Private Equity Investments in Health Care Practices

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PRIVATE EQUITY FUNDS ARE GENERALLY PROHIBITED FROM OWNING ENTITIES THAT EMPLOY LICENSED PROFESSIONALS AND MAY NOT INVEST DIRECTLY IN MEDICAL OR DENTAL PRACTICES IN MANY STATES BECAUSE OF LAWS THAT PROHIBIT THE CORPORATE PRACTICE OF MEDICINE AND FEE-SPLITTING BETWEEN LICENSED PROFESSIONALS AND NONPROFESSIONALS.

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Recently, I have seen an increase in funds seeking investments in large health care practices — such as specialty medical, dental and veterinary practices — and other health care providers — including ambulatory surgery centers, drug treatment centers
and other behavioral health facilities. Many of these investments have closed. But others have been derailed, often because of the unanticipated, complex health care regulatory compliance requirements associated with the target’s business, the adverse impact of the compliance requirements on the anticipated economics of the proposed investments, or the potential for significant penalties based on post-closing enforcement action against a target’s pre-closing noncompliance.

Equity fund managers, and counsel specializing in financial services or corporate transactions, frequently are unfamiliar with key health care regulatory doctrines that could significantly and adversely affect their investments if the investments are not properly structured. This article provides a brief and non-exhaustive overview of some of the most important health care regulatory issues encountered in the acquisition of a large medical or dental practice including:

1. (i) state law prohibitions against the corporate practice of medicine (CPOM); (ii) state law fee-splitting prohibitions; and (iii) federal and state fraud and abuse laws, in particular the federal Anti-Kickback Statute (AKS), all of which should be carefully considered when structuring an investment in a health care provider.

Corporate Practice of Medicine

The CPOM prohibition has been adopted in one form or another by most states and refined by state court decisions, state professional licensing boards and other health care regulatory agencies. Under the prohibition, only licensed professionals, e.g., physicians and dentists, may employ or otherwise control the provision of health care by similarly licensed professionals. The doctrine essentially bans unlicensed individuals and entities from engaging in the professional practice of medicine by restricting them from employing licensed health care professionals and prohibiting the division or splitting of professional fees between licensed professionals and unlicensed individuals or entities.

The purpose of the CPOM doctrine is to ensure that only licensed professionals deliver medical care and that unlicensed persons and entities do not influence treatment decisions, in order to protect patients from conflicts of interest. However, the particulars of the prohibition vary significantly from state to state, and structuring an appropriate and economically viable arrangement between investors and professional practices can be challenging, especially in light of the inherent tension between the investors’ desire to control their investments and state laws prohibiting nonprofessionals from exerting control over professional practices.
To navigate the CPOM prohibition, investors typically would establish or acquire a management services entity to acquire all unregulated assets — e.g., real estate, unlicensed staff, equipment, furniture and supplies — from the practice and provide to the practice entity all management and other services not required to be delivered by licensed professionals in exchange for fair market value compensation. The infusion of funds into the management entity may be used to acquire the practice’s unregulated assets and expand practice facilities, provided that funds expended on behalf of the professional practice are not treated as capital investments by either the practice or the management entity.

The services provided by the management entity typically comprise all nonclinical services involved in the operation of a professional medical practice, such as providing office space, overseeing nonclinical personnel, and handling business, office and administrative services, such as managed care contracting, recordkeeping, support services, marketing and public relations, accounting and legal services, billing and collections, and financial planning. The practice, through its professional personnel, retains and exercises independent professional judgment in all matters concerning the provision of medical services to patients of the practice, and the professional personnel are solely responsible for directing and supervising any and all personnel involved in providing medical care.

**Fee-Splitting**

Fee-splitting can be broadly defined as any arrangement pursuant to which unlicensed individuals or business entities share in a provider’s professional fee income. The prohibition on fee-splitting may be based on the state’s CPOM statute, another statute or case law. Referral fees, office leases with rental payments tied to a percentage of practice revenue, management services contract fees based on a percentage of practice revenue, or other fee-sharing arrangements should be carefully scrutinized. Any arrangement that provides for a payment based on a percentage of a health care provider’s revenues should be analyzed under the applicable state fee-splitting statutes and regulations, and under the applicable CPOM laws because fee-splitting may be indicative of an impermissible ownership interest. Moreover, if the professional practice receives revenue from federal health care programs, *i.e.*, Medicare, Medicaid or Tricare, the arrangement should be analyzed for compliance with the federal fraud and abuse laws, in particular the AKS.
In light of the CPOM and fee-splitting prohibitions discussed above, structuring the management services agreement between the professional practice and the management entity requires a thorough examination of the proposed division of labor between the practice and the management entity, and the proposed economics, under applicable state laws. The two primary considerations are to ensure that:

- The practice entity and the licensed professionals are solely responsible for all clinical decisions and control all clinical functions, e.g., hiring, supervising and terminating clinical personnel; oversight of treatment options; and choices as to medical equipment and supplies, while providing the management entity with maximum permissible control over the practice and revenue therefrom.

