

MSO Gets Light Enforcement Touch by California Appellate Court Reviewing Management Services Agreement Legal Issues

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MSO Compliance Worries

Clients desiring to create MSOs or operate them in legally compliant ways often worry about enforcement efforts under the corporate practice of medicine and anti-kickback rules, and related legal rules that can create traps for the unwary.

The kinds of healthcare business seeking **healthcare legal advice** and **MSO compliance** in the past year have included:

- A high-profile, **plastic surgeon** in charge of a highly profitable **cosmetic and aesthetic medicine**. The physician decided that he would like to open a new revenue stream, by creating an MSO, alongside his lucrative practice. However, the physician was unsure about how to create value in the MSO, so it could later be sold for a high multiple. Unlike the medical practice, which could only be sold to another physician (or MD majority owner in a professional medical corporation), the MSO could be sold to anyone, including a layperson. Unlike the plastic surgery practice, the MSO would attract investors. And, the physician hoped to build value in the MSO and have the branding successes and marketing dollars go to benefit the MSO.
- More typically, **non-physician investors and entrepreneurs** seeking to create a branding and marketing success. The venture folks behind the idea have access to capital, and an intelligent way to capture and bring potential patients to the medical practice.
- **Chiropractors** or **acupuncturists** wanting to create a multidisciplinary healthcare care, such as a holistic health care or center for integrative medicine, or simply a collaboration with practicing physicians.
- **RNs, NPs, or PAs** seeking to create a **medical spa** or model of care that integrates esthetic treatments with aesthetic medicine treatments.

We've written extensively about **MSO Legal Issues** in many prior posts. See, for example:

Kickbacks, Fee-Splitting, Corporate Practice of Medicine, Stark, MSOs: Guiding Healthcare Ventures through the Maze

Corporate Practice of Medicine on Steroids: How Your MSO and Professional Medical Corporation Could Work Together Without Courting Legal Disaster

Can an MSO control physicians given corporate practice of medicine?

Is it fee-splitting for medical doctors to share revenues with non-medical business owners?

One of the questions that comes up again and again is a variation of: How likely is it that the MSO will get in legal trouble?

Legal Jeopardy: From Fines to Criminal Penalties

Make no mistake about it: penalties for violating the anti-kickback laws are serious.

Criminal penalties are possible. The Government provides [a Roadmap for New Physicians: A Guide to Fraud and Abuse Laws](#), in which it warns:

...[I]t is crucial to understand these laws not only because following them is the right thing to do, but also because violating them could result in criminal penalties, civil fines, exclusion from the Federal health care programs, or loss of your medical license from your State medical board.

Among other things, the Roadmap explains the federal anti-kickback statute (AKS) as follows:

The AKS is a criminal law that prohibits the knowing and willful payment of “remuneration” to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). Remuneration includes anything of value and can take many forms besides cash, such as free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies. In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks—those who offer or pay remuneration— as well as the recipients of kickbacks—those who solicit or receive remuneration. Each party’s intent is a key element of their liability under the AKS.

A few days ago, I was on the phone with a new client that owned a healthcare business. The client was describing a complicated scheme involving physician equity in an MSO, a “point system,” and what essentially sounded like paying the physicians for every patient referral. With every detail the client reported, my legal Spidey-sense tingled. The client reported that many potential investors were excited by this model, and had received assurances from various salespeople for the investment vehicle that they had found a “workaround” to the anti-kickback statute.

The client then asked, “what’s the best way to do this and not get caught.”

I was tempted to jokingly say: “Use a leather briefcase with small, unmarked bills.” Instead, I assured them that it wasn’t my job to “get around” laws (and I also advised that they get a legal opinion from the MSO’s lawyer that we could seriously and rigorously evaluate).

Much of the time, reviewing fee-splitting and anti-kickback rules requires a rigorous evaluation of the model, to see whether the self-referral and kickback prohibitions are triggered (usually, both federal and state), and if so, whether there are applicable safe harbors and exceptions.

Enforcement Varies

Having said that the penalties can be serious, it’s also important to note that enforcement priorities vary. Sometimes there can be “technical” violations of the statutes yet enforcement will be light or the arrangement might be regarded as creating a low risk of fraud and abuse. One can find this attitude expressed in many OIG advisory opinions regarding the anti-kickback laws.

