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**THE BUSINESS OF HEALTH CARE:  
NAVIGATING THE CORPORATE PRACTICE OF MEDICINE DOCTRINE**

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## **Introduction**

The discussion below provides an overview of state corporate practice of medicine laws with some state specific examples. There is a wide variance in state definitions and applications of the Corporate Practice of Medicine (“CPOM”) Doctrine (the “CPOM Doctrine” or the “Doctrine”) and readers cannot rely upon this general overview for a complete interpretation of a state’s laws.

### **I. What is the Corporate Practice of Medicine Doctrine?**

The CPOM Doctrine is a doctrine developed by the American Medical Association (“AMA”) to protect the public and physicians from abuses that could result from commercial exploitation of the practice of medicine.<sup>1</sup> Simply put, the CPOM Doctrine prohibits any unlicensed person or entity from practicing medicine or interfering with a medical professional’s clinical judgment. The CPOM is applied broadly, not only to physicians but also to other health care professional disciplines, such as dentistry, optometry, chiropractic and psychology.

Generally, the CPOM Doctrine restricts three aspects of the medical industry: 1) entrance/admission; 2) ownership; and 3) profits.<sup>2</sup> With regard to entrance/admission, CPOM states typically limit those who can practice medicine to individuals licensed to provide medical services in the state in which the services are delivered. Any person or entity that holds itself out as providing medical services must have a valid license to practice medicine. However, statutes typically state that corporations and artificial entities have no professional rights, privileges or powers. This effectively prohibits non-licensed persons, including business entities, from employing physicians to practice medicine on their behalves, unless a specific exception applies.

Ownership is also restricted in CPOM jurisdictions to ensure physician control over medical decision-making. All or a majority of equity interests in medical practices must be held by individuals licensed to engage in the practice of medicine.

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<sup>1</sup> 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).

<sup>2</sup> See Huberfeld, *supra*, at 244.

Finally, medical practices may not share fees earned for their professional services with unlicensed persons, including business entities. This often precludes the payment of management fees to other businesses based on percentages of net revenues.

The Doctrine exists in some form in a majority of the states. However, there is significant variance in the type of authority on which a state may rely to enforce the Doctrine, ranging from statutes, regulations, case law, attorney general opinions and administrative rulings to board or agency guidance and interpretations. As medical practices consolidate, networks expand through telemedicine and innovative treatments and equipment evolve, the CPOM Doctrine provides hurdles for physicians as they attempt to restructure their practices, associate with companies providing new diagnosis and treatment tools and engage third parties to handle certain healthcare related services. On the other hand, the Doctrine provides protection against corporate interference with decisions that may be best left to medical clinicians.

## **II. History of the Corporate Practice of Medicine Doctrine.**

The United States entered into a tremendous period of growth in the nineteenth century. The industrial and population surge in the United States arrived with an increased demand for medical services. In order to capitalize on emerging market opportunities, the practice of medicine became a crowded field as many non-licensed individuals and corporations held themselves out as health care industry providers. Some claimed to be faith healers, others sold elixirs, while even more offered unique medical procedures.<sup>3</sup> Large corporations, such as mining giants, began to hire physicians to care for their employees.<sup>4</sup> With this influx of large corporations and other untrained individuals in the medical industry, lawmakers recognized the potential threat to the health of America, and soon focused on restricting the corporate practice of medicine.

In order to protect physicians from corporate dominance, the AMA planted the seeds for the CPOM Doctrine on the basis of patient protection, and to ensure differentiation between licensed physicians and those who claimed to be healthcare professionals.<sup>5</sup> As the nineteenth century reached its end, physicians and the AMA began to lobby for the enactment of statutes to codify the Doctrine.<sup>6</sup> Acting on the persistent calls from the AMA and its physician members, several state legislatures promulgated statutes restricting the practice of medicine to licensed physicians and ownership in medical practices to licensed professionals.<sup>7</sup> In states where CPOM laws were not passed, many courts developed such law based on public policy.<sup>8</sup>

Over the last 100 years, many states have continued to enforce the CPOM Doctrine. On the other hand, some states have abolished the Doctrine, and still others have diluted it by creating

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<sup>3</sup> *Id.* at 246.

