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Lawyer Recommending Prohibited Medical Practice Structure Liable for its Improper Insurance Claims

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Holland & Knight Healthcare Blog

Charles A. Weiss

New Jersey has had historically high auto insurance rates in part because the policies have generous coverage. Among the cost drivers is PIP (Personal Injury Protection) coverage, which applies on a no-fault basis to pay the medical expenses of persons injured in an insured vehicle. In a partial attempt to control such costs by deterring abusive insurance claims, the Legislature adopted the Insurance Fraud Prevention Act in 1983. Among other things, it provides that a person violates the IFPA if he "knowingly assists, conspires with, or urges any person or practitioner to violate any of the provisions of this act." N.J.S.A. 17:33A-4(b).

New Jersey also prohibits a physician from being employed by a chiropractor. N.J.A.C. 13:35-6.16(f) (person with plenary license may not be employed by person with limited license).

In the mid-1990s a New York healthcare attorney (Robert Borsody) and California chiropractor (Daniel Dahan) gave seminars marketed to chiropractors on how to create multi-disciplinary practices. Their activities would ultimately result in a judgment against them of nearly $4 million under the IFPA on account of some $91,000 paid for insurance claims submitted by a practice organized by a New Jersey chiropractor and an additional $330,000 claims that were submitted but not paid. Among the interesting features of this case is that Borsody and Dahan were found liable despite having had no interest in the New Jersey practice, and not having participated in the submission of the insurance claims. *Allstate Ins. Co. v. Northfield Medical Center, P.C.,* 2017 WL 1739692, A.2d (N.J. 2017).

The story begins in 1996, when New Jersey chiropractor J. Scott Neuner attended a lecture in New York given by attorney Borsody under the auspices of Dahan's company "Practice Perfect," which marketed to chiropractors interested in setting up multidisciplinary practices. Borsody described a business model under which the chiropractor could effectively control and profit from a medical practice that was nominally owned by a physician, which he referred to as a "doc in the box arrangement." To guard against the physician owner from "walking off with the practice" or seeking control of the finances, this person would only receive a fee for his or her participation, and not be employed by the practice, see patients, or control the hiring and firing of the doctors who actually worked in the practice. As stated by the trial court, Borsody "testified that an earlier experience in the State of New York led him to conclude that his chiropractor clients needed protection from ruthless medical doctors." At the end of his lecture, Borsody said that he was available to set up such a practice for $7,500, but advised that participants should also consult lawyers in their own states.

Rather than retain Borsody to set up his practice, Neuner signed a consulting agreement with Practice Perfect and was referred to a company called Management Legal Services (MLS), which for $2,600 sold him the necessary forms. Neuner sent these forms to a New Jersey attorney and consulting him regarding practice structure. The New Jersey lawyer told Neuner that he would not simply "fill in the blanks" on the forms, but had to do his own analysis of New Jersey law. When Neuner told Dahan that the fees for the New Jersey attorney might exceed $5,000, Dahan told Neuner that this was "outrageous," and Neuner proceeded to complete the form by filling in the blanks.

Neuner engaged a physician referred to him by Dahan as the owner, shareholder, director, and incorporator of the practice for a "standard annual consulting fee" of $4,000. At trial, it was revealed that this doctor similarly "owned" about two dozen medical corporations in New Jersey and New York.

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Neuner's practice also entered into a service agreement with a management company solely owned by Neuner to manage its nonprofessional aspects.

The following year, after the nominal physician-owner sought to become more involved with the practice, Neuner terminated her using forms from the set he had purchased from Dahan. He engaged a different doctor for the owner's role at a lower annual fee.

Later that year, after having paid about $91,000 toward claims submitted by Neuner's practice, Allstate stopped paying claims submitted by Neuner's practice and asked him to give a statement under oath regarding its arrangement with the management company. Allstate never paid additional claims of approximately $330,000 submitted by Neuner's practice.

Allstate then sued Neuner, Borsody, Dahan, and others for violation of the IFPA, contending in part that Neuner's practice was ineligible to bill Allstate for PIP benefits because the practice was not owned by a physician. After settling with Neuner, Allstate went to trial against Borsody and Dahan and prevailed. Under the IFPA, Allstate was entitled not only to damages based on the roughly $91,000 in claims that it paid, but also to trebled attorneys' fees, for a total judgment of almost $4 million.

The Appellate Division reversed, finding the evidence at trial insufficient to prove under IFPA that they had "knowingly" assisted or encouraged Neuner to violate the Act by submitting bills from an improperly structured practice. Specifically, the court held that the evidence was not sufficient to show that New Jersey law was settled enough at the time to conclude that Borsody and Dahan knew the structure they advocated was illegal, as opposed to being simply "frowned upon" by the New Jersey entity that licenses physicians. 2014 WL 8764091.

The New Jersey Supreme Court granted Allstate's petition for discretionary review, and reversed in a unanimous decision released in May 2017. Because the Appellate Division had reversed the trial court's judgment in Allstate's favor based on its conclusion that the evidence was insufficient to show the defendants' knowledge that Neuner's practice structure was illegal, the Supreme Court's opinion focused on this issue. Defending the Appellate Division's holding, the defendants argued that IFPA's knowledge requirement could be met only by evidence that they had to know, from dispositive case law or other binding interpretive action, both that (i) the practice structure they advocated violated New Jersey law, and (ii) mere violation of restrictions on the business structure of a medical practice could invalidate otherwise-insurance claims rendered by that practice. The Supreme Court rejected this argument.

In concluding that the evidence was sufficient to support the trial court's finding that the defendants knew the practice structure they advocated was illegal, the Court emphasized their attempts to conceal the reality of the chiropractor's control of the medical practice:

[W]e find no basis for crediting the argument that defendants could not have known that their structure violated the Board's regulatory requirements. The documents and structure promoted and designed by defendants accomplished what the regulations sought to avoid. They placed control over the medical practice in the hands of a chiropractor, subjecting plenary licensees to his effective control through interconnected contracts and the imposition of the threat of substantial monetary penalties. Importantly, the plan sought to conceal those features to appear compliant.

Here, there was an abundance of proof that the contracts and penalties—imposed on the doctor named as nominal owner in title of this practice—placed control of the medical practice in the hands of a chiropractor. That clearly supported finding is not overcome by any form-over-substance argument based on the placement of bare legal title in the plenary licensee who participated in this scheme. The trial court demonstrated clarity of vision in recognizing that this medical practice structure violated both the letter and spirit of the Board's rule.

Moreover, the lengths that defendants went to in shielding the true controller of this practice from view undermine any basis for interfering with the trial court's assessment of the mixed question of fact and law that was presented to the

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court. . . . Considering all of the circumstances involved in defendants' interactions with Neuner, the trial court could reasonably conclude that defendants knowingly assisted Neuner in violating the Board's rules and submitting ineligible and fraudulent medical claims for reimbursement through that practice structure, contrary to law.

As did the Supreme Court, the trial court also relied on the concealment of ownership and control in the structure advocated by Borsody as evidence that knew it violated the law:

Borsody knew that he was placing in the hands of a chiropractor the control that was lacking in his first experience in New York. The simple fact that the practice was intended to look as though a medical doctor was in control yet, with various side agreements, he was not, constitutes sufficient basis for the Court to conclude that Borsody knew what he was doing was not proper. . . . The truth can only stand the light of day. It need not hide in the shadows of side agreements.

A second key issue was the responsibility of Dahan and Borsody for the insurance claims made by Neuner's practice. Dahan and Borsody argued that they could not have known that an unauthorized practice structure automatically voided even otherwise-legitimate insurance submissions, contending that a reasonable actor would not have appreciated this feature of New Jersey law until it was made clear by an Appellate Division opinion that post-dated their seminar and advice to Neuner. The Supreme Court rejected this argument, concluding that because the outcome of that case had been predictable, the defendants could not plead ignorance of the eventual outcome. Citing several earlier decisions, the Court held that the defendants were on notice that bills submitted to insurance by an improperly organized medical practice were disallowed:

The theory of all those cases reflects that in New Jersey a practice entity must comply with all statutes and regulations governing the permissible structures for control, ownership, and direction of a medical practice, including the use of professional services interconnected with a medical practice.

Health care services are highly regulated, and professionals engaged in the provision of health care—including persons such as defendants, who undertook to facilitate that activity—are on notice of the legal requirements applicable to their practice and operations. We do not deal here with an honest mistake made in the course of completing a reimbursement form submitted to an insurer. This case goes to the basic structure of a practice and how it is owned, controlled, and directed. Those concerns go to the core of who may practice medicine in this State. The practice of medicine is a privilege to be exercised in accordance with all licensing and practice requirements and restrictions. One cannot claim, or feign, ignorance of those regulatory requirements and restrictions until there is an express command applicable to a precise set of facts. (citation omitted)

What are we to make of this case? Does it stand for anything more than the proposition that "if it sounds too good to be true, it probably is?" In the author's opinion, the answer is "yes."

