Physician Alignment Strategies

Prepared for American Health Lawyers Association

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Tax Issues for Healthcare Organizations
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D. Physician Alignment Strategies

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The Private Practice of Medicine is Under Attack

- The private practice of medicine is under attack by Congress, the Centers for Medicare and Medicaid Services, commercial payors and hospitals.
- Congress has implemented substantial Medicare reimbursement cuts aimed at traditional equity joint ventures:
  - Ambulatory Surgery Centers paid at 65% of the Hospital Outpatient rates.
  - Specialty hospitals hit by implementation of severity adjusted DRGs; Stark Law exception eliminated.
- Congress has implemented substantial Medicare reimbursement cuts:
  - Physician office imaging payment rates reduced by 20%.
  - Medicare Advantage payments being reduced.
  - Sustainable Growth Rate fee cuts went into effect, then Congress enacted legislation that postponed the cuts.

The Centers for Medicare and Medicaid Services have adopted or proposed new regulations that are designed to eliminate the ability of physicians to profit from ancillary services.
The Private Practice of Medicine is Under Attack

• More generally, physicians are experiencing financial pressures that make private practices increasingly difficult to sustain:
  • Overall downward pressure on physician reimbursement.
  • Growth in Medicaid and Medicare.
  • Increased malpractice, EHR and other operating costs.

New physicians are seeking hospital employment
The Private Practice of Medicine is Under Attack

- Hospitals are choosing to employ physicians to support:
  - Pursuit of mission objectives.
  - Programmatic growth.
  - Ensure supply of physicians.
  - Ancillary business development at the highest and best reimbursement level.
  - Avoid paying for call.
  - Global fee contracting/value based purchasing/pay for performance coming soon.
Critical Questions

- Choice of “Partners”
- Location and Services Mix
- Legal and Financial Feasibility
- Capital Requirements
- Overall Strategy
- Implementation
Goals & Objectives

• Enhance ability to decrease cost and increase quality across the continuum of care

• Increase the tax-exempt hospital’s agility and ability to respond effectively to advancing population health models of care

• Improve market position by strengthening alignment with physician practices
Key Issues

• Governance
• Compensation
• Control of Operations
• Terms, Conditions, and Agreed-upon Practice
Overview of Non-Tax Legal Principles

• Stark Law – Civil
  • Covers direct and indirect financial relationships
  • Prohibits referrals for designated health services (DHS) absent specific exception
  • Three types of exceptions (compensation, ownership/investment, services)
    – Compensation set in advance (non-employees)
    – Fair market value, commercially reasonable, determined without regard to referrals, other business
  • May be enforced by private parties (relators) in a “qui tam” action under the False Claims Act
Overview of Non-Tax Legal Principles

- Anti-kickback Statute (AKS) - Criminal
  - Payment of remuneration
    - Anything of value
    - Opportunity to earn a fee
  - “One purpose” is to influence or reward referrals or the arranging for or recommending of items or services payable in whole or in part under a Federal health care program
  - Not limited to physician, family member
  - Safe harbors are for protection, not mandatory, government/relator must show intent
Stock Sale Structure

Physician Practice

Tax-Exempt Hospital

100%

$ Stock or LLC Interests

Structuring Options

- Subsidiaries of For-Profit Organizations
- Conversion to Tax-Exempt Entities
- Subsidiaries of Tax-Exempt Hospitals
Purchase/Physician Employment: Stock Sale

- Purchase of owner’s shares of Corporation/LLC
- Proceeds taxed at capital gains rates - 15%
- Transfers an entire company-assets, employees, real estate
- Assume responsibility of all known/unknown/future liabilities
- All assets are included
- Physician practice’s basis in its assets remains the same
- Not necessary to re-title assets
- Obtain selling company’s nonassignable contracts, permits, and licenses without the consent of the other party
- Physician practice’s employer identification number remains in tact
- Technical termination if Physician practice is LLC
- Depreciable lives of LLC’s assets re-start (meaning a longer period of time to re-coup the remaining tax basis)
Unknown and Unintended Consequences

• Consideration of any guarantees on the debt
• Real estate considerations
• Valuation issues (i.e., stock v. asset sale)
• Potential need for new corporation to serve as “consolidator” of physician groups
Legal Challenges for Stock Sale

• Restrictions on Ownership of Stock
  • State business organization laws typically limit ownership, for any time, to licensed physicians
  • Two-step transaction, mergers and Corporate Practice of Medicine
  • Assumption of unknown liabilities (malpractice, coding, compliance, environmental, recoupment)

• Legal Benefit/Push of Stock Sale
  • Less likely to require consent for assignment of contracts
  • Purchase price should be a wash in theory (reduced by amount of built-in gain)
Asset Sale Structure

Identified Assets
(AR, Fixed Assets, Equipment, Etc.)

