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Health Care Regulatory Primer: Management Service Organizations

A health care management services organization (MSO), also known as a medical management company, provides non-clinical, administrative support services to physician group practices and other health care providers. One of the primary purposes of a MSO is to relieve licensed health care providers of non-medical business functions so they can focus on the clinical aspects of their medical practices. To that end, MSOs have become increasingly common as health care reform continues to complicate the billing and reimbursement process and link payment to patient experience and the quality of care. Additionally, MSOs are used to navigate state "corporate practice of medicine" (CPOM) laws prohibiting non-physician-owned business entities from practicing medicine or employing licensed health care providers. In order to avoid regulatory pitfalls, however, contractual MSO arrangements need to be structured carefully to ensure that the MSO does not exert undue control over the health care practice in contravention of CPOM principles.

The following health care regulatory primer: (1) provides a brief overview of the corporate practice of medicine doctrine and its application; (2) describes the MSO business model and how a contractual MSO relationship can be used to comply with the CPOM; and (3) discusses regulatory pitfalls to avoid in MSO relationships.

The Corporate Practice of Medicine

In its simplest terms, the CPOM prohibits corporations from practicing medicine or employing a physician to provide professional medical services. Public policy considerations underlying the CPOM include concerns that the corporate employment or control of a licensed professional:
(1) commercializes and debases licensed professions;
(2) undermines the physician-patient relationship and the physician's exercise of independent medical judgment; and
(3) allows unlicensed corporate entities to practice medicine without being subject to professional standards or regulations.[1] Accordingly, the main objective of the CPOM is to shield physicians from outside influence or control—particularly from non-physician-owned corporate entities which might subordinate patient care and treatment decisions to the maximization of profits and the reduction of costs.

The CPOM is state specific and often comprised of a mix of statute, administrative regulation, case law, and state attorney general opinions. Although the doctrine is applied in a majority of states,[2] 19 states have no CPOM restrictions.[3] Of the 19 states that have not explicitly adopted the CPOM doctrine, some utilize fee-splitting laws that create similar issues or state medical board opinions that echo the CPOM. Depending on the jurisdiction, corporate practice prohibitions may also extend to other licensed health care professionals such as dentists, psychologists, physical therapists, or social workers. It should be noted that certain states without CPOM restrictions may have corporate practice laws relating to other professions. For example, while Florida has no CPOM, it does restrict the corporate practice of dentistry.[4]

The CPOM and a state's willingness to enforce it varies greatly among jurisdictions. In states with "strong" CPOM prohibitions—such as California, New York and Texas—physicians (or other licensed health professionals) can only provide medical services through a professional corporation owned by professionals that are licensed in that state. Therefore, in these "strong states," non-professional corporations cannot hire physicians without meeting a specific exception set forth in the CPOM laws. On the contrary, while a "weak" CPOM state may generally prohibit non-physicians from practicing medicine, or prevent unlicensed professionals from intruding into other aspects of the medical practice, it generally will not prohibit non-professional corporations or laypersons from employing physicians if the licensed physicians maintain actual control over the practice of medicine.

Even in the most restrictive of CPOM states, there are exceptions to the rule. For example, some states permit certain

entities such as hospitals or medical schools to employ physicians. In addition, almost all states permit physicians to practice medicine through partnerships, professional corporations (PCs), or professional service limited liability companies (PLLCs) comprised exclusively of physicians and certain other licensed professionals, and share fees and profits among themselves.

The CPOM presents a significant concern to physician business ventures as failure to comply with a state's CPOM laws can result in:

- Physician licensure action or revocation.
- Civil (and in extreme cases, criminal) liability for non-physician business partners (e.g., a MSO) for engaging in medical practice without a license.
- Voiding of an underlying business arrangement (e.g. a management services agreement) for illegality.
- Commercial or government insurers (e.g., Medicare and Medicaid) seeking to recoup reimbursement payments due to illegality of the underlying business structure.

MSO Business Model and the CPOM

In order to comply with a state's CPOM laws restricting a non-professional entity from owning or operating a physician practice, lay entities seeking a business relationship with a physician practice often use what is known as the "friendly PC" MSO model. When properly operationalized, this model allows the MSO to maintain control over the administrative and management side of the medical practice without infringing on the professional judgment of the physicians. Additionally, MSO's can bring economies of scale, operational efficiencies, and professional management and compliance experience into physician practices, thereby improving the quality of care and patient experience, while reducing overhead costs.

