

INTEGRATING WITH PHYSICIANS IN
2010 AND BEYOND:
DEFINING THE LEGAL PARAMETERS

PRESENTATION TO
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A. History of Physician Integration.

1. Where we have been with physician integration.

- The buying craze of the 1990s in the face of proposed "Clinton Era" healthcare reform.
- Usually aimed at the acquisition of primary care practices to address managed care models.
- Typically resulted in losses to the hospital and unproductive, unhappy physicians.
- Practices lost value and were often resold to original physician owners at far less than original price.
- A proliferation of ambulatory surgery center and imaging center joint ventures began as specialists started pulling outpatient surgery and imaging modalities out of hospitals and into their practices.

2. How we got there.

- Pressures from anticipated changes in healthcare delivery combined with aggressive predatory growth tactics by some proprietary hospital systems.
- Hospitals paid significant amounts to acquire practices (some were competitive situations).
- Compensation systems not based on productivity measures.
- Many hospitals were unable to manage practices and did so as they would a hospital department.
- Failure to effectively align hospital and physician goals.
- Federal healthcare reform never emerged and managed care efforts largely failed.
- Joint ventures with surgeons and physicians allowed hospitals to retain a portion of the fleeting outpatient surgery and imaging businesses.

B. Factors Influencing Integration Today.

1. Why are we going back?

- a) Physicians' Drivers.
 - Reimbursement pressures.
 - Increased administrative burdens.
 - Escalating costs, e.g., malpractice premiums.
 - Declining value of retirement portfolios.
- b) Hospital Drivers.
 - Capturing and preserving markets.
 - Physician shortages.
- c) Other Drivers.
 - Capital constraints.
 - Changes in law.
 - Improve clinical quality.
 - Improve efficiencies and help control health care costs.
 - Health care reform and government push towards integration.

2. What are we doing differently?

- Giving greater regard to fair market value (“FMV”) determinations.
- Developing compensation models that align physician and hospital goals (productivity, quality initiatives, patient satisfaction, etc.).
- Providing for greater physician practice autonomy.
- Providing physicians a voice in governance and management.
- Creating exit strategies up front.

3. What is different today?

- a) Further Developed Law – a vast body of law, regulations, and standards developed in health care transactions over last the 18 years presents both challenges and opportunities.
- b) Experience - from the efforts and mistakes of the 1990's.
- c) Health Care Reform – the passage of Federal Healthcare Reform – Patient Protection and Affordable Care Act (“PPACA”) and a shift towards bundled payments and quality improvements.
 - Recognition that fee for service payment system encourages provision of services.

C. Legal Standards – The Fundamentals.

1. Anti-Kickback Statute.

- a) Prohibition - The Anti-Kickback Statute makes it a criminal offense for "knowingly and willfully" paying or offering to pay, soliciting or receiving any remuneration to induce or reward referrals of patients for services paid under a federal health care program. The Anti-Kickback Statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction.¹

- b) Safe Harbor or Not - The Department of Health and Human Services ("HSS") promulgated safe harbor regulations under the Anti-Kickback Statute. The benefit of staying within a safe harbor is that the Office of Inspector General "OIG," as a general rule, will not seek to prosecute parties to an arrangement if the arrangement fits within a safe harbor. An arrangement outside of a safe harbor does not necessarily violate the Federal Anti-Kickback Statute; however, the parties to such a transaction do not have the same certainty that they are not in violation of the statute as they do with an arrangement that fits within a safe harbor.
 - (i) Existing Safe harbors to consider:
 - Employment
 - Personal Services and Management Contracts
 - Space Rental
 - Small Entity Investments

 - (ii) If a transaction is outside of a safe harbor, it is important to document the objective reasons for the parties entering into the transaction and the benefits to patients and the communities served by the health care providers who are entering into the transaction.

- c) Fair Market Value Determinations – It is critical to document the FMV of compensation by objective evidence (many times this will include independent appraisals). Potential concerns include:
 - (i) Payments are shared in a way that reflects the ability or level of referrals of the parties to a transaction.

 - (ii) Payments to referral sources are inflated to encourage referrals.

 - (iii) Charges to referral sources are discounted to encourage referrals.

¹ 42 U.S.C. §1320 2-7b; Regulations: 42 C.F.R. §1001.952.

- d) Joint Ventures – When forming a company jointly owned by a hospital and physicians where potential Anti-Kickback Statute issues exist, it is important to structure all elements of the company in proportion to the capital contributions of the investors. To accomplish this, each investor’s voting rights, profit and loss distribution rights, and capital call and debt guarantee obligations should be in the same percentage as their capital contributions to the company. Additionally, all transactions between the entity and its referring physician owners (including any entities in which they own interests) should be structured and documented as being at FMV. Both of these recommendations will help negate any assertions that disproportionate risk or returns from a company or non-fair market value transactions constitute indirect remuneration to compensate a referring physician for his or her referrals.

2. Stark Law.

- a) Prohibition. The Stark law prohibits a physician from referring Medicare patients to an entity, with which the physician has a financial relationship, for “designated health services” (“DHS”) and prohibits entities from billing for DHS furnished pursuant to a prohibital referral (it is possible that in the future Medicaid services could be made subject to Stark).²
 - (i) If a prohibited financial relationship exists, the parties, nevertheless, may refer and bill if the relationship fits into an exception.
 - (ii) In essence, the parties are required to document their way out of the Stark prohibition.
- b) Exceptions. Existing exceptions to consider:
 - (i) Employment exception
 - (ii) Office space and equipment rental exception
 - (iii) Isolated transaction exception
 - (iv) Physician recruitment exception

² 42 U.S.C. §1395nn; 42 C.F.R. §411.351.

