus the Department of Insurance has no authority nor an effective mechanism to monitor the financial well being or performance of such provider organizations.

The Department currently is considering regulatory or legislative action to make such organizations subject to Department of Insurance oversight. Such regulation might encompass minimum capital and cash requirements, reporting requirements, and licensing or certification standards.

2. PSO Solvency Regulations

A preview of such standards for Texas provider organizations, and the PPM's with whom they are affiliated, might be the recently published PSO solvency regulations. The Social Security Act was amended by Congress in 1997 to create the Medicare+Choice Program. Medicare+Choice authorizes provider sponsored organizations ("PSOs" to contract directly with Medicare to deliver healthcare services to Medicare beneficiaries under a managed care environment. The federal legislation requires that any state licensing standard more stringent than the federal standard will be preempted by the federal standard. On August 7, 1998 the Department of Insurance published proposed regulations authorizing and licensing PSO's in Texas. Because PSO's ordinarily would be regulated as HMO's, and the standards for HMO's are more stringent than the published federal standards, the Department of Insurance has proposed the same solvency requirements for PSO's as those established under the federal regulation. PSO's would be required to be licensed under the same process as HMO's, although the solvency standard would track federal regulation which provides for a minimum of \$1,500,000.00 net worth and a \$100,000.00 cash insolvency deposit at the time of application, as well as other solvency standards. Proposed 28 TAC ' 11.2301 et seq. The proposed rule limits the ability of PSO's to provide services only pursuant to a contract with the Medicare program related to Medicare beneficiaries. PSO's wishing to provide services to commercial enrollees must be licensed as HMO's or approved nonprofit healthcare corporations ("ANHC's"), as under current law.

3. Financial Incentive Guidelines

On a related issue, in addition to the new PSO rules, and possible provider organization regulations, the Department of Insurance recently published proposed financial incentive guidelines to identify the factors that the Department considers in determining whether a financial incentive arrangement induces physicians to limit medically necessary services in violation of Article 20A.14(l) of the Texas Insurance Code. The Department of Insurance held a hearing on September 24, 1998 concerning the effect of such financial incentives in managed care agreements with physician groups. HMO's, PPM's, and medical groups should be aware that the Department is closely scrutinizing managed care contracts to eliminate "inappropriate" financial incentives. Any further regulation in this area could impact compensation received by the physician group under the managed care contract, and consequently compensation received by the PPM under the management contract.

D. Patient Referrals

Section 161.091 of the Texas Health and Safety Code, which is patterned after the federal statute, makes it a misdemeanor if a:

"person intentionally or knowingly offers to pay or agrees to accept any remuneration directly or directly, overtly or covertly, in cash or in kind, to or from any person, firm, association of persons, partnership, or corporation for securing or soliciting patients or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency."

The language of Section 161.091 is virtually identical to the federal anti-kickback statute, 42 U.S.C. ' 1320a-7b, and Texas authorities interpret the statute in accordance with federal interpretation of ' 1320a-

7b. The Texas law in fact provides that it will be construed to permit any payment practice permitted under federal law. Section 161.091(e). A Texas Attorney General opinion provides that "[t]his provision is intended to prohibit only payments, business arrangements, and business practices prohibited by the [federal law] and regulations promulgated thereunder." Tex. Atty. Gen. Op. LO 93-84. Thus, an analysis of compliance with the federal anti-kickback statute generally is sufficient to reach a similar conclusion under Texas law.

III. CURRENT FEDERAL LAW DEVELOPMENTS

A. IRS

1. Tax-Deferred Transactions

a. General

The Internal Revenue Code, ' 368(a), provides for special treatment of transactions that qualify as tax-free reorganizations. Generally, the parties to a tax-free reorganization recognize no gain or loss on the transaction (exception with respect to boot, discussed below). The Acquiror takes a carryover basis in the Target's assets or stock, depending on the type of reorganization. Thus, the tax on the appreciation of Target's assets or stock up to the time of the transaction is deferred until Acquiror later disposes of the assets or stock. The tax to each shareholder Target or the appreciation of such shareholder Target stock up to the time of the transaction, in turn, is deferred until the shareholder disposes of the Acquiror's stock. Many PPM's attempt to structure their acquisitions as tax free reorganizations.

b. Treatment of Boot

Cash, and any other property other than Acquiror stock (including certain nonqualified preferred stock) received by a shareholder of Target in a transaction that qualifies as a tax-free reorganization is considered "boot." The shareholder will not recognize gain or loss on the exchange of the shareholder's Target stock to the extent that the shareholder receives Acquiror stock in the reorganization but will recognize any gain to the extent of boot received by the shareholder.