First, the structuring of business and corporate relationships to avoid or exploit laws and regulations is part of the lawyer's stock in trade, ranging from tax to real estate to trust and estates. Whether Borsody was too aggressive and got what he deserved for crossing the line, or was unfairly held liable for zealous and aggressive representation, is for the reader's judgment (although we know how the New Jersey Supreme Court answered the question in its unanimous opinion). Perhaps a better way to frame the issue is distinguishing between structuring a clever work-around of regulations (permissible) and structuring to conceal a violation (not permissible).

Second, regulated healthcare practices that submit bills to insurance companies are held to a higher standard than ordinary businesses. This not appear to sway the Appellate Division, which wrote that Dahan and Borsody "believed that the scheme was a legitimate tool for accomplishing the goal of allowing limited license holders to increase their earnings by creating multi-disciplinary practices." The Supreme Court, by contrast, shattered this view with its observation that the defendants' structure relied on a physician who "'sold' her license to multiple practices utilizing the

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so-called ‘Doc-in-the-Box’ structure” and was “subject to the direction and financial control by a chiropractor-owner of a management company.” Any arrangement subject to characterization in this manner is one that raises a red flag in a regulated profession.

Third, it may be difficult for out-of-state or non-specialist lawyers to appreciate the local emphasis on certain types of activities. For example, the issue of automobile-insurance rates and the perceived impact on them by insurance fraud has been of concern in New Jersey for decades.

It is notable that the investigation of Northfield’s insurance claims and resulting prosecution of this case arose from claims submitted for PIP to an auto insurer and not in the context of health insurance. Dahan and Borsody may not have appreciated the risk of conduct in New Jersey that could be viewed as fraud on an automobile insurer, or the possibility that their positions one step removed from the actual medical practice, and two steps removed from its submission of PIP insurance claims, would nevertheless expose them to liability under New Jersey’s Insurance Fraud Prevention Act for a judgment of almost $4 million based on $91,000 of claims.

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—from a declaration of the American Bar Association

The Corporate Practice Of Medicine Doctrine: Is it Applicable to Your Client?

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Introduction

Many clients are not sure if the state in which they want to form their medical practices has adopted the Corporate Practice of Medicine Doctrine (CPOM Doctrine), and if it has, whether it is applicable to their particular practices' corporate structure. The rapid and complex changes in the healthcare delivery system have led to a renewed focus by federal and state governments and insurance companies on the corporate structure of medical entities that could complicate the establishment of such entities and even lead to potential violations by your client's current corporate structure.

Under the auspices of protecting the public, the American Medical Association (AMA) promulgated the initial version of the CPOM Doctrine.[1] In simple terms, the CPOM Doctrine essentially bans unlicensed individuals and entities from engaging in the practice of medicine by restricting them from employing licensed physicians.[2] In practice, many states with CPOM laws permit professional service entities to practice medicine, but only if owned by physicians licensed in that state.[3] Authority for state CPOM laws ranges from statutes and rules to case law and state attorney general (AG) opinions.



Healthcare providers must be careful to comply with local laws because violating these laws could result in a provider's loss of license and repayment of all revenue for billed services to insurance companies and the government. It is also important for parties that enter into ventures with physicians to understand the CPOM Doctrine because it can affect the structures of these types of relationships (i.e., employment versus independent contractor).

Background

In the nineteenth century, the AMA created the CPOM Doctrine to protect the public and the professional status of medical doctors.[4] To protect its membership from the alleged threat posed by others claiming to practice medicine, the AMA warned the public of the "dangers" of corporations practicing medicine, regardless of the reason and structure of such a corporation.[5] States followed the AMA's warning and promulgated statutes to restrict the practice of medicine to licensed physicians and to empower physicians as the sole legitimate professionals to provide medical care.[6] This resulted in an amalgamation of state laws and regulations shielding medical doctors from outside control, especially by corporations.[7]

The rationale for prohibiting employment of physicians by corporations is derived from the concept that individual physicians, not entities, should be licensed to practice medicine.[8] The basic premise is that there is a divided loyalty between the interests of a corporation and the needs of a patient. Simply stated, the patient's need for treatment and care and the physician's related judgment conflicts with the corporation's interest in maximizing its profits and reducing its costs. Consequently, the CPOM Doctrine's intent was to ensure that only licensed professionals could provide medical care and that lay persons and entities would not be able to influence treatment decisions. Patients would thereby be protected from potential abuses because commercialized medicine could not interfere with the physician's judgment and, by extension, the patient's treatment. Consistent with these ideals, the Pennsylvania Supreme Court held that:

> A corporation as such cannot possess the personal qualities required of a practitioner of a profession. Its servants, though professionally trained and duly licensed to practice, owe their primary allegiance and obedience to their employer rather than to the clients or patients of their employer. The rule stated recognizes the necessity of immediate and unbroken relationship between a professional man and those who engage his services.[9]

In recent years, most states have repealed CPOM laws in favor of other means to protect the medical profession's integrity. Many states' laws simply require that an individual must be licensed to practice medicine. However, other states such as Texas still employ a detailed CPOM statutory scheme, albeit with many exceptions.[10] Appendix A identifies which states still use some form of the CPOM Doctrine and the statutory citation, case law, or AG opinion that is the primary CPOM authority in that state.

The CPOM Doctrine's Current Incarnations

The CPOM Doctrine's current incarnations vary from state to state, but some generalizations can be made from examining the various states' laws. The CPOM Doctrine is an overall prohibition on non-licensed persons, lesser-licensed persons, or corporations (or other entity-types) from employing physicians to practice medicine, restricting the delivery of medical services to those entities owned and controlled only by licensed professionals, and prohibiting the division or splitting of professional fees between licensed medical doctors and non-licensed or lesser-licensed individuals or entities. In many states, physicians remain prohibited from entering into relationships with lesser-licensed professionals or non-physicians where the physician's practice of medicine is in any way controlled or directed by, or fees shared with a non-physician. For instance, in Pennsylvania:

> . . . no person other than a medical doctor shall engage in any of the following conduct except as authorized or exempted in this act: (1) practice medicine and surgery; (2) purport to practice medicine and surgery; (3) hold forth as authorized to practice medicine and surgery through use of a title, including, but not necessarily limited to, medical doctor, doctor of medicine, doctor of medicine and surgery, doctor of a designated disease, physician, physician of a designated disease, or any abbreviation for the foregoing; or (4) otherwise hold forth as authorized to practice medicine and surgery.[11]

States such as Texas allow physicians to enter into independent contractor arrangements with non-physicians and avoid application of the CPOM Doctrine.[12] The question of whether an independent contractor situation exists is a question of law and attendant facts. The mere designation of a physician as an "independent contractor" is not dispositive. It is important to review the Internal Revenue Service's guidance for determining whether an individual is an employee or an independent contractor, but such classification remains very fact-specific.[13]

In states such as Indiana, an exception to the CPOM Doctrine allows hospitals to employ physicians because hospitals are formed for the specific purpose of treating patients and providing healthcare services and are themselves licensed entities. The Indiana statute provides that "this article, as it relates to the unlawful or unauthorized practice of medicine or osteopathic medicine, does not apply to . . . a hospital licensed under [Indiana Code § § 16-21 or 12-25]."[14]

States such as New Jersey allow physicians to provide medical services through a professional corporation or limited liability company (LLC), but generally each shareholder or member of the corporation or LLC must be a licensed physician. The New Jersey statute permits the following professional corporation practice forms.

Solo

A practitioner may practice solo and may employ other licensed practitioners with the same license or a license with a smaller scope than that of the employing practitioner.[15]

Partnership, Professional Association, LLC

The entity must be composed solely of licensed practitioners authorized to perform the same service or a "closely allied professional service" including but not limited to chiropractic, dentistry, nursing, nurse midwifery, optometry, physical therapy, podiatry, psychology, social work, etc.[16]

Associational Relationship With Other Practitioner or Professional Entity

However, a plenary-licensed practitioner may not be employed by a practitioner with a limited license. Plenary-licensed practitioners are MDs and DOs.[17]

Shareholder or Employee of a General Business Corporation

This form is permitted only if the corporation is:

- Licensed by the New Jersey Department of Health and Senior Services as a health maintenance organization, hospital, long or short-term care facility, ambulatory care facility, or other type of healthcare facility; or
- A medical clinic providing first aid to customers or employees and/or for monitoring the health environment of employees; or
- A nonprofit sponsored by a union, social, religious, fraternal-type organization providing services to members only; or
- An accredited educational institution that maintains a medical clinic for healthcare service to students and faculty; or
- Licensed by the New Jersey Department of Banking and Insurance as an insurance carrier.[18]

A Professional Practice That is a Limited Partner to a General Business Corporation That has an Agreement With the Practice

However, the corporation may only provide non-professional services.[19]

In conjunction with the CPOM Doctrine, many states prohibit fee-splitting, a form of corporate practice that encourages payments for referrals, whether from one physician to another physician or from a corporation to a physician. This fee-splitting prohibition also bars physicians from sharing their reimbursement for services with any non-licensed person or entity. For instance, in Wisconsin:

> Except as otherwise [permitted under the statute], no person licensed or certified under this chapter may give or receive, directly or indirectly, to or, from any person, firm or corporation any fee, commission, rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a licensee in a professional capacity, or for any professional services not actually rendered personally or at his or her direction.[20]

The CPOM Doctrine exists in various forms throughout the country, but the next section outlines some general ideas that should be reviewed when structuring a medical practice in any state where the CPOM Doctrine is in effect.