3. False Claims Act.

- a) Prohibition – The Federal Civil False Claims Act ("FCA") prohibits a person from "knowingly" submitting claims or making a false record or statement in order to secure payment of a false or fraudulent claim from the federal government, *or* to conceal, avoid, or decrease an obligation to pay or transmit property to the federal government.³
- b) Basis for a Claim – Under the FCA, liability may be imposed upon an individual or entity based upon the civil burden of proof of a "preponderance of the evidence" (versus the criminal burden of beyond a reasonable doubt) that a defendant "knowingly" violated the statute. The FCA defines the terms "knowing" and "knowingly" to include that a person "(1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information;" and provides that "no proof of specific intent to defraud is required."⁴
- Stark and Anti-Kickback Statute violations have been successfully used by the government as the basis to establish a false claims case.

4. Civil Monetary Penalty.

- a) Prohibition – Civil Monetary Penalty ("CMP") Law provides a penalty against a hospital that knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who ... are entitled to benefits under [Medicare or Medicaid] ... and are under the direct care of the physician.⁵
- b) Inducement to Limit Care – Special Advisory Bulletin on Gainsharing in July 1999 reflects the OIG's perspective that:
- (i) CMP proscription is very broad and payment need not be tied to actual reduction in care.
 - (ii) Any hospital incentive plan that encourages physicians through payments to reduce or limit clinical services directly or indirectly violates the statute.
 - (iii) A violation can occur regardless of whether a service is medically necessary or appropriate.

³ 31 U.S.C. §3729(a).

⁴ 31 U.S.C. §3729(a).

⁵ 42 U.S.C. §1320(a)-7a(b); SSA §1128A(b).

5. Tax Exemption.

- a) Organizational and Operational Test. To qualify as an organization exempt from federal income tax pursuant to Internal Revenue Code (“IRC”) Section 501(c)(3), an entity must be organized and operated exclusively for charitable, scientific, or educational purposes. (This requirement creates a two pronged test for exemption in that an entity must meet both the “organizational” and “operational” tests to be properly classified as tax-exempt pursuant to IRC Section 501(c)(3)).
- (i) An entity will meet the “operational test” only if it is operated exclusively for one or more exempt purposes.
 - (ii) An organization will not be regarded as exempt under Section 501(c)(3) if more than an insubstantial part of its activities is not in furtherance of an exempt purpose.
 - (iii) The presence of a single non-exempt purpose, if substantial in nature, will destroy the exemption regardless of the number or importance of truly exempt purposes.
- b) Private Inurement Prohibition. No part of a 501(c)(3) organization’s net earnings may inure to the benefit of any private shareholder or individual. Private inurement exists when a 501(c)(3) organization transfers its resources to an insider for less than adequate consideration. This can occur where the organization’s assets are transferred to an insider in excess of reasonable compensation for goods or services rendered.
- (i) The private inurement prohibition will not allow equity type ownership of a 501(c)(3) organization by a private party.
 - (ii) Incentive based compensation arrangements are problematic and have to be carefully structured within a 501(c)(3) organization as the Internal Revenue Service (“IRS”) interprets the statute as forbidding the sharing of the net profits of the organization with a private party.
- c) Private Benefit. An organization will not be organized or operated exclusively for exempt purposes unless it serves a public rather than a private interest. The organization must be capable of demonstrating that any private benefits which flow from its activities to private interest are incidental, in a qualitative and quantitative sense, to the public benefits derived from the activity.
- (i) Unlike the private inurement prohibition, the private benefit prohibition is not limited to insiders.

- (ii) In order to be quantitatively incidental, the private benefit must be insubstantial when measured in the context of the overall tax-exempt benefit conferred by the activity.
- (iii) In order to demonstrate that private benefit is qualitatively incidental, the entity must be able to demonstrate that the exempt purpose sought to be accomplished by the activity could not be achieved without conferring the private benefit upon the private party. (This test is often articulated as a “but for” test. That is, but for the conferment of the private benefit the larger exempt purpose to be obtained from the activity could not otherwise be achieved.)

d) Unrelated Business Taxable Income.

(i) Concept.

- Imposition of Tax. A 501(c)(3) organization, while generally exempt from tax, may be subject to unrelated business income tax (“UBIT”) on its unrelated business income (“UBI”). UBI is generally income derived from certain activities outside the scope of a 501(c)(3) organization’s exempt purpose.⁶
- Objective. The purpose of the UBIT is to prevent tax-exempt organizations from unfairly competing against taxable entities conducting the same or similar types of activities.⁷

(ii) General Rules.

- Definition of Unrelated Trade or Business. An unrelated trade or business exists where three factors are met.
 - The activity constitutes a “trade or business.”
 - A trade or business generally includes any activity carried on for the production of income from the sale of goods or performance of services.⁸
 - The Supreme Court has held that the organization’s primary purpose for engaging in the activity must be for the production of income or profit.⁹
 - The activity is “regularly carried on.”
 - Essentially, an inquiry is made into whether an activity is conducted in a manner comparable to competing with for-profit taxable activities.¹⁰

⁶ See IRC §§ 511-514.

⁷ See Treas. Reg. 1.513-1(b); H. Rep. No. 2319, 81 St Cong., 2nd Sess. (1950) at 36-37.

⁸ See IRC § 512(a)(1), 513(a) and Treas. Reg. 1.513-1(b).

⁹ United States v. American Bar Endowment, 477 U.S. 105 (1986).

¹⁰ See IRC § 512(a) and Treas. Reg. 1.513-1(c).

- An activity that is conducted only once a year is not “regularly carried on.” There is more risk an activity is regularly carried on if planning and preparation for the event occur at various times throughout the year.¹¹
 - The trade or business is “not substantially related” to the organizations exempt purposes.
 - An activity is “substantially related” if it “contributes importantly” and has a “substantial casual relationship” to the achievement of exempt purposes.¹²
 - The fact that an activity may serve as a source of funding for the organization’s other exempt activities is not, in itself, sufficient to show “substantial relatedness.”¹³
- Substantial Unrelated Business Income. More than an insubstantial amount of UBI can lead to loss of tax exempt status (as it conflicts with the operational requirement).
 - Facts and circumstances test as to whether UBI is more than insubstantial.
 - Organization is probably at risk if more than 25-30% of its total revenues are derived from unrelated trade or business activities.