2. Requirements for Tax-Deferred Reorganizations

a. Statutory Requirements

To qualify as a tax-free reorganization, a transaction must meet certain statutory requirements that depend on the particular type of reorganization. One of these requirements that applies to certain types of reorganizations and is significant in the context of physician practice acquisitions, is the "substantially all" requirement. To meet this requirement, Target must transfer substantially all of its assets to the Acquiror. For Internal Revenue Service ("IRS") ruling purposes, substantially all means 70% of the fair market value of the gross assets of Target and 90% of the fair market value of the net assets of Target. If the proposed tax-free practice acquisition involves a "spin-off" of a new professional corporation ("PC") to carry on the practice after the acquisition, satisfaction of this requirement may be affected by the fair market value of the tangible and intangible assets transferred or deemed to have been transferred from the old PC to the new PC.

b. Judicial Requirements

Additionally, there are certain judicially created requirements that apply to all reorganizations.

To qualify as a tax free reorganization, a transaction must satisfy three tests: the Continuity of Interest test, the Business Purpose test (there must be a bona fide business purpose for the reorganization), and the Continuity of Business Enterprise test (Acquiror must 1) continue at least one significant line of business of Target or 2) use in a business a significant portion of Target's historic business assets, including goodwill and other intangibles.)

The continuity of shareholder interest requirement generally requires that target shareholders receive stock of the Acquiror with a value equal to or greater than 50% of the value of the target immediately before the reorganization. The IRS recently issued revised regulations that generally liberalize the "continuity of shareholder interest" requirement that must be satisfied for a reorganization to qualify for tax-deferred treatment under Section 368 of the Internal Revenue Code. While previously, post-acquisition dispositions of Acquiror stock by a shareholder of Target that were contemplated at the time of the acquisition counted against satisfaction of the continuity of shareholder interest requirement, this is no longer the case unless the Acquiror stock is repurchased by the Acquiror or an affiliate of the Acquiror. In at least one respect, however, the regulations contain a new provision that, if upheld, makes it even less likely that an acquisition of a corporate medical practice pursuant to the structure utilized by many PPM's can be structured to qualify as a tax-deferred reorganization under Section 368. Temporary Regulation Section 1.368-1T(e)(1)(ii) generally provides that the continuity of shareholder interest

requirement will not be satisfied to the extent that prior to and in connection with the reorganization the Target corporation redeems any of its shares or makes an extraordinary distribution with respect to its shares (other than certain tax-free spin-off transactions). The regulations do not define the term "extraordinary distribution" other than to say that it is a facts and circumstances determination. The regulations contain an example of a disqualifying extraordinary distribution in which, immediately before the merger of target into acquirer, target distributes a note to its sole shareholder in an amount equal to 85% of the value of all of the target stock immediately before the distribution.

The regulation adversely impacts any proposed tax-free practice acquisition that involves a "spin-off" of a new PC to carry-on the practice after the acquisition. The value of the tangible and intangible assets transferred or deemed to have been transferred from the old PC to the new PC will likely be treated as an extraordinary distribution. To the extent the sum of the value of the extraordinary distribution and the value of any "boot" received in the reorganization exceed 50% of the value of the old PC before the distribution, the IRS can be expected to take the position that the continuity of shareholder interest requirement has not been met and the reorganization does not qualify under Section 368.

EXAMPLE. Assume PPM will acquire old PC for \$700,000, consisting of \$400,000 of PPM stock and \$300,000 cash. In connection with the acquisition, old PC will transfer its patient records, drugs and other "professional assets" to new PC and distribute the stock of new PC to old PC's shareholders. Assuming 50% is the correct continuity threshold (some caselaw suggests 40% may be sufficient), if new PC has a value greater than \$100,000 at the time of the distribution, the continuity requirement will not be met. Another way to look at it is that before the transaction old PC had a value of \$800,000 (\$100,000 attributable to new PC and \$700,000 attributable to post-distribution old PC). Thus, the old PC shareholders must receive at least \$400,000 of PPM stock ($\$800,000 * 50\%$) in order for the transaction to qualify.