<sup>4</sup> Allegra Kim, *The Corporate Practice of Medicine Doctrine*, California Research Bureau (October 2007), *citing* Frank D. Campion, *The AMA and U.S. Health Policy Since 1940*, Chicago Review Press (1984).

<sup>5</sup> 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](http://www.law.uh.edu/Healthlaw/perspectives/2009/(CC)%20CorpPractice.pdf) (last visited Jan. 5, 2015).

<sup>6</sup> See Conway, *supra*, at 1-2.

<sup>7</sup> See Michael F. Schaff, *The Corporate Practice of Medicine Doctrine: Is it Applicable to Your Client?*, 3 Business Law And Governance 2 (May 2010).

<sup>8</sup> See Kim, *supra*, at 1.

numerous exceptions for entities such as hospitals, nursing homes, and medical schools. With the widespread changes in the healthcare industry, many are clamoring for change in this area of the law.

### **III. Rationale for the Corporate Practice of Medicine Doctrine.**

It is a fundamental premise in business law that corporations have a duty of loyalty to their shareholders.<sup>9</sup> The chief goal of corporations is to maximize profit for their owners. Likewise, physicians also have a duty of loyalty. Each physician takes the Hippocratic Oath which, among other things, requires them to abide by certain ethical principles. These principles include the requirement that physicians place the care of their patients above all other responsibilities and influences.

As shown by the mining companies that hired physicians in the early 1900s, the primary goals of corporations often are not aligned with physicians' primary ethical responsibilities. Lawmakers began to codify the CPOM Doctrine on the theory that corporate employment of physicians would result in an inherent division of loyalty between the physicians' patients and the physicians' corporate employers.

The CPOM Doctrine is based on the same public policy. Not only are lawmakers concerned about the negative health impact corporate owners could have on the care rendered by their physician employees,<sup>10</sup> they are also concerned that corporations may utilize patient information for corporate gain.<sup>11</sup>

### **IV. How is the Doctrine Applied by the Different States?**

The CPOM Doctrine is state-specific, and may be expressly addressed by statute in professional practice laws or corporate, licensing and advertising regulations that disallow corporate employment of professionals or ownership of professional practices. Often the CPOM ban is not directly addressed in state laws but rather, evolves through a mixture of opinions, complaints and guidance of the state's attorney general, legislative counsels, regulatory boards, agencies and case law.

Below we address some of the ways that states apply the CPOM Doctrine and some general exceptions found in state statutes. A more in-depth analysis of each of the fifty states is available in the AHLA publication, "Corporate Practice of Medicine: A Fifty State Survey."

#### **A. Professional Business Entities**

While banning the practice of medicine by corporations, CPOM states allow medical professionals to practice through certain types of business entities, which often are distinguished as

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<sup>9</sup> *North American Catholic Educational Programming Foundation, Inc. v. Gheewalla*, 930 A.2d 92, 99 (Del. 2007).

<sup>10</sup> The purpose is to protect the public "against the unskilled treatment of the sick or diseased by persons having neither the preparation or skill to diagnose diseases or to administer powerful and poisonous drugs. *State v. Baker*, 212 Iowa 571, 581, 235 N.W. 313, 317 (1931).

<sup>11</sup> *See Conway, supra*, at 2.

“professional” entities, such as professional corporations, professional limited liability companies and professional services organizations. States vary on the type of business form permitted and may specify that all or a majority of the shareholders, members, directors and officers be professionals licensed to provide the medical services the corporation is organized to provide.