(iii) Modifications and Exclusions.

- Modifications. UBI subject to tax does not include:
 - 1) Dividends¹⁴
 - 2) Interest¹⁵
 - 3) Royalties¹⁶
 - 4) Rent from real property, subject to various limitations¹⁷
 - 5) Gain/loss from sale of property (other than stock in trade or inventory)¹⁸
 - 6) Research income¹⁹

¹¹ See Treas. Reg. 1.513-1(c)(2).

¹² See Treas. Reg. 1.513-1(d).

¹³ See Treas. Reg. 1.513-1(d)(1).

¹⁴ IRC § 512(b)(1).

¹⁵ IRC § 512(b)(1).

¹⁶ IRC § 512(b)(2).

¹⁷ IRC § 512(b)(3).

¹⁸ IRC § 512(b)(5).

¹⁹ IRC § 512(b)(7).

- Debt Financed Income. If income is produced from debt-financed assets, then the income may constitute unrelated debt-financed income notwithstanding the general exclusions in item above.²⁰
- Exclusions. UBI does not include amounts derived from:
 - A trade or business in which substantially all of the work is performed by volunteers (e.g., gift shops operated by hospital auxiliaries).²¹
 - The sale of goods, substantially all of which have been received by the organization as gifts or contributions (e.g., a thrift shop).²²
 - In limited situations, the provision of certain types of services by one tax-exempt hospital to another.²³
 - Services are limited in nature (data processing, purchasing, warehousing, billing and collection, food, clinical, industrial engineering, laboratory, printing, communications, records center or personnel), and must be services the recipient hospital could perform for itself as part of its own activities.
 - Must be provided only to facilities servicing less than 100 inpatients.
 - Services must be provided at cost.
 - The distribution of low-cost article as an incident to the solicitation of charitable contributions.²⁴
 - The rental or exchange of mailing lists.²⁵

e) Intermediate Sanctions.

- (i) Concept. Intermediate sanctions are an attempt by Congress to provide sanctions short of revocation of exemption for tax-exempt entities. They are in the form of excise tax penalties on insiders who received excess benefits in a transaction with an exempt organization and on the organization managers and board members who participated in those transactions knowing them to provide excess benefits.

²⁰ See §§ 512(b)(4) and 514; see also PLR 200320026.

²¹ IRC § 513(a)(1).

²² IRC § 513(a)(3).

²³ IRC §§ 513(e) and 501(e); Treas. Reg. 1.513-6.

²⁴ IRC § 513(h)(1)(a).

²⁵ IRC § 513(h)(1)(b).

- (ii) Imposition of Tax. Intermediate sanctions are imposed on:
- The disqualified person receiving the excess benefit – a first tier tax of 25% of the amount of the excess benefit and a second tier tax of 200% of the amount of the excess benefit if the transaction is not corrected in a specified time period.
 - The organization manager (defined to include any officer, director, trustee, or other person having powers similar to those of officers, directors, or employees) – subject to a tax of 10% of the amount of the excess benefit, up to the maximum of \$10,000.
 - All participating organization managers are jointly and severally liable.
 - There is no second tier tax.
 - The tax applies on the organization manager who participated in the excess benefit transaction, “knowing” that it was such a transaction, unless such participation is not willful and is due to reasonable cause.
 - Excess Benefit Transactions. Two types of transactions result in such tax:
 - A disqualified person receives an economic benefit in a transaction with the organization that exceeds the value of the consideration (including the performance of services) received for providing such benefit – this includes a non-fair market value transaction or the receipt of unreasonable compensation.
 - A disqualified person receives payment based on the income of the organization in an arrangement that violates the private inurement proscription (i.e., including payment based on a percentage of net income). Regulations on such revenue-sharing transactions have been deferred.
 - Disqualified Person.
 - Any individual in a position to exercise substantial influence over the affairs of the organization.
 - Certain individuals are *per se* disqualified persons (e.g., directors, CEO, CFO, COO), while others are subject to a facts and circumstances test.
 - It includes certain family members, businesses in which a disqualified person owns 35% or more interest, and any person who has been a disqualified person at any time in the last five years.
 - Physicians can be (but are not necessarily) disqualified persons. If a physician was not previously involved with the hospital (within the five years before the transaction), the physician will not be a disqualified person.

- Rebuttable Presumption of Reasonableness. The Regulations provide that the parties to the transaction will be entitled to “a rebuttable presumption of reasonableness” with respect to a compensation arrangement with a “disqualified person” if the arrangement was approved by an authorized body (board of directors, committee, or others authorized by Board) that:
 - Is composed entirely of persons not related to or controlled by the “disqualified person;”
 - Retained and relied upon appropriate data as to comparability; and
 - Adequately and contemporaneously documented the basis for its determination.

If presumption is obtained, this essentially flips the burden of proof to the IRS to provide that an arrangement was *not* reasonable and fair. See PLR 200413014 (ruling that aspects of bond financing process would meet criteria to obtain rebuttable presumption).

- Protecting Organization Managers.
 - Opinion. The Regulations provide that an organization manager is not liable for excise taxes even if the transaction is an excess benefit transaction so long as the organization manager, after full disclosure of the factual situation to an appropriate professional, relied on a reasoned written opinion of legal counsel, accountants with appropriate expertise, or independent valuation experts. The opinion must address the facts and the applicable standards.
 - Rebuttable Presumption. An organization manager will be deemed to have not acted “knowingly” if steps were taken in order to achieve the rebuttable presumption.

f) Effect of Joint Venture Participation on Exempt Status.

- (i) Applicable Exempt Organization Tax Law Principles. A 501(c)(3) organization is exempt from federal income tax only if it is both organized and operated exclusively for charitable purposes (organizational test and the operational test).
 - Only the operational test is typically at issue in joint venture analyses.
 - Rev. Rul. 98-15 – attributes activities of limited liability company back to 501(c)(3) member. As a result, participation needs to be screened in light of the private inurement, private benefit, intermediate sanctions and UBI standards.

(ii) Exempt Status and Joint Venture Participation.