Physician Practice

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Tax-Exempt Hospital

Structuring Options

• New subsidiary formed to hold assets (for profit or tax-exempt)
• Single Member Limited Liability Company
• Assets integrated into existing organization
Purchase/Physician Employment: Asset Sale

- Purchase of selling company’s assets – facilities, equipment, inventory, etc.
- Generally involves sale by corporation/LLC of some or all assets and then liquidation of corporation/LLC with distributions to shareholders/owners
- For the seller, double tax situation
- Purchase price > aggregate tax basis = stepped-up basis
- Depreciable assets written off in future fiscal years
- Goodwill may be amortized by the buyer for tax purposes over a period of 15 years
- Ability to sell less than all the assets
- Ability to limit assumed liabilities
- May need to re-title assets
- Third party consents for assignments of certain contracts (leases, employees, business relationships)
Legal Challenges for Asset Sale

• Valuation of Assets (similar issue for stock sale)
  • Intangibles as disguised payment for referrals
  • Assembled workforce (cost vs. income/market approach)
  • Effect of changes in overhead, pay scale, benefits

• Noncompetes
  • Enforceability
  • Assigning value

• Related Party Leases
  • Non-arm’s length terms, need for space/equipment
  • Pass through vs. current fair market rental value
Tax-Exempt Considerations - Purchase/Physician Employment

• Activities must further charitable purposes
• Physicians must participate in Medicare/Medicaid and provide indigent care
• Prohibition on any non-incidental private benefit
• Financial arrangements at arm’s-length terms and at FMV
• Upon conversion of a corporation to a tax-exempt entity, gain must be recognized to the extent FMV exceeds tax basis (built-in gain)
Legal Challenges for Direct Employment

- Corporate Practice of Medicine Doctrine
  - State by state
  - Prohibits employment by lay persons of physicians for the provision of professional medical services to the public
  - Exceptions vary (e.g., nonprofit corporations, hospitals, hospital affiliates, universities, HMOs)
  - Workarounds include medical foundation and captive or friendly PC models
Legal Challenges for Direct Employment

• Fee Splitting
  • State by state; licensure and/or criminal
  • Makes it illegal for physicians to split or divide a fee with another physician or other person for providing care to patients
  • Typically does not apply to members of the same group practice or permitted employment
Legal Challenges for Direct Employment

• Potential Vulnerabilities in Compensation
  • Historical vs. prospective compensation, productivity and duties
  • Disconnect in survey data between physicians realizing highest per wRVU rate and those receiving the highest cash compensation
  • Absolute dollars and Total Cash Compensation percentile
  • Documenting shortages and difficulties in recruiting/retaining needed physicians
  • Protections for quality, charity care, Medicare and Medicaid enrollees
Traditional PSA Basic Components

• Contract with physician(s) for professional services
• Hospital may employ the practice’s staff and is responsible for certain administrative services (i.e., billing/collecting for the services provided by the physicians)
• Physician compensation that is generally based upon physician work relative value units ("wRVU") and a compensation to wRVU conversion factor
Other PSA Models

• **Global Payment PSA**: Hospital contracts with physician practice at a global payment rate to include physician compensation and all administrative expenses. Practice maintains all management responsibilities.

• **Practice Management Arrangement**: Hospital employs physicians with practice structure retained. Practice contracts with the hospital for management services. Practice employs administrative staff and provides for services in separate agreements.

• **Hybrid Arrangement**: (Least common) Hospitals and physician mix and match contracts for professional/administrative services.
PSA Advantages

• Provide high-level of self-governance and decision making over physician compensation distribution

• Alleviate physician administrative burdens associated with managing and operating a full-service physician practice

• Provide physicians with more flexibility over retirement and benefit options

• Improves quality and efficiency, aligning practice and hospital interests

• Effective first step to integration if hesitant to completely acquire a physician practice
Professional Services Agreement

Physician Practice

Responsible for:
- Office lease
- Staffing
- Benefits
- Billing
- Supplies
- Equipment
- Malpractice
- Physician services

Professional Services Agreement

Leased Services Agreement

Tax-Exempt Hospital

Responsible for:
- Contract negotiations
- Fee schedule establishment
- Collections

Per wRVU
Professional Services Agreement

• Contracts with an independent physician group to provide professional services on behalf of hospital.