Through these corporate entities, licensed professionals can provide medical services and associate with lay entities in carefully structured business arrangements. However, if the lay entity controls the professional’s judgment, it may not escape the jaws of the CPOM ban but rather, be engaged in the unlawful, unlicensed practice of medicine. This unlawful engagement may jeopardize the license of the physician, who may be found to have aided and abetted the lay entity.<sup>12</sup>

### 1. *California*

California permits licensed professionals to form professional corporations, but not limited liability companies, for the delivery of medical and certain other professional services.<sup>13</sup> At least fifty-one percent of the shareholders must be medical professionals licensed to deliver the primary category of medical services provided by the professional corporation. Persons licensed in other professional disciplines, as specified in the statute, can own the remainder of the shares; however, the number of licensee shareholders holding the majority interests must equal or exceed the number of the shareholders of the other professional disciplines.<sup>14</sup> For example, where two physicians own 70% of a medical corporation, three psychologists cannot own 30%.

Under AB 1000 (effective January 1, 2014), California’s professional corporation statutes were amended to eliminate certain limitations on professional corporations’ employment of professionals licensed in disciplines different from the primary services of the professional corporation. Professional licensing statutes may still impede those efforts in some disciplines, however.

### 2. *Minnesota*

In contrast to California, Minnesota allows professional corporations, partnerships, limited liability companies and limited liability partnerships to engage in certain professions so long as the licensed professionals hold all ownership interests.<sup>15</sup>

### 3. *New York*

New York law also permits providers to practice through professional entities. However, the owners must not only be licensed to practice the profession that the entity is authorized to practice, but must also be "engaged in the practice of such profession in such corporation or a predecessor entity, or who will engage in the practice of such profession in such corporation within thirty days of the date such shares are issued."<sup>16</sup>

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<sup>12</sup> See Section IV.D, *infra*.

<sup>13</sup> Moscone-Knox Professional Corporation Act, CA Corps Code § 13401.5.

<sup>14</sup> *Id.*

<sup>15</sup> See Minn. Stat. Chap. 319B. See also Minn. Stat. §§ 319B.02, 319B.03, 319B.07.

<sup>16</sup> NY CLS Bus Corp § 1507.

In a December 8, 1999 advisory letter, the New York State Education Department Office of Counsel, provided some direction regarding the degree of engagement required of a physician-owner. In response to a specific inquiry, the letter opined that a physician shareholder must be involved in some aspect of patient treatment. The physician cannot be a non-practicing shareholder; rather, at a minimum must participate in “nominal” patient treatment duties. The Office of Counsel failed to set forth clear guidance as to the type of activities that would qualify but stated that quality assurance functions to ensure that patients are receiving proper care and treatment may be sufficient for a physician to be considered engaged in the practice.

The “engaged in the practice” issue was litigated in a 2009 case<sup>17</sup> (discussed in further detail below). The jury was instructed that the practice of medicine includes diagnosing, by way of MRI scanning, any human disease, pain, injury, deformity or physical condition and that a physician is engaged in the practice of medicine if he, either directly or indirectly, is involved with making professional medical decisions concerning individual patients. The Court held that the jury instructions were proper since the law requires not only that professional corporations be owned by licensed individuals but also that all shareholders be engaged in the practice of such profession in such corporation.

In setting aside the jury's verdict that the physician was not actively engaged in the practice as contrary to the weight of the evidence, the Appellate Court stated that a shareholder physician's failure to engage in the practice of medicine within the professional corporation renders such professional corporation ineligible to recover no-fault benefits. The Court however determined that the medical practice was ineligible to receive reimbursement based on a different theory, fraudulent incorporation.<sup>18</sup>

In another insurance reimbursement case, the Court listed factors that an insurer could allege to show fraudulent incorporation of a practice including "is the medical provider actually performing the medical services for which the professional corporation was formed, to what extent is the licensed professional involved in the decisions relating to the operation of the medical facility and is the licensed professional more like a salaried employee or the owner of the business."<sup>19</sup> The Court also said "stated more simply, is the licensed professional involved both medically and operationally in the operation of the business or has the medical professional simply provided a license that permits persons who lack a license to operate, control and benefit from the operation of a medical facility or practice".