- GCM 39005 (Dec. 17, 1982). In analyzing the exempt organization's participation in a joint venture articulated a two-pronged "close scrutiny test" that asks:
 - Whether the exempt organization's participation furthers a charitable purpose; and
 - Based upon a close scrutiny of the facts does the joint venture permit the exempt organization to act exclusively in furtherance of the charitable purposes or does the arrangement allow private interests or other than incidental private benefit to be conferred upon private investors or other for-profit persons.
- Rev. Rul. 98-15.²⁶ The IRS analyzed two assumed factual situations, a "good fact pattern" and a "bad fact pattern," dealing with whole hospital joint ventures. The IRS takes the position that where the exempt organization wants to rely upon the activities of the joint venture as furthering its exempt purposes, in the whole hospital joint venture context, the exempt organization must be able to exercise control over the joint venture so as to assure that joint venture activities are conducted in a charitable manner.

Significance:

- (a) *Rev. Rul. 98-15 reaffirms the two-pronged close scrutiny joint venture analysis*
- (b) *The ruling reaffirms the aggregate theory of analysis for flow through entities such as partnerships and LLCs. For purposes of the operational test the activities of a limited liability company are considered the activities of the owners when evaluating whether a nonprofit organization's member is operated exclusively for exempt purposes.*
- (c) *Public charity status remains available under 509(a)(1) and 170(b)(1)(A)(iii) where the principal purpose of the organizations remain the provision of health care, even though through the activities of the limited liability company.*
- (d) *Rev. Rul. 98-15 seems to suggest a need to have majority governing board control (i.e., to assure that*

²⁶ 1998-1 C.C. 718.

charitable joint venture assets are used to further a charitable purpose but subsequent court decisions have not imposed this requirement.

(iii) Summary. Based on the outcomes of several court decisions subsequent to Rev. Rul. 98-15, the following standards are applicable to a 501(c)(3) organization's participation in a joint venture with for-profit persons or entities.

- An exempt organization's participation in a joint venture with a for-profit person will not disturb the exempt organizations tax-exempt status when the joint venture's activities are insubstantial in comparison to the exempt organization's activities.
- An exempt organization's participation in a joint venture with for-profit interests can be properly structured to satisfy the control requirements of Rev. Rul. 98-15 so long as the joint venture agreements include adequate protections to ensure that the joint venture is operated at all times for charitable purposes. Properly structured joint ventures will protect exempt organization participants from UBIT and possible loss of tax-exempt status. Appropriate protections include:
 - Binding charitable purpose provisions;
 - Governance rights reserved to the exempt organization;
 - Rights upon dissolution reserved to the exempt organization; and
 - Policies that require the joint venture to provide specific community benefits.

g) Tax-Exempt Bond Considerations. Rev. Proc. 97-13 – hospitals with tax-exempt bond financing cannot use more than a certain percentage of tax-exempt financed space for “private use.” Management agreements and service agreements have to meet certain conditions if the agreements pertain to bond financed facilities.

6. Employment Tax.

- a) IRS Control Test – 20 common law factor analysis to ascertain whether, based on the level of control present, whether a worker is an employee or independent contractor.
- b) Employer Liability – Employer is responsible for employment tax if classification of independent contractor is incorrect.
- c) Section 530 Relief – If a business meets the requirements of Section 530 of the Revenue Act of 1978, the business will not have retroactive

employment tax liability with respect to the misclassified workers at issue. The business must meet the following consistency and reasonable basis requirements before the relief provision of Section 530 apply:

- (i) Consistency Test – The business must meet both aspects of the consistency test by:
 - (1) filing all required Forms 1099 (reporting consistency); and
 - (2) treating all workers in similar positions the same (substantive consistency).
- (ii) Reasonable Basis Test – The business must reasonably rely on one of the following:
 - (1) prior audit safe haven;
 - (2) judicial precedent safe haven;
 - (3) industry practice safe haven; or
 - (4) other reasonable basis.²⁷

Meeting the consistency and reasonable basis tests of Section 530 will give the business relief from employment taxes with respect to the workers whose status is in question.

7. Income Tax.

a) Joint Ventures.

- (i) Choice of Entity – the limited liability company is normally entity of choice for flow through tax treatment to private parties.

b) Deferred Compensation.

- (i) Qualified Plans – IRC requirements and ERISA. Coverage requirements across entities have to be evaluated.
- (ii) Constructive Receipt – Will require immediate taxation of income even if not paid.
- (iii) Substantial Risk of Forfeiture – Can be used to defer tax.
- (iv) Life Insurance Arrangements - Sometimes used to add incremental compensation and shelter tax.

²⁷ H.R. Rep. No. 1748, 95th Cong. 2nd Sess. 4 (1978), 1978-3 C.B. (Vol. 1) 629, 633.

8. State Self-Referral and Anti-Kickback Statute.

- a) The South Carolina Provider Self-Referral Act prohibits referrals by a physician for designated health services to an entity in which the physician is an investor or has an investment interest, unless an exception applies (the “State Statute”).
- b) The State Statute makes a referral by a physician to an entity outside the referring physician’s office or group practice illegal when the physician has an investment interest in the entity. “Office practice” means the facilities at which the physician provides or supervises the provision of health care services on an ongoing basis.
- c) The general prohibition of the State Statute does not apply (i) where the referring physician directly provides the designated health services within the entity or (ii) where the referring physician will be personally involved in the provision, supervision, or direction of care to the referred patient. However, unlike the federal prohibition, (i) the state prohibition applies to all services regardless of whether federal program dollars are involved, and (ii) there exists little interpretative guidance as to arrangements that may violate the Act and none of these provisions have ever been enforced against any person or entity.
- d) The State Anti-Kickback Statute also makes it unlawful for a physician to offer, pay, solicit, or receive a kickback for referring or soliciting patients. A “kickback” is defined as remuneration or payment pursuant to an investment interest or compensation arrangement as an incentive or inducement or refer patients for future services when the payment is not tax deductible as an ordinary and necessary expense. The only guidance as to the application of the State Anti-Kickback Statute is that the South Carolina Board of Medical Examiners, which is responsible for enforcement of the State Anti-Kickback Statute, has previously advised that it will construe the state statute consistent with the Federal Anti-Kickback Statute. Accordingly, the advice recommended above with respect to the Federal Anti-Kickback Statute is also relevant for mitigating risks with the State Anti-Kickback Statute.