General Considerations

When setting up a medical practice, the following points should be considered to avoid a possible violation of the CPOM Doctrine:



Ensure That a Medical Doctor has Complete Control Over Certain Decisions

There are several types of decisions that are unequivocally in the purview of medicine and should be made by a medical doctor. The Medical Board of California provides some examples of these decisions:

- Determining what diagnostic tests are appropriate for a particular condition;
- Determining the need for referrals to or consultation with another physician/specialist;
- Responsibility for the ultimate overall care of the patient, including treatment options available to the patient;
- Determining how many patients a physician must see in a given period of time or how many hours a physician must work;
- Ownership is an indicator of control of a patient's medical records, including determining the contents thereof, and should be retained by a California-licensed physician;
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff, and medical assistants;
- Setting the parameters under which the physician will enter into contractual relationships with third-party payors;
- Decisions regarding coding and billing procedures for patient care services; and

- Approving of the selection of medical equipment and medical supplies for the medical practice.[21]

The Type of Entity Chosen Must Comply With That Particular State's Requirements

States such as Nevada require physicians who form practice entities to use a specific type of entity or not to use certain types of entities. For example, in Nevada no corporation can practice medicine except a professional corporation owned by licensed physicians and incorporated under Nevada's professional corporation act.[22]

The Physician Must be Able to Make Medical Decisions Without Being "Controlled" by a Non-Physician

Physicians should be able to make medical decisions free from the control of non-physicians, including a lesser-licensed individual or a corporation's board of directors. The corporate organizational documents should reflect this premise, but this consideration must also be employed in practice. The CPOM Doctrine is premised on the idea that the physician-patient relationship should be preserved free of taint by corporate interests. This is the main idea to keep in mind when structuring a medical practice.

Research the Appropriate Employment Relationship

States such as Texas will allow providers to work around the CPOM Doctrine by having providers contracted as independent contractors as opposed to employees. All attorneys should research this issue with the applicable state's statute and regulations and, most importantly, case law, for guidance on this particular issue. However, the employment relationship must really be one of principal-contractor as opposed to employer-employee, and not just principal-contractor in name only. In *Flynn Brothers, Inc. v. First Medical Associates*, a Texas appellate court found that the practical effect of an employment contract between a lay entity and medical professionals was that of employer-employee, not independent contractor.[23]

Case Study

The following is a case study for the application of the CPOM Doctrine's general ideas.

Facts

C is a licensed chiropractor. P is a licensed physician. L is a LLC. L's business principally consists of providing physical therapy, chiropractic, and pain management services to patients. Orally, P and C agree that they will work hand-in-hand with equal input in

Editor's Notes

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Friends and Colleagues,

Welcome to the latest issue of *Business Law & Governance*. In this issue, we are once again "spanning the globe" to bring you the wide world of healthcare transactions and corporate governance. Michael Schaff and Glenn Prives take us on a cross-country tour of the corporate practice of medicine doctrine, taking on a renewed importance in the next generation of physician-hospital integration. Karen Gledhill moves us inside the boardroom to discuss the lawyer's role in the business aspects of joint ventures. Dale Van Demark takes us to the metaphysical plane, with an update on avoiding ambiguity in contract drafting. Finally, Gordon Schatz guides us through China, where a different version of healthcare reform offers opportunities for U.S. healthcare companies.

Indeed, healthcare business lawyers face a wide world of challenges—and opportunities—today. With the capital markets still unsettled, with healthcare reform changing everyone's game plan, with the enforcement authorities continuing to ramp up their scrutiny of provider transactions and relationships, it has never been more important for healthcare lawyers to stay one step ahead of the curve.

And that is what the Business Law and Governance Practice Group (BLG PG) wants to help you do. Through our newsletters, Member Briefings, Executive Summaries, email alerts, webinars, and our Affinity Group activities, we want to give you the insights and tools that you need to help your clients navigate today's turbulent tides.

To do that, we need your help. Please share your knowledge, expertise, and predictions for the future with your fellow BLG PG members. Write an article for the newsletter or contribute to one of our other publications. Get involved in an Affinity Group. Post a question (or an answer!) on our discussion list. Share a webinar idea, or let us know what you would like to see us cover in a tutorial. Your colleagues in the BLG PG need you to help all of us make this the best PG it can be.

Best of all, come join us in Seattle at the AHLA Annual Meeting. We will have a great lunch. We will enjoy top-notch Continuing Legal Education. We will network with friends. We will share ideas on how to make 2010-2011 the best year yet for AHLA's newest PG. I hope that we can count on seeing you there.

In the meantime, enjoy this issue, and let us hear from you.

Best,

Bill

managing L, C being mainly responsible for running the day-to-day business operations of L while P would devote all of his time to the treatment and supervision of treatment of patients.

According to the operating agreement of L, C owned 60% of the ownership interests and P owned 40%. The operating agreement provided for the annual election by the members of a Non-Medical Manager and a Medical Manager, and designated C as the initial Non-Medical Manager and P as the initial Medical Manager. C and P are the two members of L and their votes, in their capacities as members, are based on their ownership percentages. According to the operating agreement, the Non-Medical Manager and the Medical Manager would each have one vote on all matters other than certain matters designated as "plenary licensure matters."

C exercises control over all of L's affairs, including medical matters. P and C meet periodically to discuss office management issues, such as hiring and terminating employees, employee salaries, office protocols, and certain expenditures and business opportunities. However, no vote is ever taken on any matter. Additionally, C and P each have employment agreements with L, but C's employment agreement provides for compensation based on a share of L's profits, while P is to be compensated with a base salary only.

Application of the CPOM Doctrine

The limited control rights that P has under the operating agreement create the appearance of control, but in reality it could be argued that P is but a mere employee of C. Consequently, P does not have the power to control L's affairs, which generally violates the CPOM Doctrine. The arrangement of L permits C to have control over plenary licensure matters, thereby allowing him to practice medicine. Although the operating agreement declares that the Medical Manager will have the sole vote on "plenary licensure matters," an argument could be made that by owning 60% of L, and thereby controlling who was appointed as Medical Manager, C essentially had control over plenary licensure matters. By controlling which physician had the power to manage the medical affairs of L, C, in effect, had control over the diagnosis and treatment of illness or injury, which is clearly a plenary licensure matter.

Moreover, the contrast in salary structure between P and C supports the idea that P is a mere employee. C receives a percentage of the gross profits of L, while P simply receives a base salary. This arrangement is more analogous to one of employer and employee, as opposed to co-owners. An argument could be made that this is a CPOM Doctrine violation.

Potential Penalties

There are a variety of penalties and other adverse effects that could flow from a physician's involvement individually and/or with an entity that violates the CPOM Doctrine. Such penalties vary from state to state, but generally involve fines, civil penalties, actions against licenses, and even imprisonment. For example, in Pennsylvania:

> Any person, or the responsible officer or employee of any corporation or partnership, institution or association, who violates [the statutory CPOM prohibition] commits a misdemeanor of the third degree and shall, upon conviction, be sentenced to pay a fine of not more than $2,000 or to imprisonment for not more than six months, or both, for the first violation. On the second and each subsequent conviction, he or she shall be sentenced to pay a fine of not less than $5,000 nor more than $20,000 or to imprisonment for not less than six months nor more than one year, or both. In addition to any other civil remedy or criminal penalty provided for in this act, the [Pennsylvania State Medical Board] . . . may levy a civil penalty of up to $1,000 on any current licensee who violates [the statutory CPOM prohibition] or on any person who practices medicine and surgery or other areas of practice requiring a license, certificate or registration from the board without being properly licensed, certificated or registered to do so . . . . [24]

Although some states may have CPOM prohibitions that have not been enforced in recent years, the lack of enforcement should not be viewed by providers as tacit approval to ignore these laws. Consequently, providers must structure their practices accordingly. In addition, insurance companies have used violations of the CPOM Doctrine to avoid paying providers and to seek reimbursement of all monies previously paid to a violating provider.[25]

Besides criminal and civil penalties, courts have applied the CPOM Doctrine to void improper employment contracts. For instance, in *Vera E. Carter-Shields, M.D. v. Alton Health Institute*, the Supreme Court of Illinois voided Dr. Carter-Shields' employment agreement with Alton Health Institute because Alton Health Institute, as an entity, was not licensed to practice medicine inasmuch as Illinois law provides that a corporation cannot practice medicine.[26] Thus, because a corporation cannot employ a physician who practices medicine in Illinois, the contract between Carter-Shields and Alton Health Institute was invalid.[27]

Conclusion

Economic forces have changed the healthcare landscape in recent years. The industry has exploded into a proliferation of corporate entities, ranging from solo physicians to mid-sized ambulatory surgical centers, to large for-profit hospitals. Nonetheless, the CPOM Doctrine and associated regulations continue to affect the structuring of relationships with physicians.