Recently, a New York court has stated that the issue of who owns a professional entity cannot “necessarily be resolved simply by examining the [entity's] certificate of incorporation. Rather, the question of ownership is considered a question of fact, or a mixed question of law and fact.”<sup>20</sup>

In the absence of a clear definition of when a physician-owner is "engaged in the practice of such profession in such corporation," each corporation's ownership must be analyzed in light of all of

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<sup>17</sup> *In the Matter of Andrew Carothers, M.D., P.C.*, 888 N.Y.S.2d 372 (2009).

<sup>18</sup> See discussion in Section IV.D below regarding reimbursement issues based on violations of the CPOM Doctrine.

<sup>19</sup> *Huntington Regional Chiropractic, P.C. v. Allstate Insurance Company*, 967 N.Y.S.2d 639, 641 (2013)

<sup>20</sup> *United States v. Zemlyansky*, 945 F. Supp. 2d 438 (2013).

the circumstances. To reduce the risk of a finding to the contrary, the governing documents should specify that each of the owners shall be engaged in the practice of medicine on behalf of the practice and directly or indirectly be involved with the professional medical care decisions concerning the practice's patients. An owner who ceases to be so engaged should be required to provide notice of such decision and the practice should promptly redeem his/her ownership interest or the physician should transfer his ownership to another physician-owner. One or more of the owners should regularly communicate with and supervise the practice's physicians at all offices of the practice.

## B. Anti-Fee-Splitting Laws

Some states prohibit a licensed individual from sharing fees received from professional services with non-licensees. These anti-fee-splitting laws effectively prohibit the same conduct as the CPOM Doctrine – laypersons profiting from and controlling medical practices. Physician compensation that is based on something other than the fair market value of the services is suspect and fees paid to management services organizations must be structured so as not to be characterized as profit-sharing. Some CPOM states regard a management fee based on a percentage of net profits as illegal fee-splitting. In those states, fees may be paid on a percentage of gross profits or on a flat fee basis, commensurate with the value of the services.

### 1. *Illinois*

The Illinois Medical Practice Act expressly prohibits fee-splitting. A licensee may not “directly or indirectly divide, share or split any professional fee or other form of compensation for professional services with anyone in exchange for a referral or otherwise, other than as provided [herein].”<sup>21</sup> The law goes even further and states that a licensee may not “divide, share or split a professional service fee with, or otherwise directly or indirectly pay a percentage of the licensee’s professional service fees, revenues or profits to anyone for: (i) the marketing or management of the licensee’s practice...[or] (iv) negotiating fees, charges or terms of service or payment on behalf of the licensee...”<sup>22</sup>. Therefore, in Illinois, you could not pay a management company based on a percentage of profits. The law does contain certain exceptions, including the dividing of fees among licensee owners of a professional practice.<sup>23</sup>

### 2. *Indiana*

The Medical Licensing Board of Indiana regulations prevent a practitioner from “divid[ing] a fee for professional services with another practitioner who is not a partner, employee, or shareholder in a professional corporation, unless: (1) the patient consents to the employment of the other practitioner after a full disclosure that a division of fees will be made; and (2) the division of fees is made in proportion to actual services performed and responsibility assumed by each practitioner.”<sup>24</sup>

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<sup>21</sup> 225 ILCS 60/22.2(a).

<sup>22</sup> 225 ILCS 60/22.2(f).

<sup>23</sup> 225 ILCS 60/22.2(c).

<sup>24</sup> 844 IAC 5-2-10.

### 3. California

California's anti-fee splitting ban is rooted in Section 650(a) of its Business and Professions Code. The statute prohibits physicians and other licensed professionals from offering or receiving rebates, refunds, commissions or other consideration, as compensation or inducement for the referral of patients, clients or customers to any person. The statute does allow payments or other consideration made or received for services other than patient referrals to be based on a percentage of gross revenues so long as the "consideration is commensurate with the value of the services furnished or the fair rental value of any premises or equipment eased or provided by the recipient to the payer."<sup>25</sup> Often times management companies charge fixed, flat fees out of an abundance of caution and where the physicians provide services under the managed practice to federally-funded beneficiaries.