Accordingly, pursuant to the regulations, if new PC has a post-distribution value in excess of 50% of old PC's pre-distribution value, the transaction can never qualify as a Section 368 reorganization. The wild card is that no one knows what the post-distribution value of new PC is. If a significant amount of the practice goodwill is deemed to follow the physicians and the patient records into new PC, the value of new PC will not be de minimis. Accordingly, if parties are attempting to structure such an acquisition as a qualifying reorganization, appraisals of old PC before the distribution and of the value of new PC immediately after the distribution would seem to be absolutely necessary.

3. Allocation of Purchase Price

In the acquisition of a physician practice, whether or not the acquisition is of stock or assets and whether or not the acquisition is intended to be taxable or qualify as a tax-deferred reorganization, the IRS may argue that a significant portion of the purchase price should be allocated, not to the stock or assets being transferred but to the service agreement entered into with the PPM and/or the non-compete agreements that may be entered into by the practice or new PC or the selling physician. Generally, the portion of the purchase price allocable to such items would be taxed as ordinary income rather than capital gain. Failure to 1) agree to an allocation between the parties, or 2) secure a bona fide appraisal of the practice to support the allocation may jeopardize the allocation, resulting in additional tax and penalties and could cause an acquisition intended to qualify as a tax-free reorganization not to so qualify.

B. HCFA/OIG: Advisory Opinion 98-4

Perhaps the most interesting regulatory development affecting PPM's (some would say the most alarming) has been the publication of an advisory opinion addressing practice management agreements. On April 15, 1998, the Office of Inspector General of the Department of Health and Human Services (OIG) released advisory opinion 98-4 ("AO 98-4"). The opinion was addressed to a Dr. Kenneth B. Lee concerning a proposed Management Agreement with Southwest Medical Management ("Southwest") whereby Southwest would provide management services to Dr. Lee's family practice, Countryside Medical, P.A. ("Countryside"). The OIG refused to approve the proposed management arrangement. It is important to remember that the advisory opinion process under the anti-kickback statute was only recently authorized by Congress and implemented by the Department of Health and Human Services ("HHS"). See 62 Fed. Reg. 7350 (Feb. 19, 1997) and 42 C.F.R. Part 1008. It is similar to the advisory opinion process under the Stark statute. HHS and the OIG historically have been opposed to an advisory opinion process. Each advisory opinion request is based upon and limited to the facts of the specific request. Therefore, the usefulness of an advisory opinion for general purposes is limited. Moreover, an advisory opinion that finds that a particular arrangement is "problematic" under the statute (as in AO 98-4) does not mean the statute has in fact been violated or that prosecution is likely. The purpose of an

advisory opinion is to advise specific parties about particular transactions, and its general applicability, while important as a clue to the OIG's thinking, should not be overstated.

1. Analysis of AO 98-4

Dr. Lee proposed to enter into a management relationship with Southwest pursuant to which Southwest would provide "a suitable location for the clinic and furnish the initial capital for the office, furniture, and operating expenses. . . Southwest will provide or arrange for all operating services for the clinic, including accounting, billing, purchasing, direct marketing, and hiring of non-medical personnel and outside vendors." AO 98-4, p.2. In exchange Southwest would receive a fee comprised of (i) a capital contribution, (ii) reimbursement for costs incurred, and (iii) 20% of monthly net revenues of the practice. There were several factors that the OIG found problematic in the proposed Southwest arrangement. Probably most important, Southwest, in addition to its duties on behalf of Countryside, was in the business of setting up unrelated provider specialty networks to which Countryside may be required to refer its patients. The networks were totally outside of the management services arrangement with Countryside, except for the referral requirement. The OIG expressed concern that it did not have any other information available on that specialty network proposal, and because of the requirement for referrals by Countryside, the OIG expressed concern about that aspect of the relationship.

The OIG also was concerned that Southwest would receive a percentage of the revenues of Countryside as compensation for its management services, and those management services included marketing and advertising activities. This concern on the part of the OIG historically has been limited to advertising or marketing activities aimed at a particular beneficiary or group of beneficiaries who did not have the sophistication to make a reasoned business judgment as to whether or not to contract with the party for whom the marketing services were being provided. On the other hand, marketing and advertising directed at the public generally, or at managed care plans in particular, are not subject to the same potential for abuse and should be at worst "technical" violations of the statute.