Some states have no CPOM Doctrine, and many healthcare lobbyists are attempting to eliminate the doctrine altogether. However, CPOM laws are still alive in many states. In any association or transaction with physicians, attorneys need to research the current status of the CPOM Doctrine in the applicable state.

Appendix A

State	CPOM Doctrine	Primary Legal Authority
Alabama	No	Declaratory Ruling of the Medical Licensure Commission, Oct. 21, 1992
Alaska	No	N/A
Arizona	Yes	Ariz. Rev. Stat. §§ 10-2201 *et seq.*
Arkansas	Yes	Ark. Code §§ 4-29-301 *et seq.*
California	Yes	Cal. Com. Code §§ 2400 *et seq.*
Colorado	Yes	Colo. Rev. Stat. §§ 12-36-134
Connecticut	No	N/A
Delaware	No	8 Del. C. § 6-101
District of Columbia	No	N/A
Florida	No	N/A
Georgia	Yes	Ga. Code § 33-18-17
Hawaii	No	N/A
Idaho	No	N/A
Illinois	Yes	*Carter-Shields, M.D. v. Alton Health Inst.*, 777 N.E.2d 948 (Ill. 2002)
Indiana	Yes	Burns Ind. Code § 25-22.5-1-2
Iowa	Yes	Iowa Code §§ 147.1101 *et seq.*
Kansas	Yes	Kan. Stat. Ann. §§ 65-2801 *et seq.*
Kentucky	Yes	Ky. Rev. Stat. Ann. §§ 311.560 and 311.565
Louisiana	No	La. Rev. Stat. Ann. § 37:1271-101
Maine	No	Me. Rev. Stat. Ann., tit. 32 § 3270-101
Maryland	Yes	Md. Code, Health Occ. Law §§ 14-101 - 14-702 and Corps. and Ass., § 5-104
Massachusetts	Yes	Mass. Gen. Laws, ch. 112 § 2-101 and ch. 156A § 2-101
Michigan	Yes	Mich. Att'y. Gen. Op. No. 6592 (Jul. 10, 1989) and Mich. Att'y. Gen. Op. No. 6770 (Sep. 17, 1993)
Minnesota	Yes	Minn. Att'y. Gen. Op. No. 92-B-11 (Oct. 5, 1955)
Mississippi	No	State Board of Medical Licensure "Policy as to the Corporate Practice of Medicine in Mississippi" (May 16, 1996)
Missouri	No	N/A
Montana	Yes	Mont. Code Ann. § 37-3-322
Nebraska	No	N/A
Nevada	Yes	Nev. Rev. Stat. Chs. 78 and 89
New Hampshire	No	N/A
New Jersey	Yes	N.J.A.C. § 13:35-6.16(f)
New Mexico	No	N/A
New York	Yes	N.Y. Educ. Law §§ 6521 and 6527
North Carolina	Yes	33 N.C. Att'y. Gen. Rep. No. 43 (1955)

State	CPOM Doctrine	Primary Legal Authority
North Dakota	Yes	N.D. Cent. Code § 43-17-42
Ohio	Yes	Ohio Rev. Code §§ 4731 *et seq.* and § 1785.02
Oklahoma	No	Okla. Stat. tit. 59 § 510
Oregon	Yes	*State ex rel. Sisemore v. Standard Optical Co.*, 182 Or. 452, 188 P.2d (1947)
Pennsylvania	Yes	63 Pa. Cons. Stat. §§ 422.1 *et seq.*
Rhode Island	No	N/A
South Carolina	Yes	*Ezell v. Ritholz*, 188 S.C. 39, 198 S.E. 419 (S.C. 1938)
South Dakota	Yes	S.D. Codified Laws § 36-4-8.1
Tennessee	Yes	Tenn. Code Ann. § 63-6-201
Texas	Yes	Tex. Rev. Civ. Stat. Ann. art. 4495b, §§ 3.06 - 3.08, § 5.01
Utah	No	Utah Code Ann. § 58-1-501
Vermont	No	N/A
Virginia	No	1992 W. Va. Att'y. Gen. Op. No. 147
Washington	Yes	Wash. Rev. Code Ann. § 18.71.021 and §§ 18.100 *et seq.*
West Virginia	Yes	W. Va. Code § 30-3-15(b)
Wisconsin	Yes	Wis. Att'y. Gen. Op. No. 39-86 (Oct. 21, 1986)
Wyoming	No	N/A

1 *See* Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 Health Matrix: Journal of Law-Medicine 243, 245-249 (2004) (citing Am. Med. Ass'n, 1922 Report of the Judicial Council (interpreting Section 6 of the Principles of Medical Ethics), *abstracted in* Principles of Medical Ethics 40 (1960)).

2 *Id.* at 243.

3 *See* U.S. Dep't of Health & Human Svcs., Office of Inspector General, State Prohibitions on Hospital Employment of Physicians, Document No. OEI-01-91-00770 (Nov. 1991), *available at* http://oig.hhs.gov/oei/reports/oei-01-91-00770.pdf.

4 *See* Huberfeld, *supra*, at 245-46.

5 *See* Craig A. Conway, *Legislative Update: Texas' Corporate Practice of Medicine Doctrine*, Health law perspectives, Health Law & Policy Institute, University of Houston Law Center (October 2009), *available at* www.law.uh.edu/Healthlaw/perspectives/2009/(CC)%20CorpPractice.pdf (last visited Mar. 15, 2010).

6 *See* Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 Vand. L. Rev. 445, 447 (Mar. 1987).

7 *See e.g.*, N.Y. Educ. Law § 6522 (2006) ("only a person licensed or otherwise authorized under this article shall practice medicine.") and N.Y. Educ. Law § 6527 (2006) ("a non-profit medical or dental expense indemnity corporation or a hospital service corporation may employ licensed physicians.").

8 *See Painless Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932).

9 *Neill v. Gimbel Brothers Inc., 330 Pa. 213* (1938).

10 *See* Tex. Rev. Civ. Stat. Ann. art. 4995b §§ 3.06 - 3.08 and 5.01 (Vernon 2009).

11 *See* 63 Pa. Cons. Stat. § 422.10.

12 *See* Texas Med. Board, *Corporate Practice of Medicine, available at* www.tmb.state.tx.us/professionals/physicians/licensed/cpq.php (last visited Feb. 28, 2010).

13 *See* Internal Revenue Service, *Independent Contractor or Employee . . . , available at* www.irs.treas.gov/pub/irs-pdf/p1779.pdf (last visited Feb. 28, 2010).

14 Burns Ind. Code Ann. § 25-22.5-1-2(a)(21).

15 N.J.A.C. § 13:35-6.16(f)(1).

16 N.J.A.C. § 13:35-6.16(f)(2). *See also* N.J.S.A. § 14A:17-3 (stating that professional corporations may be formed among members of "closely allied professional services," including "any branch of medicine and surgery").

17 N.J.A.C. § 13:35-6.16(f)(3).

18 N.J.A.C. § 13:35-6.16(f)(4).

19 N.J.A.C. § 13:35-6.16(f)(5).

20 Wis. Stat. Ann. § 448.08(1).

21 Med. Board of California, Department of Consumer Affairs, *Corporate Practice of Medicine, available at* www.medbd.ca.gov/licensee/corporate_practice.html (last visited Feb. 28, 2010).

22 *See* Op. Nev. Atty. Gen. 219 (Oct. 3, 1977).

23 *Flynn Brothers, Inc. v. First Medical Associates*, 715 S.W.2d 782, 785 (Tex. 1986). The parties acknowledged that they drafted the contract with the hope of avoiding CPOM Doctrine violations. *Id.*

24 63 Pa. Cons. Stat. § 422.39.

25 *See Allstate Insurance Company v. Northfield Medical Center*, PC, 2001 WL 34779104 (N.J. Super. L. 2001).

26 201 Ill. 2d 441, 460 (2002).

27 *Id.*

How Rich Investors, Not Doctors, Profit From Marking Up ER Bills

TeamHealth, a medical staffing firm owned by private-equity giant Blackstone, charges multiples more than the cost of ER care. All the money left over after covering costs goes to the company, not the doctors who treated the patients.

by Isaac Arnsdorf, June 12, 2020, 6 a.m. EDT



Photo Illustration: Lisa Larson-Walker/ProPublica; Source: iStock/Getty Images Plus, Dana Neely/Stone/Getty Images

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In 2017, TeamHealth, the nation's largest staffing firm for ER doctors, sued a small insurance company in Texas over a few million dollars of disputed bills.