#### C. Exceptions to the CPOM Doctrine

State legislatures have enacted statutes that authorize certain types of licensed or certified entities and facilities where corporate ownership is specifically permitted, such as ambulatory surgical centers.<sup>26</sup> States also have adopted a variety of exceptions to the CPOM Doctrine in response to case law or particular community needs. The exceptions may apply only to a lay entity's employment of or joint ownership with physicians and surgeons, or may be applied to licensed professionals in other disciplines.

The permissible structures are based upon a plethora of situational needs and for the purposes of providing: health care to low income populations; training residents and students; research; alternative health care; increasing access to health care; and other public purpose needs. Despite their excepted status, the professionals still retain the right to practice their professions without corporate interference with their professional, clinical judgment.

The following are examples of exceptions enacted by various state legislatures:

- Academic medical centers and clinics operated primarily for medical education (limited to non-profit entities in some states)
- Clinics operated for scientific and charitable purposes
- Charitable institutions and foundations
- Hospitals and institutions owned by health care districts or public health systems
- Licensed health care plans or HMOs

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<sup>25</sup>CA Business & Professions Code § 650(b). The meaning of "commensurate with the value of the services furnished" is not defined. See *Blank v. Palo Alto-Stanford Hospital Center*, 234 Cal.App.2d 377 (1965) (compensation by a hospital to a radiologist based on a percentage of gross revenues of the hospital's radiology department, which was commensurate with certain direct and indirect expenses incurred by the hospital/manager upheld); See also *People v. Duz-Mor Diagnostic Laboratory, Inc.*, 68 Cal.App.4th 654 (1998). But see 55 Op. Cal.Atty.Gen. 103 (March 3, 1972) where the California Attorney General opined that a physician's rent to the hospital based on a division of net income from the physicians' services was an illegal payment for referrals where the physician's rent was not related to the hospital's cost of providing the facility.

<sup>26</sup> CPOM laws also may not apply to physician-owned clinics operated in the physician's office since the physician is providing the services under the physician's license. See e.g., California Health & Safety Code § 1200. These may or may not be specified in state statutes.

- School districts
- Federally qualified health centers
- Migrant, community or homeless health centers
- Prisons
- Birthing centers
- Ambulatory surgical centers
- Employer-based clinics
- Stand-alone urgent care centers
- Hospital out-patient departments

The excepted organizations provide options that may make sense for certain corporations to consider when their typical business models are inconsistent with state CPOM laws. In many cases, though, the regulatory requirements – including operational and reporting functions – may be so burdensome or inconsistent with their business models that they may find it better to pursue other business arrangements (see below, Investment Strategies).<sup>27</sup>

#### D. Penalties and Consequences for CPOM Violations

State penalties for CPOM violations vary but many statutes classify violations as criminal misdemeanors with monetary penalties and imprisonment – typically up to one year. In addition, states have injunctive authority and may be authorized to order redress to consumers through refunds of fees or other costs.<sup>28</sup>

Importantly, the professionals who provide the medical services in association with the lay corporation are at risk of loss or suspension of their licenses.<sup>29</sup> States may allege CPOM violations based on:

- Unauthorized employment by the lay corporation
- Allowing the lay corporation to use the professional's license to engage in the practice of medicine
- Aiding or abetting the lay corporation in engaging in the unauthorized practice of medicine
- Fee splitting (of professional fees)
- Patient brokering or referrals

State agencies often lack the funds necessary to investigate and prosecute those engaged in CPOM violations. However, private litigants frequently fill that gap by filing class action suits

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<sup>27</sup> In Texas, employment contracts by certain hospitals allowed to employ physicians, dentists or other health care professionals are limited to four years. TEX. H&S Code 281.0282.