In the preamble to the safe harbor regulations, the OIG itself acknowledged this distinction:

"We, of course, recognize that many of these advertising and marketing activities do not warrant prosecution in part because (1) they are passive in nature, i.e., the activities do not involve direct contact with program beneficiaries, or (2) the individual or entity involved in these promotions is not involved in the delivery of health care. Such individuals or entities are not in a position of public trust in the same manner as physicians or other health care professionals. . ."

56 Fed. Reg. 35974.

The OIG was concerned that the management agreement did not provide any safeguards against overutilization. That has not been a traditional concern of the OIG, but reflects the language in the advisory opinion preamble which allows the OIG to protect arrangements "containing limitations, requirements, or controls, that give adequate assurances that federal health care programs cannot be abused." 62 Fed. Reg. 7350, 7351. Therefore, having in place a corporate compliance plan, or similar controls should be evidence of such safeguards. Also, the management agreement should make it clear that referrals are not required by virtue of the parties' relationship under the agreement.

Finally, the OIG was concerned that Southwest would receive a percentage of Countryside's revenue and would provide Countryside's billing services, thereby implicitly creating an incentive for Southwest to overbill for services provided. While this admittedly has been a long-standing concern of the OIG, it is not a violation of the anti-kickback statute. It is also a long standing practice among billing companies in the medical industry, and a practice that historically has not been prosecuted.

While AO 98-4 has caused great concern in the industry, the Advisory Opinion process, by its own design, is unlikely to result in advisory opinions finding particular business practices favorable and acceptable under the statute, unless those practices are such that they probably should not have generated an advisory opinion request in the first place. While it should not be taken to have general applicability to the industry involved, in this case AO 98-4 should be taken as an indication that the OIG has concerns about percentage based management fees when other aggravating factors are present. In AO 98-4, there were facts present that raised sufficient concern with the OIG that it refused to approve the arrangement. It should not be taken to preclude percentage management fees at all, but parties should examine their agreements to reduce some of the more obvious areas of risk.

2. Remedial Measures

To address AO-98-4, following are examples of safeguards that could be inserted in PPM management agreements to reduce the possible exposure for claims of overutilization or fraud and abuse. They are offered in relative magnitude of importance, or impact on the degree of risk involved.

a. Flat Fee.

To completely insulate the parties from scrutiny under the federal anti-kickback statute, the safest protective measure is to convert any percentage based management agreement to a flat fee set in advance, in an effort to qualify the agreement under the personal services arrangement safe harbor of the anti-kickback statute. Most state anti-kickback statutes defer to the federal legislation, and this change should eliminate uncertainties under state law as well. It also may minimize exposure under state corporate practice of medicine and fee splitting statutes since the flat fee is no different than a flat fee paid to any other advisor or supplier such as a law firm or a landlord under an office lease. The safe harbor requires the contract must be in effect for at least one year, and so the parties could annually renegotiate the fee to more accurately reflect the level of business and, accordingly, the fair market value of the services being rendered by the management company. While this change presents more risk from a business standpoint, as well as practical problems associated with the annual fee renegotiation process, it does provide the most comprehensive regulatory protection to the parties that is possible.

b. Other Modifications.

If a flat fee is unacceptable or is not feasible to one or both parties for various business reasons, the parties may wish to consider certain modifications to the standard percentage arrangement, resulting in a hybrid fee which closely approximates the original business intent of the parties, while offering additional levels of regulatory protection. Possible modifications to the standard fee are as follows:

- 1.) The portion of the management agreement which describes the responsibilities of the company to provide marketing or advertising services should be revised to incorporate a separate flat fee for that portion of the arrangement. That flat fee should approximate the fair market value of the actual marketing and advertising services rendered (remember that costs incurred for advertising activities, such as Yellow Pages or media buys, typically would be passed through as a shared practice expense), and the overall percentage management fee could be reduced proportionately to the anticipated fee from the marketing services.
- 2.) The parties could place a cap on the amount of total annual compensation paid under the contract. This cap itself could be renegotiated annually, as business needs demand, but it does offer an argument that despite the percentage nature of the base fee, some portion of the fee is an aggregate amount, set in advance, and therefore in compliance with the personal services safe harbor.
- 3.) If the PPM also provides "network development" or managed care negotiation activities, those activities should be simply part of the overall general management services provided by the manager, and should not be paid any additional percentage fee for such activities. Additionally, any provision in the agreement which requires the practice to refer patients within the PPM network or to other PPM affiliated practices should be deleted. If referrals within network are important, such as in the context of a capitation contract, such referral requirements should be contained in that managed care contract rather than the management agreement.
- 4.) Where possible, and unless prohibited under state law (such as in California), percentage based management agreements should be based upon a percentage of net revenues rather than gross revenues. The theory of course is that a management company that receives a percentage of gross revenues will benefit dollar for dollar for each "referral" or amount of new business generated, whereas compensation based upon a percentage of net revenues more rewards the achieving of economies of scale and efficiencies in the practice as opposed simply to developing new business.
- 5.) Finally, in a "belt and suspenders" approach, the parties may wish to address the OIG's concerns expressed in AO 98-4 about percentage-based billing arrangements which increase the risk of upcoding and other abusive billing practices. Negotiating a flat fee for such billing services either on a monthly basis, or a per claim basis, would address those concerns. This would create more work for the parties, however, and would not function very smoothly in the context of capitation contracts, and thus this suggestion may have more operational problems than any benefits to be achieved.