Over 2 1/2 years of litigation, the case has provided a rare look inside TeamHealth's own operations at a time when the company, owned by private-equity giant Blackstone, is under scrutiny for soaking patients with surprise medical bills and cutting doctors' pay amid the coronavirus pandemic.

Hundreds of pages of tax returns, depositions and other filings in state court in Houston show how TeamHealth marks up medical bills in order to

boost profits for investors. (Some of the court records were marked confidential but were available for download on the public docket; they were subsequently sealed.)

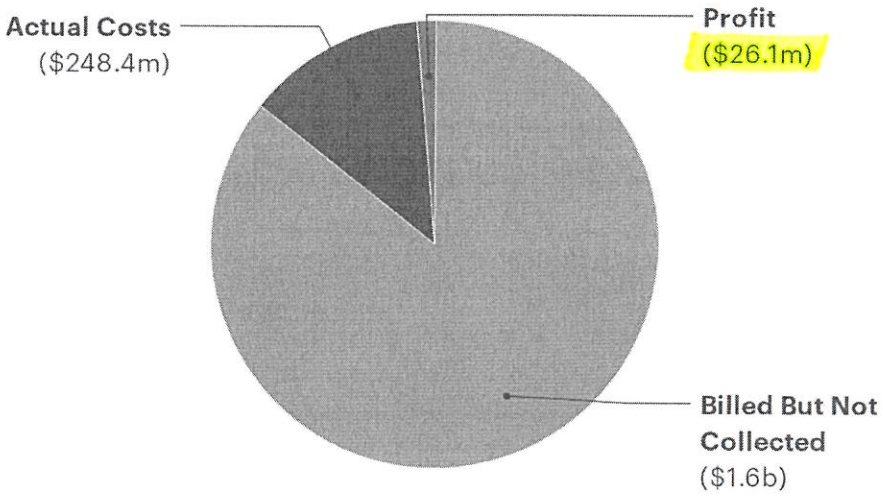
TeamHealth declined to provide an interview with any of its executives. In a statement for this story, the company says it's fighting for doctors against insurance companies that are trying to underpay: "We work hard to negotiate with insurance companies on behalf of patients even as they unilaterally cancel contracts and attempt to drive physician compensation downward."

But the Texas court records contradict TeamHealth's claims that the point of its aggressive pricing is to protect doctors' pay. In fact, none of the additional money that TeamHealth wrings out of a bill goes back to the doctor who treated the patient.

Instead, the court records show, all the profit goes to TeamHealth.

Anatomy of an ER Bill

Two TeamHealth affiliates in Texas billed 7.7 times more than their actual costs of paying for clinicians and support services. The bulk of the charges were discounted or written off. About 10% of the money actually collected went to corporate profits.



Source: Tax returns filed in Texas state court (Isaac Arnsdorf/ProPublica)

"These companies put a white coat on and cloak themselves in the goodwill we rightly have toward medical professionals, but in practice, they behave like almost any other private equity-backed firm: Their desire is to make profit," said Zack Cooper, a Yale professor of health policy and economics who has researched TeamHealth's billing practices and isn't involved in the Texas lawsuit.

"In the market for emergency medicine, where patients can't choose where they go in advance of care, there's a real opportunity to take advantage of

patients, and I think we're seeing that that's almost precisely what TeamHealth is doing, and it's wildly lucrative for the firm itself and its private equity investors."

Some of TeamHealth's own physicians say they're uncomfortable with the company's business practices.

"As an emergency medicine physician, I have absolutely no idea to whom or how much is billed in my name. I have no idea what is collected in my name," said a doctor working for TeamHealth who isn't involved in the Texas lawsuit and spoke to ProPublica on the condition of anonymity because the company prohibits its doctors from speaking publicly without permission.

"This is not what I signed up for and this isn't what most other ER docs signed up for. I went into medicine to lessen suffering, but as I understand more clearly my role as an employee of TeamHealth, I realize that I'm unintentionally worsening some patients' suffering."

Most ER doctors aren't employees of the hospital where they work. Historically they belonged to doctors' practice groups. In recent years, wealthy private investors have bought out those practice groups and consolidated them into massive nationwide staffing firms like TeamHealth and its largest competitor, KKR-owned Envision Healthcare.

These takeovers have affected patients, too, because the groups have gotten into payment disputes with their insurers. As a result, patients can receive huge medical bills even when they pick a hospital within their insurance plan's network, because the individual doctor working for a contractor like TeamHealth could be out of network. This practice, known as surprise billing, caught the attention of lawmakers who have spent months working on legislation.

TeamHealth said surprise bills are "rare and unintended," but with millions of patients, it has happened tens of thousands of times. The company has called surprise billing a "source of contracting negotiating leverage" to demand higher payments from insurers.

"Underneath this are patients who may well be charged outrageous amounts of money, but that's just not a core consideration," said Joshua Sharfstein, a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health. "The situation a lot of patients feel like they're in is they're collateral in this financial tug of war."

TeamHealth and Envision Healthcare have poured millions into political ads attacking surprise billing legislation. The companies have said they

want to settle out-of-network bills through arbitration instead of using average local rates, as some lawmakers have proposed.

As an alternative to going after patients themselves, TeamHealth said it sues insurers to demand higher payments for out-of-network charges. The company has filed 38 such lawsuits since 2018.

In the Texas case, two TeamHealth affiliates that provide doctors and nurses to emergency rooms in the Houston and El Paso areas sued a small insurance company called Molina Healthcare. TeamHealth identified almost 5,000 out-of-network claims in 2016 and 2017 for which it billed $6.6 million and Molina paid $760,000. TeamHealth sent a letter demanding that Molina pay $2.3 million. Molina's lawyers viewed this as an admission that the original bill was far higher than even TeamHealth thought was fair.

The actual costs of medical services are not a factor in setting TeamHealth's prices, according to the deposition of Kent Bristow, a TeamHealth executive in charge of revenue. At some locations, TeamHealth's prices were higher than those of 95% of other providers and eight or nine times more than what Medicare would pay, according to Bristow's deposition.

Most of the two TeamHealth affiliates' charges were never actually collected, according to their tax returns and a deposition of the accountant who prepared them. For the years 2016 and 2017, the two affiliates billed a combined $1.9 billion, the tax returns show. But $1.1 billion, or 58%, was discounted according to negotiated deals with insurers. An additional $528 million was written off as bad debt that would never get repaid. So the combined revenue that the two affiliates actually received across the two years was $274.5 million, or about 14% of the amount initially billed, according to the tax returns.

The amount that TeamHealth charges doesn't determine how much TeamHealth pays its doctors who perform those services, the company's chief financial officer, David Jones, said in an October 2019 deposition. Instead, the doctors are paid a base compensation plus an incentive tied to how much work they do (which is not the same as the price billed for their services). For the two TeamHealth affiliates in the Molina case in 2016 and 2017, the company paid doctors a total of $170.5 million, or 62% of the net revenue, according to the tax returns. Other health care providers such as nurse practitioners and scribes received another $48.4 million.

The administrative services that TeamHealth provides — such as billing, printing and malpractice insurance — added up to $29.5 million, according to the tax returns.

After covering all those expenses, the amount of money left over — commonly called profit — was $26.1 million, about 10% of the two

affiliates' net revenue in 2016 and 2017. (The accounting method that TeamHealth uses for its tax returns is different from how it prepares financial statements regulated by the Securities and Exchange Commission. Under the latter method, the tax returns note a total of $36.8 million for the two affiliates in 2016 and 2017. Because of these accounting variations, it's impossible to compare the figures on the TeamHealth affiliates' tax returns to profits reported by publicly traded health care companies.)

The TeamHealth executive in charge of the two affiliates said he assumed the profit would be shared with the doctors who did the work. "It would most likely go back to the providers," the executive, Lance Williams, said in a deposition. Under further questioning, he admitted, "Yeah, I'm not sure."

In fact, the entire leftover $26.1 million went to TeamHealth's "management fee." The management fee is not a fixed rate but rather everything that remains after covering costs, regardless of the amount, according to the CFO's deposition. "If the revenues exceed the expenses, that is essentially the management fee," Jones said.

In other words, out of the $1.6 billion that was originally billed but not collected, any additional dollar that TeamHealth managed to recover would be passed through to the corporate parent. The doctors would not see it.

Jones said doctors benefit from increasing collections because their incentive-based pay is adjusted over time. In addition, Bristow said the management fee is not the same as profit because there may be additional expenses at the corporate level.

"The economic benefits created by these practices, any profit, if you will, ultimately flows up to the TeamHealth entity," Ron Luke, a health economics expert hired by Molina, said in a deposition.