<sup>28</sup> See, e.g., Fla Admin. Code Ann. r. 64B8-8.001

<sup>29</sup> See, e.g., *Watt v. Texas State Board of Medical Examiners*, 303 S.W.2d 884 (Tex.Civ. App.-Dallas 1957, writ ref'd n.r.e.), cert. denied, 56 U.S. 912 (1958); *F.W.B. Rockett v. Texas State Board of Medical Examiners*, 287 S.W.2d 190 (Tex. Civ. App.-San Antonio 1956, writ ref'd n.r.e.)



alleging damages based on violations of public policy, unfair business practices and deceptive advertising statutes.<sup>30</sup>

Finally, payors have sought to deny reimbursement to providers on the basis that their provider contracts were void where the providers' business arrangements violated the CPOM Doctrine. Enforcement of the contracts generally depends on several factors, including the type of violation, the policy aims of the violated laws and the particular facts of the case. "In compelling cases, illegal contracts will be enforced in order to 'avoid unjust enrichment to a [payor] and a disproportionately harsh penalty upon the [medical provider].'"<sup>31</sup> In other words, these cases often do not allege patient harm or substandard medical care and thus reimbursement may be appropriate for the services rendered, despite an improper corporate structure. On the other hand, where a provider knowingly violates corporate practice laws, the contract may be voided, resulting in the provider's inability to collect the earned reimbursement from the payor.<sup>32</sup>

#### E. Other Providers

As mentioned above, the same principles of the CPOM Doctrine often apply to not only physicians but also to other healthcare providers.

##### 1. *New Jersey*

New Jersey has a prohibition on the corporate practice of dentistry. The New Jersey Dental Board laws define "practicing dentistry" to include "a manager, proprietor, operator, or conductor of a place where dental operations are performed"<sup>33</sup>. The terms "manager, proprietor, operator or conductor" include "any person who (1) employs operators or assistants; or (2) places in the possession of any operator, assistant, or other agent such dental material or equipment as may be necessary for the management of a dental office on the basis of a lease or any other agreement for compensation for the use of such material, equipment or office; or (3) retains the ownership or control of dental material, equipment or office and makes the same available in any manner for the use by operators, assistants or other agents..." This broad definition limits the types of services that can be provided by business entities such as management companies, including leasing space that is fit out to provide dental services, leasing dental equipment to a practice and providing dental supplies. Currently in New Jersey, the New Jersey State Board of Dentistry is reviewing a proposed regulation that states

"Except as otherwise provided by law, every dental practice in New Jersey shall be wholly owned and controlled by one or more dentists duly licensed to practice

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<sup>30</sup> See, e.g., the California Unfair Competition Act, CA Business & Professions Code §§ 17200, 17500; California Consumer Legal Remedies Act, CA Civil Code 1750 *et. seq.*

<sup>31</sup> *California Physicians' Service v. Aoki Diabetes Research Institute* (2008) 163 Cal.App.4<sup>th</sup> 1506, 1516. The Aoki case, addressed a provider's violation of California's CPOM Doctrine where Blue Shield sought to avoid reimbursing the provider for medical services rendered to Blue Shield enrollees. The Appellate Court concluded that the provider violated the CPOM ban but that the contract should be enforced in order to avoid unjust enrichment of Blue Shield. See *Western Nat'l Mut. Ins. Co. v. Stand Up Mid-America MRI, Inc.*, 2010 Minn. App. Unpub. LEXIS 1151 ((Minn. Ct. App. 2010) No. A10-566; *Isles Wellness, Inc. v. Progressive Northern Ins. Co.*, 725 N.W.2d 90 (Minn. 2006);

<sup>32</sup> *Western National*, *supra*, at 3-4..