9. Other Laws.

- a) Anti-Trust laws
- b) HIPPA and other privacy laws
- c) Physician recruitment standards
- d) Medicare reassignment and billing rules
- e) State constitutional issues for governmental hospitals
- f) State corporate practice of medicine prohibition
- g) State laws and policies concerning patient records

10. Keys to Compliance.

- a) Carefully designed relationships that are carefully documented in written agreements that conform to the regulatory standards.
- b) Documentation of FMV for compensation components.
- c) Perform analysis and enter into written agreements prior to entering into the relationships.

D. Practice Acquisition.

1. Tax Costs - with Stock Purchase or Asset Purchase.

- a) Stock Purchase.
 - (i) Liquidation Tax – IRC § 337(b) require liquidation tax when liquidating a for-profit entity into a 501(c)(3) entity.
- b) Asset Purchase.
 - (i) If C-Corp, “double tax” implications to the selling physicians.

2. Valuations.

- a) Standards – The IRS has issued extensive guidance on standards it will require for valuations used by the exempt organizations when purchasing physician practices.
 - (i) The transaction must meet the standard of “commercial reasonableness.”
 - (ii) Commercial reasonableness is defined as an arrangement that would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential business referrals between the parties.
 - (iii) The key driver in a practice valuation is the forecast. The forecast must include tax costs even when the practice is purchased by a tax-exempt entity.
 - (iv) The forecast cannot include any referral benefits and the forecast cannot include any revenue that is the result of the combination of entities (synergy of the buyer).

- (v) The expenses should be arm's length/FMV – particularly compensation and any related-party leases.
 - (vi) Most importantly, the compensation paid to physicians should match the compensation assumption used in the forecast.
 - (vii) There is no “safe harbor” method to determine FMV.
- b) Recommendations.
- (i) Retain valuation consultants through legal counsel to preserve, to the extent possible, attorney-client privilege.
 - (ii) Have legal counsel actively engaged in the valuation process – review draft valuation reports and provide comments to ensure compliance with applicable regulatory standards. Inaccurate, stale or incomplete material facts, financial data and/or assumptions may affect the reliability and validity of the conclusion as to FMV.
 - (iii) Have the hospital board of directors approve the transaction, specifically reviewing and confirming both the FMV nature of the purchase price and compensation to be paid to the physicians under the proposed compensation plan, as well as the “commercial reasonableness” of the overall transaction.

3. Other Considerations.

a) Cobra Liabilities.

- (i) Normally, acquisition agreements exclude all liabilities in a purchase transaction except those specifically identified and assumed in the acquisition agreement.
- (ii) Beware of COBRA.
 - Under Tres. Reg. § 54.4980B-9, parties may allocate responsibilities of providing COBRA continuation coverage by agreement.
 - If Seller retains obligation (which will occur if the agreement is silent), but eliminates group health plan post-closing then buyer's group health plan has obligation to make COBRA continuation coverage available to qualified beneficiaries.²⁸

²⁸ Q&A-4 of §54.4980B-9

- Potential COBRA exposure:
 - American Recovery and Reinvestment Act of 2009: Effective February 17, 2009, 65% of COBRA premium for “Assistance Eligible Employees.”
 - Potentially much more exposure if Buyer’s plan is self-funded.
 - Buyer’s may have contractual recourse against Seller, but suing is typically neither practical nor cost-effective.
 - Possible front-end solutions.
 - If Seller retains COBRA liability, escrow portion of purchase price.
 - If Buyer assumes COBRA liability, reduce purchase price accordingly.
- b) Non-compete issues.
- (i) Payments for non-compete agreements are treated as taxable compensation, not acquisition payments.
 - (ii) Need “substantial risk of forfeiture” to avoid immediate taxation.
- c) Unwind Provisions.
- (i) A provision allowing a physician to unwind the transaction and re-purchase their practice does not result in physician recouping the tax paid in the original sale.
 - (ii) Buy-out terms should be specified.
 - (iii) Valuation of the repurchased interest in practice (or entire practice) should be clearly outlined.
- d) Dealing with leases in excess of FMV.
- (i) Identify ASAP
 - (ii) Communicate early with physician owners
 - (iii) Consider impact on compensation of lowering rent to FMV

(Lower Rent → Higher Net Revenue → Higher \$/wRVU in Compensation Analysis)

E. Physician Leases.

1. Real Estate Lease.

- a) Stark - If referring physician ownership, then the lease must meet all elements of “Rental of Office Space” exception which requires:²⁹
- lease be in writing and signed by parties;
 - term of at least one year;
 - space leased does not exceed that which is reasonable and necessary;
 - rent set in advance and FMV;
 - rent does not vary with volume or value of referrals;
 - agreement would be commercially reasonable if no referrals; and
 - no “per click” or % lease arrangements.
- b) Anti Kickback - Safe Harbor – A real estate lease will meet the safe harbor requirements if the following six standards are met:
- 1) The lease agreement is set out in writing and signed by the parties.
 - 2) The lease covers all of the premises leased between the parties for the term of the lease and specifies the premises covered by the lease.
 - 3) If the lease is intended to provide the lessee with access to the premises for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals.
 - 4) The term of the lease is not for less than one year.
 - 5) The aggregate rental charge is set in advance, is consistent with FMV in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs.
 - 6) The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

²⁹ 42 C.F.R. §411.357(1)(1)-(7).