To establish this business model, TeamHealth had to find a way to deal with long-standing state laws that were specifically designed to protect the medical profession from becoming beholden to profit motives. These laws, known as the corporate practice of medicine doctrine, require doctors to work for themselves or other doctors, not lay people or corporations like TeamHealth. Court records in the Molina case show how TeamHealth's lawyers use shell entities to avoid directly employing doctors.

"TeamHealth monetizes this process by unilaterally setting charges and then billing patients and payors for those amounts and retaining all of the profits of the enterprise," Robert McNamara, a former president of the American Academy of Emergency Medicine, wrote in a memo as an expert

witness against TeamHealth in the lawsuit. "The fees generated, billed, and retained by TeamHealth reflect the type of overt commercialization of the medical profession that the prohibition on the [corporate practice of medicine] is designed to prevent."

TeamHealth said its business arrangements comply with all laws and no court or agency has ever found otherwise. "TeamHealth's clinicians are supported by a world-class operating team that provides them with comprehensive practice management services that allow our clinicians to focus on the practice of medicine," the company said. Envision Healthcare also said it follows all local, state and federal laws and regulations.

State laws against the corporate practice of medicine date as far back as the 19th century, as doctors strove to distinguish themselves from quacks and snake oil salesmen. According to the American Medical Association, the laws are meant to prevent profit motives from influencing medical judgments — a recognition that corporations' devotion to shareholder value shouldn't mix with doctors' Hippocratic oath.

Another way to think about it is: Practicing medicine requires a license, and only a real human being can possibly have the education, training and character qualifications that licensing boards require.

Courts have scrutinized these arrangements for decades. No judge has ever ruled that TeamHealth or Envision Healthcare specifically violate state licensing rules. But such allegations have repeatedly cropped up in lawsuits involving the companies, some of which settled favorably to the other side, according to McNamara, who was consulted on many of the cases.

TeamHealth and Envision have themselves acknowledged that they operate on questionable legal ground. During periods when the companies were publicly traded, their investor disclosures highlighted the controversy surrounding their compliance with state licensing regimes. TeamHealth and Envision said they believed their business models were legal but recognized that prosecutors, regulators and judges could conclude otherwise. TeamHealth specifically cited "laws prohibiting general business corporations, such as us, from practicing medicine."

"While we believe that our operations and arrangements comply substantially with existing applicable laws relating to the corporate practice of medicine and fee splitting, we cannot assure you that our existing contractual arrangements, including restrictive covenant agreements with physicians, professional corporations and hospitals, will not be successfully challenged in certain states as unenforceable or as constituting the unlicensed practice of medicine or prohibited fee splitting," the company said in its 2015 annual report. "In this event, we could be subject to adverse judicial or administrative interpretations or to

civil or criminal penalties, our contracts could be found to be legally invalid and unenforceable or we could be required to restructure our contractual arrangements with our affiliated provider groups."

TeamHealth says the laws are outdated and unnecessary — as one of the company's senior lawyers called it in a deposition, "this arcane law we call the corporate practice of medicine that nobody needs."

Not all states have such laws. In Florida, for instance, TeamHealth employs doctors directly. In states that have laws against the corporate practice of medicine, TeamHealth has a workaround depending on the specific requirements in that state. Here's how it works for the affiliates involved in the Molina litigation, just two out of hundreds of equivalent arrangements around the country.

Doctors working for TeamHealth are technically independent contractors to a "professional association," or P.A. In order to comply with Texas law, the professional association is owned by a licensed physician. The professional association then contracts with TeamHealth subsidiaries to provide administrative services — such as billing, payroll and malpractice insurance — in exchange for payment.

These professional associations, however, are hardly independent. They're "owned" by an executive at TeamHealth, and the company has the power to remove and replace him at any time. For the two professional associations involved in the Molina case, when a new executive took over as "owner" in 2019, he said in a deposition that he couldn't remember how he "bought" the entities or if he ever paid anyone the $2 nominal price of their shares.

"Everything about your right to own, operate, and manage ACS and EST [the two professional associations] is dependent upon you staying in the good graces of the TeamHealth organization, correct?" Molina's lawyer asked in the deposition.

"Correct," the owner/executive, Lance Williams, said.

"And if you were fired for any reason, you would lose ownership of ACS and EST, lose the right to manage ACS and EST, correct?"

"Correct."

Williams also said there's no "black and white" separation between clinical and financial issues.

In sum, the contract between TeamHealth and the professional associations gives investors more control of the business than doctors, according to Chuck Pine, a financial investigator who specializes in examining shell companies to determine the real beneficial owners. Pine isn't involved in the Molina litigation.

Molina's lawyers called the arrangement "a sham to permit TeamHealth to unlawfully practice medicine by allowing it to in effect employ physicians in violation of state law."

TeamHealth countered that whether or not Molina's claims are right, they aren't enforceable through private litigation; only the state's attorney general could prosecute a corporation for practicing medicine without a license.

The judge rejected Molina's claims in an order that didn't explain her rationale. Other parts of the case are still pending.

TeamHealth has used the same argument to defeat other lawsuits. It puts opponents in a Catch-22: State licensing boards have no control over a corporation that might be practicing medicine without a license because the boards don't license corporations. The boards could theoretically punish the "owners" of the professional associations, but those doctors are not always licensed in the same state as the practice, and TeamHealth could always replace them with someone else.

The Texas attorney general's office didn't respond to requests for comment. McNamara said he's brought several cases to the attention of various state attorneys general, to no avail.

Filed under: Health Care



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Information piece: TeamHealth's contractual structure appears to violate existing prohibitions on the corporate practice of medicine (CPOM)

Prepared by Robert McNamara, MD, MAAEM Past President AAEM

Summary of Opinion

The CPOM doctrine is legal doctrine designed and adopted in numerous states, some over more than 100 years ago to prevent lay intrusion into the profession of medicine. The CPOM doctrine is designed to preserve the sanctity of the doctor-patient relationship and to prevent the commercialization of the medical profession. TeamHealth is engaged in the CPOM and attempts to skirt the prohibitions on this through the use of sham professional associations. These captive professional associations and their physician "paper owners" are aiding and abetting TeamHealth to engage in the CPOM. This activity involves actions that likely constitute illegal billing of payors and forced fee-splitting of physicians employed by these professional associations. Physicians affiliated with TeamHealth unwittingly are placing their licensure and professional standing at risk by participating in this scheme.

My Expertise regarding the CPOM

My experience includes a role as a founding board member and officer in the American Academy of Emergency Medicine ("AAEM"). This was followed by 20 years of service on the Board of Directors, including 5 years as President. Currently, I am the Chief Medical Officer of the AAEM Physician Group. My professional experience also includes service on the Board of Trustees of the Pennsylvania Medical Society and as a President and long-term board member of the Montgomery County Medical Society.

I have had extensive dealings regarding the CPOM. My involvement in these issues includes representing the AAEM on a number of matters including current litigation against Envision in CA (www.aaem.org/wp-content/uploads/2023/04/Envision-Lawsuit-Lawsuit.pdf) and prior ones in Texas, including *Crystal Cassidy v. TeamHealth, Inc.* and the *AAEM v. Memorial Hermann* matters, filed in or about 2009. I have published multiple articles (Articles # 34, 47, 73 and 77 on my CV) and lectured extensively on the CPOM as it regards the specialty of Emergency Medicine.

The general background and development of the CPOM doctrine.

In the mid-1800s, the American Medical Association created the doctrine of corporate practice of medicine to protect the public and the profession of medical doctors. As part of a larger plan to ensure the public that physicians possessed a substantial ethical structure and true skills, the AMA issued pronouncements that contained warnings against the practice of medicine by a corporation, regardless of its intent, structure, or form. The guidelines and lobbying by the AMA greatly affected state legislation in subsequent years and states were encouraged to license medical doctors and to establish physicians as the sole legitimate professionals to provide

medical care. The result was an abundance of state laws and regulations protecting physicians from outside influence, including corporations.[1]

The CPOM doctrine prohibits lay corporations from engaging in the practice of medicine, either directly or indirectly through employing licensed professionals.[2] The foundation of the doctrine rests on the fact that only a human being can sustain the education, training, and character-screening processes that are prerequisites to earning a license to practice medicine.[3] In Texas, the CPOM doctrine is an overall prohibition on non-licensed persons or corporations from employing or engaging physicians to practice medicine, controlling the delivery of medical services by entities that are owned by licensed professionals, and splitting professional fees between licensed medical doctors and non-licensed individuals or entities.[4]

"In any arrangement between physicians and non-physicians, the CPOM doctrine in Texas applies and the physician must function as an independent contractor or fit another exception. However, even independent contractor agreements have come under fire in recent years. In *Flynn Brothers, Inc. v. First Medical Associates*, a Texas appellate court found that the practical effect of an employment contract between a lay entity and medical professionals was that of employer-employee, not independent contractor."[5] *Flynn Brothers* reflects the core idea that what is important is not the strict structuring of agreements to give the impression of compliance, but the economic realities of the overall transaction to determine who actually owns and operates the medical practice and who actually receives the fee, in whole or in part, for the delivery of those medical services.