<sup>33</sup> N.J.S.A. 45:6-19.

dentistry in this State. Any contract made by, on behalf of, or for the benefit of a New Jersey dental practice shall provide that the owner or owners of the practice retain the absolute, unconditional right to make all final practice management and other decisions, including but not limited to those relating to compensation, hiring, firing, financing, borrowing, leasing, purchasing, claim submissions, billing, advertising, office policies and procedures, participation in and/or termination of all dental plans including Medicaid, and the establishment of patient fees and modification or waiver thereof.”<sup>34</sup>

The regulation was proposed based on “concerns about the commercial exploitation of the practice of dentistry, including not being subject to the Board’s direct control and discipline.”<sup>35</sup>

## 2. *Minnesota*<sup>36</sup>

Minnesota law also extends the corporate practice prohibition to other providers. In a 2005 case, the Minnesota Supreme Court stated that the Doctrine prohibits the “corporate practice of health care professions.”<sup>37</sup> “When adopted by state courts, the general prohibition on corporate employment of licensed health care professionals has been based on a corporation’s inability to satisfy the training and licensure requirements set out in state statutes and related public policy considerations.”<sup>38</sup> The Doctrine “is [not] limited to medicine and...appl[ies] to other branches of the healing arts.”<sup>39</sup> However, it “does not automatically embrace every form of health care or therapy.”<sup>40</sup>

In 2014, the United States District Court for Minnesota considered two cases which questioned whether the CPOM Doctrine applies to a magnetic resonance imaging company, which was owned by a layperson. In the first case,<sup>41</sup> the court held that the technical and professional components of MRI scans are separable. Thus, since the MRI company’s technologists were “not state-licensed, undergo limited training and do not exercise independent professional judgment, the [Doctrine] does not prohibit the execution of the technical component of MRI scans by [the MRI company].” Further, the company did not violate the Doctrine by having independently-contracted radiologists interpret the scans since the MRI company did not communicate the findings directly to the patient, but rather sent the reports to the referring medical providers.

In the subsequent case,<sup>42</sup> the court reaffirmed that “the taking of an MRI scan, in and of itself, does not constitute the practice of medicine for purposes of Minnesota’s [CPOM Doctrine].” The reasoning was that the State does not impose licensing requirements on MRI technologists and the law clearly contemplated that laypersons can possess ownership in MRI facilities since these facilities

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<sup>34</sup> 46 N.J.R. 2379(a).

<sup>35</sup> *Id.*

<sup>36</sup> The authors would like to thank David Asp, Esq. of Lockridge Grindal Nauen P.L.L.P. for his contribution to this section.

<sup>37</sup> *Isles Wellness, Inc.*, *supra* at fn. 32.

<sup>38</sup> *Isles Wellness*, 703 N.W.2d at 517.

<sup>39</sup> *Spine Imaging MRI, L.L.C. v. Liberty Mut. Ins. Co.*, 818 F.Supp.2d 1133 (D.Minn. 2011).

<sup>40</sup> *Isles Wellness*, 703 N.W.2d at 522.

<sup>41</sup> *State Farm Mutual Automobile Insurance Company v. Mobile Diagnostic Imaging, Inc.*, 7 F.Supp.3d 934 (D.Minn. 2014).

<sup>42</sup> *Illinois Farmers Insurance Company v. Mobile Diagnostic Imaging, Inc.*, 2014 WL 4104789 (D.Minn. 2014).

must disclose the name of all physicians “and all other individuals” with ownership. In contrast, the court was clear that laypersons are not allowed to interpret MRI scans and stated that the crucial fact was whether the radiologists were employed by the MRI company or independent contractors. Further, even if the radiologists were independent contractors, a violation of the Doctrine could occur if the MRI company “interfered with the judgment of those radiologists or provided the reports of those radiologists directly to patients.”

### 3. *California*

California extends its CPOM ban to several other professional disciplines, including dentistry, optometry and chiropractic medicine, to which various exceptions exist. Speech-language pathology, nursing, physician assistants and nurse practitioners also have licensing restrictions and can form professional corporations but they are not prohibited from being employed by non-professional corporations.