2. Equipment Lease.

- a) Stark - If referring physician ownership, then the lease must meet all elements of “Rental of Office Space” exception which requires:³⁰
- lease be in writing and signed by parties;
 - term of at least one year;
 - equipment leased does not exceed that which is reasonable and necessary;
 - rent set in advance and FMV;
 - rent does not vary with volume or value of referrals;
 - agreement would be commercially reasonable if no referrals; and
 - no “per click” or % rental arrangements.
- b) Anti Kickback - Safe Harbor – An equipment lease will meet the safe harbor requirements as long as all of the following six standards are met:
- 1) The lease agreement is set out in writing and signed by the parties.
 - 2) The lease covers all of the equipment leased between the parties for the term of the lease and specifies the equipment covered by the lease.
 - 3) If the lease is intended to provide the lessee with use of the equipment for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their purchase length, and the exact rent for such interval.
 - 4) The term of the lease is for not less than one year.
 - 5) The aggregate rental charge is set in advance, is consistent with FMV in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or all other Federal health care programs.
 - 6) The aggregate equipment rental does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

³⁰ 42 C.F.R. §411.357(b)(1)-(6).

F. Physician Employment.

1. Choice of Entity.

a) Hospital.

- Stark – Physician employed by a hospital cannot receive compensation for “incident to” billing (e.g., services of the physician’s nurse practitioner) or be paid a share of ancillary revenues.
 - In-office ancillary exception not available (i.e., not a group practice).

b) Separate Legal Entity.

- (i) Single member LLC, captive P.A., and non-profit tax-exempt corporations are generally permissible formats.
 - Corporate practice of medicine policy prohibits limiting physician's liability for their services.
- (ii) Stark – if entity qualifies as a group practice, physician may be paid for “incident to” services and profit shares including ancillary revenues.
- (iii) Taxable and tax-exempt entities can be used.
 - Physician clinic in a tax-exempt health system can be tax-exempt.
 - UBI issues.

2. Legal Standards for Compensation.

a) Stark-Permitted Referral restrictions – A hospital (employer) may require a Physician (employee) to refer to the hospital if:

- (i) Compensation is “set in advance.”
- (ii) Compensation is FMV (does not take into account volume/value of referrals).
- (iii) Requirement to refer is set out in writing and signed.
- (iv) Requirement is “reasonably necessary to effectuate the legitimate business purposes of the compensation relationship.”
- (iv) Requirement to refer does not apply if:
 - Patient prefers different provider or supplier;
 - Patient’s insurance determines the provider or supplier; or
 - Not in patient’s best medical interests.³¹

³¹ 42 C.F.R. §411.354(d)(4)(i)-(v).

- b) Stark – Employment Exception – To meet employment exception under Stark:
- (i) No written agreement required.
 - Employment must be for identifiable services.
 - Compensation must be consistent with FMV and does not take into account the volume or value of referrals, except that productivity bonuses based on personally performed services.³²
 - Compensation must be commercially reasonable.
 - Set in advance.
- c) Anti-Kickback Safe Harbor – "Remuneration" does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs. For this purpose, the term *employee* has the same meaning as it does for purposes of employment tax classification purposes under the IRS standard.
- d) Additional Considerations.
- (i) Collections, RVU models or other productively based models permitted as long as based on personally performed services.
 - (ii) "Revenues less expenses" models utilized frequently.
 - (iii) 501(c)(3) organizations should be careful with net profit calculations.
 - (iv) Total compensation package should be documented as being at FMV.
 - (v) Caps on total compensation packages should be considered.
 - (vi) Continuous monitoring recommended to ensure FMV for each year (specify in the agreement) and have provisions in employment agreements that allow the hospitals to adjust physician compensation if it exceeds FMV.
 - (vii) Additional incentive based compensation.
 - Achievement of pre-determined quality, safety, patient satisfaction goals.
 - Compensation formula needs to be set in advance and the standards specified in the agreement in a manner that can be objectively verified.
 - (viii) Ancillary revenue and "incident to" can be included in compensation if the employer structured as "group practice" for

³² 42 U.S.C. §139nn(e)(2); 42 C.F.R. §411.357(c).

purposes of Stark and meet in office ancillary services exception for Stark.³³

- (ix) Physician members of a “group practice” must provide at least 75% of the group practice’s patient care services.³⁴ Independent contractors or leased employees do not count in the test because they are not “members of the group.”³⁵ Therefore, if more than 25% of the physician patient care services provided by the entity are not performed by employed physicians, then the entity will not qualify as a “group practice” within the meaning of the Stark regulation.
- (x) Amendments permitted as long as amendment made prior to compensation being earned.

G. Independent Contractor Relationships.

1. Classification Issues – IRS “control test” should be analyzed and utilized in structuring relationships, particularly when there are large numbers of independent contractor physicians whose responsibilities are similar to employed physicians.
 - Compliance with Section 530 standards can save a lot of time and expense fighting adverse IRS determinations.
2. Professional Services Agreements.
 - a) Stark – Personal Services Exception – The arrangement is in writing, signed by the parties, and specifies the services covered by the arrangement; the arrangement(s) covers all of the services to be furnished by the physician (or an immediate family) to the entity. Where multiple contracts are involved, the other agreements can be incorporated by reference or cross-reference a master list of contracts; the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement(s); the term of each arrangement is for at least one year. If an arrangement is terminated during the term with or without cause, the parties may not enter into the same or substantially the same arrangement during the first year of the original arrangement; the compensation to be paid over the term of each arrangement is set in advance, does not exceed FMV, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and the services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any

³³ 42 C.F.R. §411.352.

³⁴ 42 C.F.R. §411.352(d)(l).

³⁵ Phase I, 66 Fed. Reg. 904-05.