It is a common refrain for lay entities to try and distinguish between the clinical aspect of the practice of medicine, and the business side. Generally, the law does not draw this distinction. The practice of medicine is not compartmentalized in such a way where professionals can give up substantive economic controls to lay corporations. The California Supreme Court discussed this application of the CPOM doctrine in an early case dealing with a lay corporation that attempted to practice dentistry through a series of contracts with licensed dentists:

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1 Craig A. Conway, Legislative Update: Texas' Corporate Practice of Medicine Doctrine, Health Law Perspectives (Oct. 2009), http://www.law.uh.edu/healthlaw/perspectives/2009/%28CC%29%20CorpPractice.pdf.

2 *See Penny v. OrthAlliance, Inc.*, 255 F.Supp.2d 579 (N.D. Tex. 2003); *Fite v. Emtel, Inc.*, No. 01-07-00273, 2008 WL 4427676 (Tex. App.—Houston [1st Dist.] Oct. 2, 2008, pet. denied).

3 *Garcia v. Texas Board of Medical Examiners*, 384 F. Supp. 434 (W.D. Tex. 1974), *aff'd*, 421 U.S. 995 (1975); *Flynn Bros., Inc. v. First Med. Assoc.*, 715 S.W.2d 782 (Tex. Civ. App.—Dallas 1986, writ ref'd n.r.e.); *Berlin v. Sarah Bush Lincoln Health Center*, 179 Ill.2d 1 (Ill. 1997); *Dr. Allison, Dentist, Inc. v. Allison*, 196 N.E. 799 (Ill. 1935); *Painless Parker v. Board of Dental Examiners*, 216 Cal. 285 (Cal. 1932).

4 *In re OCA, Inc.*, 552 F.3d 413 (5th Cir. 2008); *Xenon Health, LLC v. Baig*, No. H-13-1828, 2015 WL 3823623 (S.D. Tex. June 19, 2015); *DeBeck v. United States*, No. SA-11-CA-45-FB, 2014 WL 4416078 (W.D. Tex. Aug. 20, 2014); *Penny v. OrthAlliance, Inc.*, 255 F.Supp.2d 579 (N.D. Tex. 2003); *Garcia v. Texas Board of Medical Examiners*, 384 F. Supp. 434 (W.D. Tex. 1974), *aff'd*, 421 U.S. 995 (1975); *Flynn Bros., Inc. v. First Med. Assoc.*, 715 S.W.2d 782 (Tex. Civ. App.—Dallas 1986, writ ref'd n.r.e.); *Rockett v. Texas Board of Medical Examiners*, 287 S.W.2d 190 (Tex. Civ. App.—San Antonio 1956, writ ref'd n.r.e.); Texas Attorney General Opinion JC-0304 (2000).

5 Craig A. Conway, Legislative Update: Texas' Corporate Practice of Medicine Doctrine, Health Law Perspectives (Oct. 2009), http://www.law.uh.edu/healthlaw/perspectives/2009/%28CC%29%20CorpPractice.pdf (citing *Flynn Bros., Inc. v. First Med. Assoc.*, 715 S.W.2d 782 (Tex. Civ. App.—Dallas 1986, writ ref'd n.r.e.).

> [W]e are not prepared to hold with the contention that a corporation or an unlicensed person may not be prevented from managing, conducting, or controlling what petitioner terms the 'business side' of the practice of dentistry. The law does not assume to divide the practice of dentistry into such departments. Either one may extend into the domain of the other in respects that would make such a division impractical if not impossible. The subject is treated as a whole. If the contention of appellant be sound, then the proprietor of the business may be guilty of gross misconduct in its management and violate all standards which a licensed dentist would be required to respect and stand immune from any regulatory supervision whatsoever. His employee, the licensed dentist, would also be immune from discipline upon the ground that he was but a mere employee and was not responsible for his employer's misconduct, whether the employer be a corporation or a natural person. On grounds of public policy such a condition could not be countenanced. The logical deduction from such a proposition would render the act impotent to accomplish the purpose it was intended to serve, and it would defeat the object of the legislation, which is well stated in *Ex parte Whitley*, 144 Cal. 167, 77 P. 879, 884, 1 Ann. Cas. 13, in the following language: 'But it must be remembered that the act regulating the practice of dentistry and similar acts are not passed to promote the personal ends of individuals, but as salutary enactments in the exercise of the police power of the state to legislate for the safety, health, and welfare of the people.' This end cannot be attained if the Dental Act is to be weakened or defeated by subterfuge or circumvented by devious methods.[6]

The public policy concerns underlying the CPOM doctrine.

The CPOM doctrine is concerned about the structural aspects of the profession of medicine. As the California Supreme Court explained, it's not addressed for the benefit or detriment of individual situations, but as an overall safeguard to protect patients. Specifically, the prohibition on the CPOM is supported by several public policy concerns, including the dangers of lay control over the professional judgment of physicians, the division of a physicians' loyalty between his or her patients and the profit interests of lay entities, and the over-commercialization of the medical professions.[7] As one commentator explained:

> In interpreting states' CPOM laws, courts relied not only on the plain language of the statutes in place, but also on public policy rationales based on the physician-patient relationship. First, courts were often concerned that sensitive patient information could be transmitted through a non-medical group such as a corporation. Second, courts feared that corporations practicing medicine would attempt to exploit the profession and exert influence or control over medical professionals. Finally, courts believed, to some degree, that corporations might deceive the public via false advertisements or unreasonable enticements of

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6 *Painless Parker v. Board of Dental Examiners*, 216 Cal. 285 (Cal. 1932). Texas courts have cited this opinion. *Garcia v. Texas Board of Medical Examiners*, 384 F. Supp. 434 (W.D. Tex. 1974), *aff'd*, 421 U.S. 995 (1975).

7 *Garcia v. Texas Board of Medical Examiners*, 384 F. Supp. 434 (W.D. Tex. 1974), *aff'd*, 421 U.S. 995 (1975); *Flynn Bros., Inc. v. First Med. Assoc.*, 715 S.W.2d 782 (Tex. Civ. App.—Dallas 1986, writ ref'd n.r.e.).

> medical claims in an effort to generate revenue to the detriment of a would-be patient.[8]

These concerns apply to emergency medicine.[9] For example, research on CPOM have identified multiple concerns regarding siphoning of profits from doctors to corporations, business practices that encourage the retention of less qualified professionals as a cost cutting measure, policies governing the termination of physicians or efforts to control their practices post-termination through restrictive covenants, policies encouraging upward pressure on the cost of medical care (both directly and through market share) that increase patient costs and access issues either directly or through increased premiums, efforts to encourage practices that tend to influence profits by seeing more patients or increasing revenues per patient that may not represent the treating physician's professional judgment, and lay control over rate schedules, billing practices, and contracting arrangements in a manner designed to maximize profits for shareholders instead of protecting patients.[10]

These concerns need not be present in any specific case for the arrangement to be unlawful. Rather, these public policy concerns underlie the rational for the prohibition on the CPOM in the first place. The restrictions are meant to be prophylactic, to prevent the commercialization of the medical profession. As one Texas court has explained: "The purpose of this act is to preserve the vitally important doctor-patient relationship and prevent ***possible*** abuses resulting from lay control of corporations employing licensed physicians to practice medicine."[11]

Does the TeamHealth model violate the CPOM doctrine?

TeamHealth is a lay entity owned by the Blackstone Group a private equity firm and it engages, through wholly owned and controlled subsidiaries in the practice of medicine. This is facilitated by a nationwide network of professional associations that are nothing but "shell" structures with "paper owners" specifically created to avoid scrutiny under the prohibitions on the CPOM. These are also the vehicles whereby emergency physicians unwittingly engage in fee-splitting with TeamHealth. This is a deliberate strategy of TeamHealth and they are aware of the risks of this as it is mentioned in its offerings to potential investors. In its 10/5/2009 filing (form S-1) with the SEC for an IPO, TeamHealth included this statement on page 84:

> ***State Laws Regarding Prohibition of Corporate Practice of Medicine and Fee Splitting Arrangements***. The laws and regulations relating to our operations in 46 states vary from state to state and many states prohibit general business corporations, as we are, from practicing medicine, controlling physicians' medical decisions or engaging in some practices such as splitting professional fees with physicians. We believe that we are in substantial compliance with state laws prohibiting the corporate practice of medicine and fee-splitting. We currently

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8 Craig A. Conway, Legislative Update Texas' Corporate Practice of Medicine Doctrine, Health Law Perspectives (Oct. 2009), http://www.law.uh.edu/healthlaw/perspectives/2009/%28CC%29%20CorpPractice.pdf.