3. Conclusion

As the healthcare and PPM industries continue to evolve, PPM's and their managed practices should be aware of the OIG's antipathy towards percentage based agreements. Companies must continue to reevaluate management relationships entered into in good faith, aware of the changing regulatory climate in which they operate. At least at present, percentage based agreements are not per se illegal, however, and the parties can take reasonable steps to address the most egregious factors found in AO 98-4, without changing the fundamental economic and business relationship of the parties.

C. SEC

As if tax and healthcare fraud issues were not enough with which to deal, the Securities and Exchange Commission has taken an active role in regulating financial and securities laws disclosures related to PPM operations. The SEC has actively challenged certain PPM accounting practices, restricting the methods by which PPM's may account for expense and revenues related to the acquisition of a medical practice, as well as its operations. These changes impact PPM earnings and, hence, stock value.

1. Acquisition Accounting Considerations

For financial accounting purposes, there are two methods of accounting for a business combination, the Purchase Method and the Pooling of Interests Method. The particular method used may have a significant impact on earnings. However, the methods are not elective. If a business combination meets the requirements for a Pooling of Interests, that method must be used. All other business combinations must be accounted for by the Purchase Method.

a. Purchase Method

This method accounts for a business combination as the acquisition of one entity by another. Acquiror records the tangible assets of Target at their Fair Market Value. Any difference between the total purchase price and the Fair Market Value of the tangible assets must be recorded as goodwill and amortized over a period not exceeding 40 years. The amount recorded as goodwill may be significant if Target is a service provider where typically a large portion of the value of the company is tied to intangibles such as goodwill. As goodwill is amortized, the expense reduces earnings and earnings per share which may adversely affect Acquiror's stock price.

b. Pooling of Interests Method

This method accounts for a business combination as a unification of two or more entities. Basically, the financial statements of the entities are combined. The assets and liabilities of Acquiror and Target remain at their previously recorded values and thus, no goodwill is created. In addition, the earnings of Acquiror and Target are combined for the entire fiscal year of the acquisition, often resulting in higher earnings for Acquiror.

c. Another Possibility - Reorganization Accounting

SEC Staff Accounting Bulletin 48 provides that nonmonetary assets exchanged by promoters of a new venture for all or part of a company's common stock just prior to or contemporaneously with an IPO should be recorded on the new company's books at the transferor's historical cost basis and not at fair market value. This has the same effect as a pooling of interests transaction, and avoids the creation of goodwill and any negative effect on earnings associated therewith. SEC staff believes that use of this method of accounting is being made in situations where it was not intended and the issuance of additional guidance is currently under consideration.

2. Operational Accounting Developments

a. Consolidated Accounting

Methods of accounting for practice management relationships have evolved significantly over the past several years. During the earlier years of the practice management industry, many practice management companies consolidated all revenues of the medical practices managed by them and reported those revenues as revenues of the practice management company, while other practice management companies included in revenues only the management fees generated by them, including reimbursement of expenses paid by the practice management company on behalf of the practice. In the last quarter of 1997, the Financial Accounting Standards Board's Emerging Issues Task Force (the EITF) published guidelines regarding when consolidation of revenues of managed medical practices is appropriate. EITF 97-2. The thrust of the EITF's findings was that in order for consolidation of all practice revenues to be appropriate, the practice management company should have a controlling financial interest in the medical practice. In order to establish that it has a "controlling financial interest" in the medical practice, the EITF guidelines indicate that the contractual relationships between the practice management company and the medical practice must meet the criteria listed below.