- The compensation structure between the practice and the management entity must comply with applicable fee-splitting prohibitions and may not provide the management company with any indicia of ownership.

In particular, setting management company compensation as equal to the net of total revenue less expenses will be fatal to the proposed arrangement in certain jurisdictions. In other jurisdictions, the management entity may receive a percentage of practice revenue in exchange for its services.

**Anti-Kickback Laws**

Structuring the proposed arrangement becomes more complex if the practice receives reimbursement from federal health care programs or the arrangement violates applicable state statutes pertaining to payments for referrals. State anti-kickback laws may be broader than the federal AKS, extending the prohibition to all referral arrangements, not just those involving federal or state funds. Compliance requires careful examination of management services arrangements between professional practices and management entities to ensure they are structured to comply with the AKS and applicable state anti-kickback statutes.

The AKS is a criminal statute that proscribes (i) the offering, payment, solicitation or receipt of any *remuneration* in exchange for a patient referral or referral of other business for which payment may be made by a federal health care program, such as Medicare or Medicaid, and (ii) payments to induce referrals of federal health care program business. Violations of the AKS can result in substantial criminal penalties (fines up to $25,000 per violation and up to five years in prison) and civil penalties, including exclusion from the
To be held in violation of the statute, parties must possess the requisite intent to offer, pay, solicit or receive remuneration in exchange for referrals or to induce referrals. The statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.

For purposes of the AKS, the term “remuneration” includes the transfer of anything of value (including any kickback, bribe or rebate), in cash or in kind, directly or indirectly, covertly or overtly. Generally, any direct or indirect economic benefit will fall within the definition of “remuneration.” Consequently, a management services arrangement with compensation based on percentage of revenue may violate the AKS unless structured properly.

Private equity funds are generally prohibited from owning entities that employ licensed professionals and may not invest directly in medical or dental practices in many states because of laws that prohibit CPOM and fee-splitting between licensed professionals and nonprofessionals. Using a management entity structure is a common technique to enable private equity funds to benefit from these investments. However, structuring these management arrangements can be complicated and may result in violations of the prohibitions against CPOM and fee-splitting, and federal and state anti-kickback laws, if not done carefully.

Endnotes

1  Veterinary practices may be subject to corporate practice of medicine and fee-splitting prohibitions. See e.g., N.Y. Educ. Law § 6706 (Corporate Practice – Veterinary). Examination of regulatory issues pertaining to ambulatory surgery centers and other health care facilities is beyond the scope of this article.

3 42 U.S.C. § 1320a-7b(b).

4 The asset acquisition must be at fair market value in order to avoid violations of the CPOM prohibition, the fee-splitting prohibition and the AKS. However, determination of fair market value for purposes of the AKS may not take into account the value or volume of referrals, contrary to general business valuation principles.

5 Some of these functions, other than direct patient care, may be delegated to the management entity, provided that all recommendations of the management entity are subject to prior approval of the practice.

6 Violations of the CPOM or fee-splitting prohibition may result in potential loss of professional license, fines and penalties, denial of claims to third-party payors, and violation of fraud and abuse statutes.

7 Ongoing operational compliance is important also, although beyond the scope of this article.

8 See 42 U.S.C. § 1320a-7b(b).

9 Violations may also result in the imposition of civil money penalties under 42 U.S.C. § 1320a–7a(a)(7), exclusion from participation in federal health care programs under 42 U.S.C. § 1320a–7a(a) (flush language), and liability under the False Claims Act, 31 U.S.C. § 3729–33 (imposing liability on any person who submits a claim to the federal government that he or she knows, or should know, is false).

10 See, e.g., United States v. Borrasi, 639 F.3d 774 (7th Cir. 2011); United States v. McClatchey, 217 F.3d 823 (10th Cir. 2000); United States v. Davis, 132 F.3d 1092 (5th Cir. 1998); United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68 (3d Cir. 1985), cert. denied, 474 U.S. 988 (1985).

11 See 42 U.S.C. § 1320a-7b(b).

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