Federal or State law; the compensation to be paid over the term of each arrangement is set in advance, does not exceed FMV, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and the services to be furnished under each arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law.³⁶

- (i) If the contract is terminated, with or without cause, the parties may not enter into same arrangement during the first year of the original term.
 - (ii) Compensation and bonuses are "set in advance" if the formula or method is specified in the agreement in a manner that can be objectively verified.
 - (iii) Compensation may be amended on a prospective basis.
 - (iv) Physicians may be paid a productivity bonus for personally performed services.
 - (v) An independent contract physician may only be compensated based on "incident to" services and "overall profits" (including ancillary revenues) if the entity engaging the physician is a "group practice" for purposes of Stark.
 - Hospital employment is not a group practice.
 - 75% of the physician services of the entity has to be through employees.
- b) Stark – Fair Market Value Exception – The arrangement is in writing, signed by the parties, and specifies the services covered by the arrangement; the writing specifies the timeframe for the arrangement, which can be for any period of time and contain a termination clause, provided that the parties enter into only one arrangement for the same items or services during the course of a year. An arrangement made for less than one year may be renewed any number of times if the terms of the arrangement and the compensation for the same items or services do not change; the compensation to be paid over the term of each arrangement is set in advance, does not exceed FMV, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; the arrangement is commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties; the arrangement does not violate the Anti-Kickback Statute, or any Federal or State law or

³⁶ 42 C.F.R. §1001.952(d).

regulation governing billing or claims submission; the services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates a Federal or State law.³⁷

- c) Anti-Kickback Personal Services and Management Contracts Safe Harbor - The agreement is set out in writing and signed by the parties; the agreement covers and specifies all of the services provided for the term; if the services are on a periodic sporadic or part-time basis, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals; the term of the agreement is for not less than one year; the aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with FMV in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties. The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law and the aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.³⁸

3. Retirement Benefits. If structured properly, independent contractor physicians would be responsible for their own retirement benefits. This can also apply to relationships between the hospital and with a physician group to provide physician services to hospital or its affiliates' patients.

4. Call Pay Agreements.

- a) Stark and Anti-Kickback concerns.
- b) Payments documented as FMV.
 - (i) Per diem payment
 - (ii) Pay for responses
 - (iii) Call volume and payor mix impact value

H. Management Relationships.

1. Stark.

- a) Personal Services Exception – See F.2. above.
- b) Fair Market Value Exception – See F.2. above.

³⁷ 42 C.F.R. §411.357(1).

³⁸ 42 C.F.C. §1001.952(d).

2. Anti-Kickback Statute. Personal Services and Management Contracts Safe Harbor
– See F.2. above.
3. Management Models.
 - a) Physician Management of Hospital Practices.
 - b) Physician/Hospital Co-Management of Hospital Practice.
 - c) Service Line Co-Management.
 - (i) Concepts.
 - The Co-Management Agreement is intended to absorb the prior relationships between the parties such as medical director agreements and complement them with a more broad slate of services and metrics by which progress will be tracked.
 - Services may include patient scheduling, medical director services, case management activities, materials management, etc.
 - Metrics will specifically identify the total amount which may be paid if all targets are met and the percentage of the total which is assigned to any particular measured item.
 - Co-Management Arrangements increasingly utilized to:
 - Directly involve physicians in the performance of a comprehensive array of services involved in the delivery of a health care service line (e.g., outpatient surgery, cardiology, etc.).
 - More thoroughly engage physicians in the efficient delivery of services by placing a substantial portion of the compensation payable at risk if predetermined goals and objectives are not met.
 - (ii) Legal Issues.
 - Complex agreement; requires independent, third-party valuation and development of quality performance targets and associated incentive compensation.
 - Can be labor-intensive for physicians.
 - Unclear how long-term arrangement can be; paying for maintenance of quality is controversial.
 - Physician time/work accountability administratively burdensome and makes arrangement labor-intensive.

I. Gainsharing.

1. What is gainsharing?

- a) Financial arrangements in which a hospital gives physician a share of any reduction in the Hospital's cost attributable in part to the physician's efforts.
 - (i) Incentive to reduce the use of specific devices or supplies.
 - (ii) Incentive to use less costly devices or supplies.
 - (iii) Use a standardized protocol to reduce costs.
- b) Promotes hospital cost reductions by aligning physician and hospital financial incentives.
 - (i) Hospitals are reimbursed a fixed fee by Medicare for inpatient services regardless of the actual cost of care (i.e., if they use more costly devices or supplies they are paid the same).
 - (ii) Physicians are reimbursed separately on a fee schedule.
- (iii) Historically, gainsharing arrangements between hospitals and physicians have been prohibited unless they were reviewed and approved by the HSS OIG.
 - (i) Federal law prohibits hospitals from inducing doctors to reduce or limit services and items to Medicare and Medicaid beneficiaries.
 - (ii) Advisory opinion process can take 2+ years.

2. Types of Gainsharing Arrangements.

- a) Providing physician incentive to
 - (i) Reduce the use of specific medical devices and supplies.³⁹
 - (ii) Switch to specific products that are less expensive.⁴⁰
- b) Adopt specific clinical practices or protocols that reduce costs.
 - (i) Adopt standardized protocols and procedures, most common type of gainsharing initiative.⁴¹

³⁹ OIG Ad. Op. 05-02 – Limiting the use of certain vascular closure devices to an “as needed” basis for inpatient coronary interventional procedures diagnostic procedures. The device will be readily available in the procedure room but unopened until it is needed.

⁴⁰ OIG Ad. Op. 05-03 – Substituting less costly items for items currently used that have no appreciable clinical significance (wrist splints and armboards).

⁴¹ OIG Ad. Op. 05-04 – Cardiology group and hospital will evaluate and clinically review vendors and products. The group would agree to use the selected products, where medically appropriate, which may require additional training or changes in clinical practice.

3. Legal Issues.

- a) Fraud and Abuse Concerns.
 - (i) An incentive to reduce the cost of care has the potential to reduce the quality of care.
 - (ii) Can be liable for Civil Money Penalty for providing incentives, directly or indirectly, to a physician as an inducement to limit items or services furnished to Medicare or Medicaid beneficiaries under a physician's direct care.
 - (iii) Do not want hospitals to pay incentives to physicians to encourage them not to provide services that are medically necessary or discharge patients too soon.

4. Advisory Opinion Requirement.

- Must secure an Advisory Opinion from the OIG to have a gainsharing arrangement.
 - Several gainsharing arrangements have received an approval from the OIG in recent years.
 - Advisory Opinion process can take up to two years to complete.

