



## Medical Practice Mergers: Bigger Can Be Better

by *Todd A. Rodriguez*



Although we have very little detail at this point about what shape health care reform will ultimately take, players in the field including hospitals and health plans have

consolidated and evolved into sophisticated businesses with deep financial and technological resources to meet the challenges of a rapidly evolving health care environment. Unfortunately, few medical practices have followed this consolidation trend, with many physicians still electing to remain in small independent practices. And while staying small enables physicians to exercise maximum control over the day-to-day operations (and expenses) of their practices, many of these practices will not be able to make the substantial investments in technology (i.e., electronic medical records, e-prescribing systems and information systems that will enable them to track clinical and financial outcomes) and management expertise required to remain competitive in the changing health care arena. For physicians unwilling to cede control of their destiny to a hospital employer, merging with other similarly situated private practices may make considerable sense.

Potential benefits from merging to form a large group practice include:

- (1) Potential cost savings through economies of scale;
- (2) Increased purchasing power;
- (3) Ability to offer ancillary services (and share revenue and expenses from those services);
- (4) Ability to hire management expertise;
- (5) Ability to invest in information technology;

- (6) Ability to invest in compliance, risk management and billing/collection resources;
- (7) Ability to improve clinical quality through outcomes analysis, sharing of best practices and development of clinical practice guidelines;
- (8) Improved lifestyle through vacation and on-call coverage sharing; and
- (9) Improved ability to negotiate with health plans.

Forming a large medical practice is not, however, without its challenges. Depending on the size of the group to be formed and the range of services it will offer, there may be a host of legal issues including antitrust considerations and issues under the federal Stark and Anti-Kickback statutes. Although a comprehensive analysis of all of the potential legal issues in medical practice mergers is beyond the scope of this article, some of the major legal considerations follow.

### Antitrust Considerations

Being bigger may certainly make a practice more attractive to managed care payors and as a result, larger groups may be able to negotiate more favorable reimbursement rates or contract terms. But while better payor contracts may be a side effect of forming a large practice, merging together for the purpose of controlling the payor market could run afoul of federal antitrust laws. For example, the Sherman Act prohibits mergers for the purpose of restraining trade and makes it unlawful for a company to monopolize trade or commerce. Similarly, the Clayton Act forbids mergers and acquisitions where the effect may be to lessen competition or create a monopoly.

Whether a medical practice merger will implicate antitrust laws will depend on a variety of factors including the potential anti-competitive effects of the merger and the available alternatives for care within the applicable market. Some practices, such as price fixing, are deemed to be so inherently anti-competitive that they are considered “per se” illegal; so a merger for the sole purpose of negotiating with payors may run into antitrust issues right from the start.

Other less egregious merger results, such as improved negotiating strength as a side effect of the affiliation, may instead be scrutinized under what is known as a “rule of reason” analysis. Generally, the more integrated a medical practice is, the less concern it will raise from an antitrust perspective. However, determining whether a merger is likely to raise antitrust concerns requires a careful analysis of the benefits of the merger and the market in which it will occur.

### Federal Stark Statute

Medical practice mergers may also raise issues under the federal Stark statute. Stark prohibits a physician or an immediate family member of the physician from making a referral to an entity with which he or the family member has a financial relationship, including an ownership interest, for the furnishing of Stark “designated health services” (such as physical therapy, diagnostic imaging or lab services) for which payment may be made under Medicare or Medicaid. This prohibition applies even to referrals by a physician within his own medical practice unless the physician’s ownership relationship with his practice falls within one of the statute’s exceptions.

There is an exception under the Stark statute for referrals by physicians for Stark services rendered within their own practices. Among other things, this “in-office ancillary services” exception requires that the services be rendered by the referring physician or another physician in the same practice, in a building used exclusively and on a full-time basis (i.e., it is owned or leased 24 hours per day, seven days per week and not shared by any other physician or practice) by the group practice for the furnishing of some or all of its Stark services. Finally, the services must be billed under a provider number assigned to the group practice.

Where a purpose of a medical practice merger is to be able to offer new or expanded ancillary services that include Stark services, the pre-affiliation practices will need to be sure they can meet the in-office ancillary services exception after they have merged. To meet the exception, the newly formed practice will need to constitute a “group practice” for purposes of Stark. This means the practice must be legally organized (e.g., LLC, partnership or a professional corporation) and the business must operate as a unified business. Importantly, the members of the practice will have to provide the bulk of their clinical services (defined as at least 75 percent, on average) through the practice entity and those services must be billed under a provider number assigned to the practice.

In addition, to be considered a unified business for purposes of Stark, the new practice will have to have at least (1) centralized decision-making by a body representative of the practice (e.g., a board of directors) that maintains effective control over the practice’s assets and liabilities (including, but not limited to, budgets, compensation and salaries); and (2) consolidated billing, accounting and financial reporting.

Finally, if the new practice will offer Stark services, the group’s income division formula will need to be structured to comply with the Stark restrictions on the allocation of revenues from Stark services. Fundamentally, no physician within the practice may receive compensation from Stark services based on the volume or value of his or her referrals for those services unless he or she personally performed those services. There are however a host of complex nuances to this basic rule that should be taken into consideration when structuring group income division, including that physicians in the group (and even subgroups of at least five physicians) may share in the “overall profits” of the group from Stark services.

### Anti-Kickback Statute

Group practice income division may also implicate the federal Anti-Kickback statute, which makes it a felony to solicit, pay, offer or receive any remuneration in exchange for the referral of a patient or for ordering, providing or recommending any item or service covered by a federal or state payor program. Specifically, remuneration from a group practice to its shareholder or employed physicians, either in the form of “return on investment” or as compensation for services rendered, particularly where that remuneration fluctuates with the volume of services ordered, could be viewed as an inducement or reward for “referrals” within the practice.

There is a regulatory safe harbor for physician investment in group practice that, if met, will protect a return on investment from liability under the statute. To meet the safe harbor, the investment by the shareholder physicians in the group practice must meet the following standards:

- (1) The equity interests in the practice entity must be held by licensed health care professionals who practice in the group;

- (2) The equity interests must be in the practice entity itself and not in a subdivision of the practice; and
- (3) The practice must meet the Stark definition of a “group practice” and, if it will offer ancillary services, must meet the in-office ancillary services exception discussed above.

While the above safe harbor would apply to investment in the new practice, there is also a regulatory safe harbor under the Anti-Kickback statute for compensation paid by an employer to an employee pursuant to a bona fide employment arrangement. For purposes of the safe harbor, bona fide employment is determined based on the common law principles applied by the Internal Revenue Service. Therefore, assuming all of the physicians in the new practice qualify as “bona fide” employees, this safe harbor would protect the compensation paid by the practice to the group physicians from liability under the statute.

### Conclusion

Accomplishing a medical practice merger, depending on how many parties are involved and the various issues that each of the merging practices brings to the table, requires careful upfront planning and analysis. If done properly, forming a large group practice can have significant rewards including increased practice stability without significant loss of control. The process also takes time, however (often six months to a year), so practices considering a merger should not wait until they are faced with a financial crisis to get the process started.

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For more information about this topic, please contact Todd A. Rodriguez at 610.458.4978 or [trodriguez@foxrothschild.com](mailto:trodriguez@foxrothschild.com).

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