Very often, investigation, enforcement and penalties arise from a “perfect storm” of negative facts and circumstances. See, for example, our prior post:

Corporate practice challenges medical management (MSO) organizations in New York AG action

In this state enforcement action, the enforcement triggers included:

- **Extensive Consumer Complaints:** There were over 300 consumer complaints to the AG about consumer experiences, including: “quality of care, billing practices, misleading advertising, upselling of medical services and products the consumers felt were unnecessary, and unclear or incomplete terms for the financing of dental care.”
- **Extensive MSO Control:** The MSO “did not merely provide arms-length, back-end business and administrative support to independent dental practices,” but rather “developed what amounts to a chain of dental practices technically owned by individual dentists but which, in violation of New York law, were subject to **extensive control** by” the MSO.
- **Profit-Sharing; A Shared Trade Name:** The control “included sharing individual clinic profits with the management company and the marketing by the management company under” a shared trade name.
- **Control over Care via Banking Arrangements:** The MSO “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.”
- **MSO Revenue Based on Percentage Gross Profit:** The MSO took a percentage of each dental office’s monthly gross profit — “*an arrangement prohibited under New York law.*”
- **Over-broad non-compete and non-solicitation:** The MSO “also subjected the dental practices to non-competition and non-solicitation agreements that effectively prevent the practices from competing with any other dental practice affiliated with” the MSO, regardless of location.

And that brings us to *Epic Medical Management v. Paquette*, a recent California appellate court decision.

An Epic MSO Enforcement Case

In *Epic*, there was a dispute between an MD and a medical management company, Epic Medical Management, LLC, with which the physician had contracted to supply non-medical management services to his practice. According to the Court:

The doctor and the management company had a falling out and agreed to terminate their contract. The management company believed it was due additional fees under the agreement; the doctor believed the management company had underperformed its duties under the contract and owed him money.

Here are some of the key elements of the Management Services Agreement in dispute in the case:

- Pursuant to the agreement, the doctor engaged the management company “to provide management services as are reasonably necessary and appropriate for the management of the non-medical aspects of [the doctor’s] medical practice.”
- Among other things, the management company was required to lease office space to the doctor, lease to him all equipment he deemed reasonably necessary and appropriate, provide support services, provide non-physician personnel, establish and implement a marketing plan, conduct billing and collections, and perform accounting services. The doctor was responsible for providing medical services.
- The management company was required to provide non-physician personnel, including nursing staff, but the physician was responsible for training and supervising the nurses.

Significantly:

- As to compensation, the contract stated the parties agreed that “it will be impracticable to ascertain and segregate all of the exact costs and expenses that will be incurred by [the management company] in performance of the [m]anagement [s]ervices. However, it is the intent of the parties that the compensation paid to [the management company] provides a

reasonable return, considering the investment and risk taken by [the management company] and the value of the [p]remises, [l]eased [e]quipment and other [m]anagement [s]ervices provided by [the management company] hereunder.” The agreement then provided, “For each month that [the management company] provides the [m]anagement [s]ervices . . . , [the doctor] shall pay to [the management company] a management fee equal to one hundred twenty percent (120%) of the aggregate costs [the management company] incurs in providing the [m]anagement [s]ervices . . . in that month but not to exceed fifty percent (50%) of the Collected Professional Revenues plus twenty five percent (25%) of the Collected Surgical Revenues” A subsequent provision defined “Collected Revenues” to mean the total received by the practice, less any refunds paid and bad-debt write-offs.

- The contract also included an arbitration clause and a prevailing party attorney’s fee clause.

According to the Court’s recitation of the background facts, the management company never charged, and the doctor never paid, a fee based on 120 percent of the management company’s costs. Instead, the management company charged, and the doctor paid, a fee calculated as 50 percent of office medical services, 25 percent of surgical services, and 75 percent of pharmaceutical expenses.

In arbitration, the arbitration concluded that the physician, not the management company, had breached the agreement; and also that the physician had to keep paying management fees accrued during the term of the Management Services Agreement.

The physician’s argument was that, “**because some of the fees were paid for the management company’s marketing services, the payments constituted an illegal kickback scheme for referred patients.**” The physician noted that some members of the MSO, who were physicians, referred patients to the physician.

The physician’s argument was based not on the federal AKS statute, but rather on the California equivalent, **California Business and Professions Code section 650** (section 650).