5. Bottom Line.

Gainsharing okay as long a quality is not adversely affected and volume/case mix changes are not rewarded. Advisory opinion process decreases the utility of the approach today.

J. Accountable Care Organizations.

1. Concept.

- a) An Accountable Care Organization ("ACO") is an organization of physicians and other health care providers accountable for the overall care of traditional fee-for-service Medicare beneficiaries who are assigned by CMS to an ACO.
- b) ACOs are to be financially incentivized by CMS to provide higher quality care and overall cost savings.
- c) By January 1, 2012, the Secretary of HHS must establish a shared savings program that:
 - Promotes accountability for a patient population;
 - Coordinates items and services under Medicare parts A and B; and
 - And encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

- d) The new Center for Medicare and Medicaid Innovation ("CMMI") is developing new funding mechanisms to enhance quality and achieve cost savings through ACOs.
- e) CMS stated during its ACO Open Door Forum on June 24, 2010, that it plans to propose ACO regulations in the fall of 2010.
- f) Groups of providers would work together to manage and coordinate care for Medicare fee-for-service beneficiaries.
- g) Those ACOs that meet quality performance standards will be eligible to receive additional Medicare payments based on risk-adjusted shared savings against historical benchmarks.
- h) Locally focused on quality and cost across the continuum of care.
- i) Inter-and multi-disciplinary care coordination.
- j) Built on collaboration and shared responsibility/accountability.
- k) Enhanced ability to capture and report data.
- l) Not limited to a single group of providers (e.g., contemplates a full range of providers) or episode of care (e.g., contemplates bundled case rate payments covering the care of a patient's entire diagnosis).
- m) Migration from volume/intensity of care to efficiency and quality.
- n) Financial model is based on shared savings.
- o) ACOs are organizational structures to incubate, facilitate, and implement innovative quality care coordination and incentive payment arrangements.
- p) ACOs are not required to follow a single prescribed organizational form and are not necessarily limited to Medicare.
- q) ACOs require a comprehensive information infrastructure to enable quality care assessment and coordination, including state-of-the-art integrated electronic health records ("EHR").
- r) Must have defined processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.
- s) Must enter at least a three-year agreement with HHS and have at least 5,000 Medicare beneficiaries, without engaging in risk selection.

- t) Must demonstrate that it meets the defined criteria for "patient-centeredness" as determined by the US HHS.
2. Bundled Payments – CBO has recommended a series of bundled payments:
- a) Acute care hospital stay and post acute care services (30 days post acute care stay)
 - (i) Covers hospital, SNF, home health, rehabilitation and LTACH.
 - (ii) Hospital receives payment and provides/contacts for post acute care services.
 - b) Acute care hospital services and physician services
 - (i) Hospital receives a single payment to cover hospital and physician services for a particular DRG (during stay and for a period following stay).
 - (ii) Goal: Align physician and hospital payments and encourage coordination of care, improve quality of care and contain costs by eliminating unnecessary readmissions and expensive post acute care services.
 - c) Five year pilot program for integrated care.
 - d) Authorizes Secretary of HHS to use bundled payments cover the costs of “applicable services” and other appropriate services during an “episode of care.”
 - (i) Three days prior to admission, length of stay and 30 days following discharge.
 - (ii) Inpatient services, physician services and post acute care services.
 - e) Secretary to establish quality measures related to care and outcome.
 - f) Accountability of performance based on quality and spending measures that are manifest in financial rewards.
 - g) The exact structure of the various ACO models is still a series of works in progress, but an ACO has three essential features:

- (i) ACOs are a collective of provider organizations (physicians, hospitals, health care systems, other providers) and can be formed as LLCs, nonprofit corporations, integrated delivery systems, etc.
 - (ii) Certain payments will be based upon the collective care that the ACO will provide to a designated population.
 - (iii) Supplemental payments will be provided retrospectively based upon the ACO's ability to meet quality goal while reducing costs.
- h) Agree to be accountable for the care of a designated set of Medicare beneficiaries.

3. Legal Issues.

- a) Today the three principal laws designed to regulate fraud and abuse in fee-for-service health care financial relationships include the:
- Anti-Kickback Statute
 - Stark Law
 - Civil Monetary Penalty Law

Current laws principally address:

- Potential for overutilization of our fee-for-service payment system.
- Removal of financial considerations from medical decision-making.
- No payments for referrals.
- Unfair competition.
- In-hospital prospective payment system: avoid stinting on care (underutilization of necessary care).

With ACO's making changes in our payment system, it is not clear how the Anti-Kickback Statute, the Stark Law and CMP law apply to:

- Shared savings programs
- Bundled payments
- Capitation programs

(i) Anti-Kickback Statute.

- FMV issues may arise around formation and capitalization of the models if physicians are investors – choice of physician investors may also implicate the statute.
- Compensation of provider participants may also implicate the statute.

- (ii) Civil Monetary Penalty Statue. Incentives to reduce medical care may implicate the CMP.
 - (iii) Stark Law Issues.
 - Existing Stark Law does not specifically address incentive payment and shared savings programs with physicians.
 - May be able to structure to meet employment, personal services, FMV or indirect compensation exception.
 - Exceptions for community-wide health information systems, e-prescribing and donation of EHR may apply to portions of relationship.
 - Uncertainties in applying current Stark Law exceptions.
 - Is payment for shared savings/efficiency directly or indirectly related to volume or value of referrals?
 - Does a change in physician behavior constitute "identifiable services" under employment exception?
 - What is the FMV of a change in physician behavior?
- b) Waiver of Authority. CMMI has waiver authority as necessary to carry to implement ACOs with respect to:
- (i) Anti-Kickback Statue
 - (ii) Stark Law
 - (iii) Civil Monetary Penalty
- c) Anti-Trust Issues. Most likely more prevalent in the ACO models where parties are jointly contracting with payors or in smaller market power crested.
- d) Corporate Issues. The structuring of ACOs will require a substantial amount of contracting experience from counsel with health care regulatory expertise.



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