Term

The contractual relationship must have a term that (i) is either the entire remaining legal life of the physician practice entity or a period of ten years or more and (ii) is not terminable by the physician practice except in the case of gross negligence, fraud or other illegal acts of the practice management company or in the event of the bankruptcy of the practice management company.

Control

The practice management company must have the exclusive decision making authority related to (i) on-going, major or central operations of the physician practice, except for the dispensing of medical services,

and (ii) total practice compensation of licensed medical professionals, as well as the ability to establish and implement guidelines for the selection, hiring and firing of them.

Financial Interest

The practice management company must have a significant financial interest in the physician practice that (i) is unilaterally saleable or transferable by the practice management company and (ii) provides the practice management company with the right to receive income, both as on-going fees and as proceeds from the sale of its interest in the physician practice, in an amount that fluctuates based on the performance of the operations of the physician practice and the change in the fair value of the physician practice.

These criteria are difficult for a practice management company to meet and are likely to be impossible to meet in states in which the corporate practice of medicine is prohibited and in practice management relationships where the physicians insist on retaining some degree of autonomy. As a result, fewer practice management companies will be able to consolidate their revenues, and the reported revenues of the companies will bear a closer relationship to those revenues actually directly controlled by the company.

b. Amortization Requirements

A further SEC staff development is the new requirement that PPM's amortize the value of practice management agreements over a more "appropriate" useful life, generally no longer than 25 years. Prior to 1998, Most PPM's amortized the goodwill attributable to management agreements over the stated term of the management agreement, typically 35 or 40 years. However, the SEC has noted that "PPMs frequently place too much emphasis on lengthy contractual periods of management agreements without adequately considering other important factors." Appendix C. Many PPM's received a letter from SEC staff this summer instructing the companies to restate the amortization period of management agreements, and future earnings accordingly. Joel Levine, Associate Chief Accountant of the Division of Corporate Finance, SEC, noted in a recent speech to the American Institute of CPA's National Healthcare Conference:

"[PPMs] with current amortization periods in excess of 25 years should reevaluate their amortization policy immediately and change to a shorter amortization period. The staff will not object to reporting the change as a change in estimate (as opposed to correction of an error) prospectively over the remaining revised period. Companies should discuss their reevaluation and report the change in their next periodic report."

The SEC noted that factors such as (a) the unproven ability of a management company and the medical practices to perform under the terms of the services arrangement over an extended period; (b) the uncertain continuity of revenues upon departure of key owner/physicians of the practice; (c) significantly increased competition and industry consolidation; and (d) the uncertain ability to withstand legal challenges concerning the corporate practice of medicine (*emphasis added*) raise questions about continued use of lengthy amortization periods. Mr. Levine concluded:

"Generally, we do not contemplate circumstances where an amortization period in excess of twenty-five years would be justified. We believe that benefit periods in the five-to-ten year range may often be reasonable." (*emphasis added*)

IV. CONCLUSION

Most lawyers had not heard of a physician practice management company scarcely five years ago, and very few firms in the entire country had participated in a PPM medical practice acquisition. Today, virtually every law firm of any size has participated in a PPM transaction either on behalf of the physician, the company, or the underwriter of a public offering. As the companies have had to adjust their business strategies to survive in the current environment, so the attorney's role continues to revolve. Counsel for the company must be sensitive to the changing regulatory environment and be able to advise the client on structuring its transactions to keep abreast of those changes both on the state and federal level. Counsel must also assist the client in restructuring asset agreements and management agreements to account for the second and third generation of issues that were not contemplated when the PPM industry was in its infancy.

Counsel for the physician should not assume that every management company proposing to acquire his client's practice is capable of performing as promised. Particularly if the company is making its first acquisition in a particular state, the transaction documents may not be responsive to the regulatory climate in that state. Companies doing business for the first time in Texas for example, may wish to

consider forming a 5.01(a) corporation as the medical practice entity, of which the PPM manager could be the sole member. Out of state companies typically are not aware of that nuance of Texas law. Counsel for the physician often can help structure the transaction in such a way that it benefits his client's interests and at the same time makes the management agreement function more appropriately under Texas law. Finally, in some cases, counsel may need to advise the physician not to enter into a transaction because of concerns about the company's ability to perform as promised, or because of substantive provisions of the transaction documents that pose an unacceptable level of risk to the physician.