• Physician practice assigns its claims to Tax-Exempt Hospital and they take on role of provider of service and responsible billing party, including collection process.

• Tax-Exempt Hospital compensates physician practice at fair market value on a per Work Relative Value Unit (wRVU) basis. Such payment is to reimburse physician practice for all overhead costs and work personally performed.

• Many physician groups prefer PSA arrangements to employment because they maintain level of independence and control.
Any contract should have some stipulations or parameters to address material changes in service mix

While payor mix shifts can and will occur, material changes should be reviewed and evaluated at least on an annual basis

Valuation opinion should be obtained to document that fees for services are fair market value

FMV analysis to consider compensation prior and after PSA transaction

FMV opinion has a typical shelf life of two or three years

Generally required to obtain an updated FMV opinion during PSA arrangements
Legal Challenges for PSA Model

• Corporate Practice of Medicine
  • Workarounds in gray area in some states

• Fee Splitting, Stark and AKS
  • Document fair market value of all arrangements
  • Documenting costs, services actually provided
  • Commercially reasonable even if no referrals

• Private Use Rules (Non-exempt PC)
  • Bond-financed facilities (more than staff privileges)
  • Limits on term, termination based on compensation model (Rev. Proc. 97-41)
Legal Challenges for PSA Model

• OIG review of provider-based clinics
• Covering Operating Losses
  • No shared equity
  • Limited to fair market value of items and services
  • Compensation must be “set in advance” (Stark – formula; AKS – amount)
  • Possible exception for all nonprofit deals, and academic medical centers
  • History of under-compensation less relevant
Affiliation Structure

JOINT VENTURE, LLC

Possible Roles of the Joint Venture:
- Managing physician practices
- Owning physician practices

Physician Practice
Physicians own individually or through group practice wholly-owned by physicians qualified to invest

Other physicians/Other entities
Physicians or other entities qualified to hold ownership

Tax-Exempt Hospital
Tax-Exempt Hospital ownership share negotiated: typically, Tax-Exempt Hospital owns at least 50% and often 51% or more
Joint Venture

- Contribution of assets and/or liabilities for an ownership interest
- Potential for gain recognition if a substantial amount of liabilities are transferred in exchange for a lesser ownership percentage and depending on how the joint venture allocates liabilities
- Joint venture’s income/loss will be reported on Form 990, which is available for public disclosure
Tax-Exempt Considerations - Joint Venture

• Sufficient hospital control is required to assure revenue stream is tax-exempt:
  – Conservative position: hospital control including majority board representation
  – Alternative structure: 50/50 board representation with hospital reserve powers to ensure venture operates to further charitable purposes

• Venture must further charitable purposes:
  – Venture participates in Medicare/Medicaid and provides indigent care
  – Venture maintains open medical staff

• Financial arrangements at arm’s length terms and fair market value

• Arrangements with for-profit parties should be for limited terms and should be terminable for cause over objections of interested parties

• Transfer of hospital assets, including existing hospital business, must be appropriately valued

• Venture should compensate tax-exempt hospital for value of transferred assets

• Joint ventures using bond-financed facilities or equipment will constitute an impermissible private use unless space or equipment can be allocated to funds reserved for non-exempt use
Legal Challenges for JV Model

- Two-prong test – purpose and control
- Shared control, UBI and exemption
  - Large gray area between good/bad facts in IRS guidance
  - Indicia of day-to-day control
  - Reserved powers – veto vs. initiation
  - Long-term contracts
  - Exit rights and limits (e.g., noncompete)
  - Value of control for AKS, Stark
Legal Challenges for JV Model

• Community board standard
  • IRS has moved beyond 20% safe in IDS rulings
  • Look to parent board
  • Distinguishing “community” from “independent”
    – Faculty practice plans

• Antitrust
  • Defining market and supply of specialists … does it look like “cornering the market”?
  • Clayton Act and board overlap between competitors
  • Sharing competitively sensitive information
Legal Challenges for JV Model

- OIG review of provider-based clinics
  - FY2013 Work Plan (p. 2) focusing on non-hospital owned practices
- Covering Operating Losses
- Sham, shell and turn-key joint ventures
  - How does the JV expand access, services
  - Significant investment and risk for both parties
  - Proportionate sharing of risk and reward
  - Fair market value arrangements
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