Corporate Practice of Medicine: Could Your Current Operating Structure Be at Risk?

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Urgent message: *State laws prohibiting the corporate practice of medicine are often skirted by business arrangements that segregate a professional entity from a management company, but these arrangements can still pose significant risks to providers unless specific steps are taken to ensure the segregation of clinical and management activities.*

Introduction

The **corporate practice of medicine doctrine** dates back to the inception of physician licensure laws. The tenet is derived from the legal requirement that only a licensed physician can practice medicine. Although our system has evolved since physicians first began to practice, requiring significant capital investment, business acumen, and administrative attention, this doctrine is still alive as a basis for imposing risk on parties to a deal between investors, management providers, and licensed professionals.

Risks

Providers, to skirt corporate practice of medicine laws, have historically created a legal structure in which a physician-owned professional entity contracts with a non-physician-owned management company. The professional entity passes all revenue through to the management entity. But there are significant risks with this arrangement, including the following:

- Physicians engaged in so-called doc-in-a-box relationships, where they are viewed as lending their license to business companies and acting in essence as glorified employees, can risk loss of their license.
- The business parties themselves risk actions by states' attorneys general, who can use the violation to prosecute consumer fraud, impose significant fines, and even threaten criminal prosecution.
- Health-care payors can use the doc-in-a-box structure as a means to seek repayment under fraud-related allegations, particularly in the no-fault and workers' compensation realm, where such allegations are becoming standard.
- Additionally, civil litigants can sue the management company and attempt to hold it responsible for malpractice injury, arguing that profit incentives resulted in inappropriate clinical decision-making. They justify such actions out of concern that the manager will exercise excessive control or pressure over the practice, directly impacting patient care, professional decision-making, and product and service recommendations, including those resulting in unnecessary service use.

In some cases, the management vehicle entity is also owned by a physician founder—but make no mistake, these same risks are still relevant to the founder's business entity to the extent that it is engaged with other physician-practice entities.

Factors Indicative of a Violation and Remediation Strategy

Illegally Splitting Income from Patients and Payors Through Profit Sharing

The cornerstone of a doc-in-a-box argument is that the physician is not the master of their own domain and is not entitled to reap the full reward of their own practice—their own

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business—including the profits and return that would naturally inure to a business owner. When a management company clears out a bank account belonging to a physician after that physician collects their salary (whether it is couched as a profit distribution or salary from themselves—that is, their own professional entity—to themselves), that manager is arguably the real practice owner. What business owner would hand the majority of its revenues or profits to a third-party vendor? Accordingly, the nature of the management fee structure is strictly scrutinized.

Each aspect of the business relationship must be charged at a rate that is truly fair market value—a price that the market would negotiate in a bona fide arm's-length transaction. However, the business investor may actually assume most if not all of the financial risk of the venture, with little or no capital contribution from the physician. The parties may decide to share this risk by entering into a percentage arrangement—where a percentage of profits or revenues is paid or split. In some states this is legal, provided that the percentage is justifiably fair market value, but a percentage could eventually fall outside of the range of fair market value as cash flow increases.

Percentage arrangements can also run afoul of legal prohibitions, such as the federal Anti-Kickback Statute and equivalent state laws. Accordingly, a flat annual fee or a combination of flat annual fees for various line items and variable cost charges should be used instead. The parties should also evaluate what portion of the investment constitutes a loan repayable by the physician entity, and formalize a promissory note representing the upfront lending.

Additional cash flow lending can be offered in the form of a contractual line of credit. Initial implementation charges from the manager, including recruiting, credentialing, branding, and marketing may justifiably be very high for the first several years, but ultimately these would have to decrease for an existing site after a certain period of time as economies are established and these functions level out.

The physician may be fearful, however, that such high initial charges will result in waiting too long for their own profit opportunity while the debt mounts. To alleviate this fear, because the parties rely on each other for mutual viability, the manager, as a creditor, can instead agree to wait in line, such that the physician-owner can pay themselves a certain amount of money per month after costs have been covered, and accordingly defer the profit margin (with interest accruing) until there is enough to cover it or a business sales transaction is consummated.

Wielding Undue Control over the Center's Finances by Controlling the Bank Accounts to Which the Practice Owners Themselves Do Not Have Access

The party that controls the bank account is viewed as the true owner of the business. If the physician is locked out of the account, the violation is an easy case to make, and similarly when the money is swept from the physician account into the manager's own account. The money should remain in the physician entity's account, and the physician should have signatory authority over their own practice income. The manager might be granted additional signatory authority to administer payables, but if it pays itself, this could be viewed as inappropriate in some jurisdictions. As protection for the manager, collateral security should be secured over cash in the bank account, and, depending on the state's enforcement environment, the manager might consider sweeping some specified portion of the funds into its own account to hold in the nature of a security deposit subject to replenishment. Naturally, after the investment of substantial funds and the guarantee of debt, more protection may be desired. Typically the physician practice owner will not be personally liable for any debt to the manager, with the fees payable only out of the actual profits available.

To create a disincentive against any threat to manager collateral rights, the contract might hold the physician personally liable in the limited instance that bank account funds or insurance payments are willfully diverted for the physician's own gain. To ensure that money is available to cover the accruing debt or create a ready funding source for co-investment in future expansion when the practice goes from red to black on its financial statements, the agreement might include an obligation for the practice to maintain a minimum reserve (i.e., not distribute all practice entity profits to its owners and employees) that is based on a specified formula, to the extent of available cash. Finally, in the event of abandonment of the business by the practice, a liquidated-damages clause can be included in the agreement that allows for the manager to assess its damages against outstanding practice accounts receivable.

Controlling Hiring and Firing of Clinical Staff

The right to hire and fire is proof positive of business control and real ownership. The practice entity must retain ultimate

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authority over the licensed professionals it hires, including the terms of employment. To protect against excessive compensation arrangements by the practice entity, covenants can be included in the management contract attesting that they will constitute fair market value. Commonly, the question boils down to whether the manager itself can fire the practice owner. In many cases the parties enter into a **nominee ownership agreement**, pursuant to which the business entity holds a contractual right to take away the stock in the professional entity from the physician and find a friendlier replacement to hand it to. In states that adhere strictly to the corporate practice of medicine doctrine, this is not permissible. The ability to remove someone is the greatest degree of control anyone can have to influence decisions and acts. In some states, it is only justifiable if the physician also has ownership in the management company, so that there is contractual privity between the individual owners and reasons borne out of fiduciary duty, which is essentially the obligation to act fairly to one's business partners and the company of which one is a part. Even when a nominee ownership agreement is not permissible, making the physician practice owner also an owner in the management vehicle provides the added benefit of alignment of interests and an ability to enforce noninterference and proprietary secret covenants.

Conclusion

These are just some of the considerations and structuring options available. Over time, the corporate practice of medicine doctrine and how it is enforced should itself evolve to recognize the inherent value that business relationships and investment have to patient-care quality and cost containment. Nevertheless, clinical decision-making autonomy should always remain sacrosanct. Thus, there is a delicate balance in any such relationship. ■