The "Friendly PC" MSO Model. Under the friendly PC model, a PC, PLLC or other state-approved legal entity with 100% physician ownership, employs the licensed health care professionals and then contracts with a MSO to provide management services to the PC in exchange for a fee. The MSO's services, and compensation for such services, are set forth in a long-term management services agreement (MSA). The MSO may purchase the non-clinical assets of a medical practice (e.g. office space or equipment) for cash and possibly MSO equity. MSOs typically incur all costs associated with the medical practice, with the exception of physician compensation, benefits and malpractice costs.

Typically, the PC is kept "friendly" or aligned with the MSO through the use of a stock transfer restriction agreement between the friendly physician and the MSO. The stock transfer restriction agreement will allow the MSO to designate or approve any future owner of PC stock.

MSO Services. MSO support services are often comprehensive, including areas such as:

- Financial management, budgeting and accounting
- Human resources and non-clinical personnel management
- Staff training and education
- Coding, billing and collection services
- Providing and managing office space
- Regulatory compliance oversight and management
- Credentialing and contract management
- Vendor management and group purchasing
- Marketing[5]

As discussed in the next section of this brief, MSO services should be carefully selected to ensure that the medical practice maintains control over the practice of medicine in accordance with CPOM principles.

MSO Compensation. MSOs can be compensated for their services in a number of ways. Common MSO fee arrangements include (1) fixed fee arrangements, (2) cost, plus a reasonable profit margin, formulas, or (3) formulas based on practice group revenues. Because fee structures may implicate state fee-splitting and other laws, the fee structure should be examined by counsel for regulatory risk. For example, compensation based on a percentage of physician revenues generally constitutes prohibited fee-splitting under New York law.[6] Permissible compensation structures are discussed in more detail below.

Structuring MSO Relationships to Avoid Regulatory Pitfalls

Although the friendly PC MSO model clears the initial CPOM non-physician-ownership hurdle, MSAs must be carefully structured to ensure that the MSO does not exercise undue control over the PC or become too deeply entangled in the PC's affairs in contravention of state CPOM principles.

In general, permissible MSO relationships will:

1. Clearly delineate between the medical and non-medical aspects of a health care practice. The MSO only should be engaged to handle the non-medical aspects of the practice. Physicians should maintain ultimate responsibility over patient care;
2. Ensure that compensation is consistent with fair market value, bears a reasonable relationship to the cost of the MSO services provided, and does not trigger any state laws forbidding certain compensation arrangements (e.g. percentage of revenue arrangements); and
3. Properly operationalize a written MSA.

MSO Services and Controls. The CPOM is a complex doctrine that often turns on a court's fact-specific analysis. Accordingly, there is no set rule as to when a given arrangement may be deemed to constitute the CPOM. The focus in any regulatory investigation likely will be on the level of control the MSO exercises over the operation of the medical practice and the professional judgment of licensed health care professionals. When the MSO exerts a high degree control, the arrangement may be found to be a sham intended to disguise the *de facto* practice of medicine by an unlicensed entity.

MSO controls that may indicate an intrusion into clinical practice in violation of the CPOM include:

- Determining which diagnostic tests are appropriate for a particular condition.
- Determining the need for referrals to or consultation with another physician or specialist.
- Determining how many patients a physician must see in a given time period or how many hours a physician must work.
- Incentivizing and otherwise pressuring staff to increase services or sales.
- Implementing revenue-oriented patient scheduling systems.

States with strong CPOM doctrines may also be suspicious of MSOs that have a high level of control over certain business aspects of a medical practice as well as control over all clinical decisions. For example, the Medical Board of California has stated that the following business decisions should be left to physicians:

- Selection, oversight, and termination of clinical personnel.
- Selections of medical equipment and supplies.
- Setting the parameters under which the PC will enter into contractual relationships with third-party payors.
- Decisions regarding coding and billing procedures.[7]

The Medical Board of California acknowledges that these types of decisions and activities can be made by a physician who consults with the MSO, but not by the MSO alone.[8]