The arbitrator “concluded that any such violation was ‘technical’ and did not impact the award.”

Let’s jump to the appellate court decision.

Here the physician also argued that the Management Services Agreement essentially violated the prohibition against the corporate practice of medicine, by referring patients to the physician, and by using the 50-25-75 method of calculating fees.

The appellate decision focuses a great deal on whether the arbitrator exceeded her powers. However, the relevant portion for us is the Court’s review of the Management Services Agreement under California Business & Professions Code 650 and California’s prohibition against the corporate practice of medicine.

The appellate Court stated:

Referral patients were a small percentage of the patients seen while the doctor and management company were operating pursuant to the agreement. The agreement was not a referral agreement, but one for management services, of which referrals played only an incidental part.

This seems to suggest that the Court finds any violation of anti-kickback rules as “incidental” and even (according to the arbitrator) “technical.” It’s difficult to completely parse this part of the opinion, as the Court focuses so much on procedural issues such as the standard of review that applies to the arbitrator’s opinion. However, one read is that the Court takes a very light enforcement stance with respect to violations that have often been considered very weighty, under relevant California law and applicable California Attorney General opinions.

The Court also looks to Business & Professions Code, Section 650(b), which allows arrangements otherwise prohibited by

650(a), if at fair market value, commercially reasonable, and not influenced by the volume or value of referrals.

Here the Court's view is important: it says that 650(b) allowed the arrangement, which included **"payment to a management company for management services based on a percentage of revenue – as long as the consideration is commensurate with the value of the services furnished (and facilities and equipment leased)."**

The Court noted:

Given this flexibility in section 650, there is no absolute prohibition on consideration being paid a management company – even one which occasionally refers patients.

Again, note the Court's emphasis on **"occasional"** referrals of patients.

The Court takes pains to go through a history of judicial opinions in California, interpreting Business & Professions Code 650. And then the Court restates 650 very narrowly:

Thus, the only basis on which the contract between the doctor and the management company could be found illegal is if a finding were made that the consideration was *not* commensurate with the services rendered and facilities and equipment provided

As to the 50-25-75 method, the Court found no violation, so long as the numbers represented a "rough correlation" to what the management company was entitled to collect under the Management Services Agreement. The Court also found no corporate practice of medicine violation, since the Management Services Agreement showed "a strict delineation between the medical elements of the practice which the doctor controls, and the non-medical elements which the doctor has retained the management company to handle."

Does *Epic* Change the Enforcement Landscape

Our reading of *Epic* suggests several lessons:

- A "cost-plus" arrangement by which the MSO charges the physician or medical group, is not necessarily suspect, and can be significant, so long as reflective of the fair market value of the MSO services (and/or space leased).
- The liberal allowance of 650(b) is at least as important as the prohibition in 650(a).
- The physician here emphasized the familiar, twin evils of prohibited kickbacks and fee-splitting, and corporate practice of medicine. The appellate Court essentially threw sand in the face of those arguments.
- As a practical matter, physicians who breach their Management Services Agreements, hoping to persuade courts or arbitrators that the agreements contain illegal arrangements, may find the legal argument much more uphill than in the past. Previously, physicians might more successfully argue that an illegal contract violates public policy and is unenforceable; but as noted, the Court resisted the argument as to illegality.
- The Court seemingly admits that prohibited (aka illegal) referrals were involved here, but calls these "occasional" and "incidental."
- The Court limits the specter of corporate practice of medicine violations, to situations in which the management company (MSO) actually has the power to interfere with, and interferes with, clinical decision-making.

Reading *Epic*, the rules haven't changed, but the courts' emphasis has shifted, from the prohibition in Business & Professions Code 650(a) to the allowance in Section 650(b).

Cases and Attorney General Opinions prior to *Epic* emphasized the public policy dangers of violations of California Business & Professions Code 650 (i.e., 650(a)). *Epic* emphasizes the legislative history that led to enactment of 650(b), and even restates 650 so as to say that the “**only**” basis on which the Management Services Agreement could be void is if the management company (MSO) did not receive fair market value for its services.

In that sense, *Epic* changes the landscape. It is not from the highest court in California, nor is the decision binding on other states – nor does the decision express views of anti-kickback rules based on federal law. Nonetheless, as an expression of a more liberal view of MSOs and their arrangements with physician and medical groups, *Epic* is a sea change in regulatory policy.