9 Derlet, McNamara, Plantz, Organ, and Richards, Corporate and Hospital Profiteering in Emergency Medicine: Problems of the Past, Present, and Future, 50 J. of Emergency Med. (2016).

10 Derlet, McNamara, Plantz, Organ, and Richards, Corporate and Hospital Profiteering in Emergency Medicine: Problems of the Past, Present, and Future, 50 J. of Emergency Med. (2016).

11 *Gupta v. Eastern Idaho Tumor Institute, Inc.*, 140 S.W.3d 747 (Tex. App.—Houston [14th Dist.] 2004, pet. denied).

> employ or contract with providers or physician-owned professional corporations to provide outsourced staffing and administrative services to healthcare facilities in the 46 states in which we provide services. Other parties may assert that, despite the way we are structured, TeamHealth could be engaged in the corporate practice of medicine or unlawful fee-splitting. Were such allegations to be asserted successfully before the appropriate judicial or administrative forums, we could be subject to adverse judicial or administrative penalties, certain contracts could be determined to be unenforceable and we may be required to restructure our contractual arrangements. The laws of other states, including Florida, where we derived approximately 16% of our net revenues less provision for uncollectibles in 2008, do not prohibit non-physician entities from employing physicians to practice medicine but may retain a ban on some types of fee-splitting arrangements.[12]

There exists pertinent case law that directly speaks to the invalid nature of this structure including *Flynn Brothers* and *Xenon Health* in Texas. Key excerpts from these cases are below:

> **Flynn:** Although it is true that Dr. Adcock was not an "employee" of FBI under their agreement, the practical effect was the same. FBI would endeavor to get hospitals to contract with FMA and, in exchange, FMA gave to FBI 66.67% of the profits made through Dr. Adcock's practice. FBI also was empowered to hire staff for FMA to use in the hospitals under contract. In effect, Dr. Adcock allowed FBI to use his license to get contracts to provide emergency medical care and staff for hospital emergency rooms in exchange for which FBI received the majority of profits made through Dr. Adcock's practice of medicine, thereby indirectly allowing FBI to practice medicine without a license. The parties admit that the whole contractual scheme was developed to do indirectly that which they freely concede they could not do directly under the Medical Practices Act. The design, effect, and purpose of the management agreement contravenes the Medical Practices Act and therefore will not be enforced by the courts of this state.[13]

> **Xenon:** The transparent purpose of this amalgam of contemporaneous contracts and Delegation of Signature Authority devised by Dr. Chaudhry and agreed by Dr. Khan was to allow Dr. Chaudhry, "a person . . . not licensed to practice medicine by the [Texas State Board of Medical Examiners]," TEX. OCC. CODE ANN. § 164.052(17), and his California business entity Xenon, to engage in providing anesthesia services in Texas through the subterfuge of a shell operation with a "paper owner." *See Flynn*, 715 S.W.2d at 785 ("[T]he whole contractual scheme was developed to do indirectly that which they freely concede they could not do directly under the Medical Practices Act"). Such a scheme is illegal under Texas law, rendering the inextricably intertwined Exclusive Management Services Agreement, Purchase and Sale Agreement, and Equity Interest Agreement all void and of no force or effect. *See id.* Defendant is therefore entitled to summary judgment on Plaintiffs' claims for tortious interference with these alleged contracts which contravene public policy and are void.[14]

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[12] TeamHealth has made similar disclaimers in its more recent SEC filings in 2015 and 2016.

[13] *Flynn Brothers v. First Medical Associates*, 715 S.W.2d 782 (Tex. Civ. App.—Dallas 1986, writ ref'd n.r.e.).

[14] *Xenon Health LLC v. Baig*, No. H-13-1828, 2015 WL 3823623 (S.D. Tex. June 19, 2015).

The physicians who lend their name to this scheme are subject to discipline by the State Board of Medical Examiners. Examples from Texas include the rulings in *Rockett v. Texas Board of Medical Examiners* and *Watt v. State Board of Medical Examiners*.[15]

The "sham" professional association structure of TeamHealth

TeamHealth engages a number of their employed physician leaders to be the "paper owner" of the professional associations. The physician will be the sole owner and shareholder and these physicians typical "own" numerous professional entities in multiple states at the behest of TeamHealth. The designated physician will generally receive no financial reward for this position instead they are paid as part of their executive role within TeamHealth. They are restricted from issuing stock, dividends or transferring ownership without the blessing of TeamHealth as they are required to sign a Stock Transfer Restriction Agreement at the time of accepting ownership of the professional association. TeamHealth can terminate their ownership at their whim. The "paper owner" generally does not practice medicine at the clinical sites and has no oversight of the financial, contractual or operational aspects of the physician practice. Each of these physicians signs the TeamHealth Code of Conduct which requires them to advance the interests of this lay corporation.

The real business of these professional associations is controlled by TeamHealth laypersons who are appointed as officers of the professional association and granted with signature authority. These laypersons establish a web of contracts to ensure that the entire business of the captive professional association will be with TeamHealth entities. The PA will use TeamHealth for management services, coding/billing/collections, financial services and the provision of scribes and physician extenders. The "paper owner" will generally not have knowledge of the actual finances of the practice, will not participate in negotiations for services and not review the bank account or tax returns of the entity. The revenue of the practice will be swept daily from the account of the professional association into a TeamHealth account.

The web of contracts and agreements similar to the *Xenon Health* matter ensures that TeamHealth has total control over these physician professional associations. The Stock Transfer Restriction Agreements make the physicians toothless owners with no power over the PAs. The PAs effectively have no option but to contract with affiliated TeamHealth entities for operation and management of the ED practices. Physicians and other providers are contractually required not do anything to adversely affect the TeamHealth contract with the hospital. The TeamHealth entities have the exclusive right to set fees. They also supply all the non-clinical personnel and support staff" and are designated the "sole and exclusive manager of all of its business and operational functions. Operational control includes determining the type and number of providers who will practice at the hospitals, essentially deciding staffing patterns and whether physicians or advanced practice providers will see the patients.

There is complete control over all of the financial aspects of the physician professional billing and collections including the setting of fees and negotiations of contracts by TeamHealth subsidiaries. There is generally no physician oversight of this key aspect of medical practice. An

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[15] *Rockett v. Texas Board of Medical Examiners*, 287 S.W.2d 190 (Tex. Civ. App.—San Antonio 1956, writ ref'd n.r.e.); *Watt v. State Board of Medical Examiners*, 303 S.W.2d 884 (Tex. Civ.App., 1957, writ ref'd).

analysis of the amount of management fees for these professional associations will generally reveal a take well beyond the fair market value for the services TeamHealth provides. Given that TeamHealth is a private equity firm the profit level sought would be expected to be on the order of at least 15-20% and this arrangement raises the concern regarding prohibited fee-splitting. Indeed, TeamHealth reported this level of profit in the aforementioned IPO filing in 2009. Certainly, the patients would not be pleased to know that a significant portion of what is being paid "to the doctor" is actually going to a lay entity ultimately owned by private equity.

Risk to the "paper owners" and employed physicians of aiding and abetting TeamHealth in practicing medicine.

In most states professionals may not aid and abet lay persons or corporations to practice medicine.[16] The paper owners of these entities are aiding and abetting TeamHealth to practice medicine by creating shell entities that are formed specifically to permit TeamHealth to influence and control the delivery of medical care. TeamHealth holds itself out as offering such services, through its affiliates and affiliated practices, and structures its arrangements with captive professional associations to try and circumvent the restrictions on the CPOM. This permits TeamHealth to bill patients and payors, and to collect, indirectly, a share of the professional fees generated by licensed professionals. TeamHealth monetizes this process by unilaterally setting charges and then billing patients and payors for those amounts and retaining all of the profits of the enterprise. The fees generated, billed, and retained by TeamHealth reflect the type of overt commercialization of the medical profession that the prohibition on the CPOM is designed to prevent.

Individual non-owner physicians working for TeamHealth may also be found liable for aiding and abetting the corporate practice of medicine albeit unwittingly. These physicians are often powerless in these circumstances as TeamHealth possesses market share and substantial resources to entice hospitals into awarding the exclusive contract for emergency services to them as opposed to a true physician owned group. In many areas, TeamHealth may be the only employment option for a physician. The American Academy of Emergency Medicine has engaged in matters related to the corporate practice of medicine on behalf of practicing physicians and intends to continue to do so.

[16] Texas Occupations Code, Section 164.052(17) (prohibiting a physician from directly or indirectly aiding or abetting in the practice of medicine by a person, partnership, association, or corporation that is not licensed to practice medicine); Texas Attorney General Opinion JC-0304 ("A physician or applicant for medical license is prohibited from aiding and abetting the practice of medicine by a person, partnership, association, or corporation not licensed to practice medicine by the Board").