Additionally, a high level of MSO-control over a medical practice's finances can trigger regulatory scrutiny. For example, in 2015 the New York Attorney General took issue with a dental practice management company, that among other clinical and business controls, "exercised undue control over the clinic's finances by controlling substantially all of the dental practices' bank accounts through a single consolidated account to which the clinic owners themselves did not have access."[9]

MSO Compensation. As discussed above, MSOs may be compensated by medical practices in a variety of ways, including by a periodic flat fee or a formula based on a percentage of a practice's revenue. When choosing a compensation arrangement, PCs and MSOs must carefully consider anti-kickback and state fee-splitting laws. First, compensation should bear a reasonable relationship to the cost of the management services provided and be consistent with fair market value. Otherwise, the compensation could be viewed as an unlawful payment for a patient referral in violation of federal or state anti-kickback statutes. Additionally, fee-splitting laws may prohibit or disfavor compensation based on a percentage of patient revenue. For example, New York expressly prohibits percentage of patient revenue compensation arrangements.[10] Other states, such as Florida, prohibit percentage of patient revenue based compensation in certain circumstances, such as where the MSO generates patient referrals.[11] In certain states, however, a percentage of patient revenue fee may be expressly permissible. For example, California law specifically recognizes the permissibility of physicians (including PC's) paying unlicensed persons percentages of gross revenue for services, provided that the payment is reasonably commensurate with the value of the services and not simply a payment for patient referrals.[12]

Conclusion

MSOs are very useful entities that can benefit both medical practices and MSO owners alike. Due to complex and state-specific CPOM regulations, however, the MSA needs to be carefully drafted. This primer is only intended to convey the basics of MSOs, the CPOM and corollary state fee-splitting laws. There are many other aspects of MSO relationships that should be considered that are not covered here, such as the federal Anti-Kickback statute and the federal Stark Law.

For More Information.

If you would like more information concerning the matters discussed in this primer, please contact Jennifer Koltse or the Chapman attorney with whom you regularly work:

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1. *See, e.g.,* Barton v. Codington Country, 2 N.W. 2d 337, 343 (S.D. 1942); Garcia v. Texas State Bd. of Med. Exam'rs, 348 F. Supp. 435, 437 (W.D. Tex. 1974); and State v. Boren, 219 P.2d 566, 568-69 (Wash. 1950).
2. The following states have some form of the corporate practice of medicine: (1) Arizona, (2) Arkansas, (3) California, (4) Colorado, (5) Georgia, (6) Illinois, (7) Indiana, (8) Iowa, (9) Kansas, (10) Kentucky, (11) Louisiana, (12) Maryland, (13) Massachusetts, (14) Michigan, (15) Minnesota, (16) Montana, (17) Nevada, (18) New Jersey, (19) New York, (20) North Carolina, (21) North Dakota, (22) Ohio, (23) Oregon, (24) Pennsylvania, (25) South Carolina, (26) South Dakota, (27) Tennessee, (28) Texas, (29) Washington, (30) West Virginia, and (31) Wisconsin.
3. The following states have no statutory prohibition against the corporate practice of medicine: (1) Alabama, (2) Alaska, (3) Connecticut, (4) Delaware, (5) Florida, (6) Hawaii, (7) Idaho, (8) Maine, (9) Mississippi, (10) Missouri, (11) Nebraska, (12) New Hampshire, (13) New Mexico, (14) Oklahoma, (15) Rhode Island, (16) Utah, (17) Vermont, (18) Virginia, (19) Wyoming.
4. *See* Fla. Admin. Code. Ann. R. 64B5-17.013.
5. MSOs that provide marketing services or otherwise generate business on behalf of a medical practice can implicate state fee-splitting laws or kickback laws. Accordingly, any marketing relationships should be analyzed by legal counsel.
6. *See* 8 NYCRR § 29.1(b)(4).
7. *See* Medical Board of California's Corporate Practice of Medicine guide, available at: http://www.mbc.ca.gov/Licensees/Corporate_Practice.aspx
8. *Id*.
9. *Id*. *See* Aspen Dental Management settlement announcement available at: https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-aspen-dental-management-bars-company-making
10. *See* 8 NYCRR § 29.1(b)(4).
11. *See e.g.,* Gold, Vann & White, P.A. v. Friedenstab, 831 So. 2d 692 (Fla. Dist. Ct. App. 2002).
12. *See* Cal. Bus. & Prof. Code § 650(b).