California has been a battle ground for optometrists and opticians, particularly with regard to private optometrists and retail opticians. Retail opticians have long sought to establish business models that would not run afoul of California’s commercial practice limitations restricting business relationships between opticians and optometrists.<sup>43</sup> Issues have centered on the amount of control that a registered dispensing optician can exert over an optometrist’s practice and the limitations of the health plan exception to the CPOM ban.

*California Association of Dispensing Opticians (CADO) v. Pearle Vision*<sup>44</sup> analyzed the degree of direct and indirect controls that a lay corporation could exercise in connection with a licensed professional’s practice and the CPOM. In *CADO*, a corporation franchised retail ophthalmic dispensing offices to optometrists, who operated the offices under the name of Pearle Vision. The California Court of Appeal ruled that the corporation was illegally practicing optometry without a license due to the substantial control it exercised over the optometrist franchisees. The Court set forth a list of business decisions made by Pearle Vision, which it determined should be considered indicia of unlawful control over a professional’s judgment and a patient’s health, including without limitation, the corporation’s right of approval of the office site, its furnishings, fixtures, inventory and supplies; mandatory fee schedules; the use of the franchisor’s labs; and periodic audits. According to the Court, determining if a business arrangement violates the CPOM Doctrine requires an evaluation of the totality of the circumstances.<sup>45</sup> The opinion and the list of factors routinely have been applied to professionals other than optometrists, including physicians.

The extent to which a health plan provides an exception to the CPOM ban in California<sup>46</sup> was also a battle fought between state interests in protecting the private practice of optometry from

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<sup>43</sup> CA Business & Professions Code § 655 prohibits certain business relationships between optometrists and registered dispensing opticians and optometrists and ophthalmic goods manufacturers (e.g., prohibitions on financial and landlord/tenant arrangements). CA Business & Professions Code § 2556 prohibits opticians from advertising the availability of optometry services or maintaining an optometrist on or near the optician’s premises.

<sup>44</sup> (1983) 143 Cal.App.3d 419.

<sup>45</sup> *Id.* at 434.

<sup>46</sup> CA Health & Safety Code § 1395(b) provides that health plans licensed under the Knox-Keene Health Care Service Plan “shall not be deemed to be engaged in the practice of a profession, and may employ, or contract

corporate, retail control. In *People v. Cole National*,<sup>47</sup> California’s Supreme Court upheld the right of health plans to employ licensed health care professionals as an exception to the CPOM Doctrine. The Court declined to extend the exception to other professional laws restricting business relationships between optometrists and opticians – in this case, registered dispensing opticians who practiced in retail locations.

#### IV. UNITED STATES SENATE REPORT

In June, 2013, the United States Senate Committee on Finance and the Committee on the Judiciary issued a Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program.<sup>48</sup> The Report highlights a significant concern about dental management companies that provide general administrative management services to dental practices. Due to complaints by whistleblowers, the Committees investigated five dental management companies to determine whether they owned the dental practices or had control over operations, including the provision of clinical care by dentists. Although acknowledging there is no federal corporate practice of dentistry prohibition, the Report found that these management companies “hide from state authorities the fact that all rights and benefits of ownership actually flow to a corporation through contracts between the company and the ‘owner dentist’. These contracts render the ‘owner dentist’ an owner in name only.”<sup>49</sup> In these instances, they concluded that profits from the practices were more important than patient care.

The Report focused mostly on one management company, Church Street Health Management (“CSHM”), which owned 70 Small Smiles dental clinics in 22 states and the District of Columbia. CSHM had management services agreements with Small Smiles dental clinics in which they assumed significant control over the practice of dentistry and took substantially all of their profits. The dentist owners of the clinics were paid a salary and flat fee. In some cases, the dentist owners had never visited the clinics they owned, were not allowed to make hiring decisions, and did not even control the scheduling of patients. In addition, dentists were required by CSHM to treat a high volume of patients daily, which the Report found had a significant impact on the quality of care to patients.

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with, any professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code to deliver professional services. Employment by or a contract with a plan as a provider of professional services shall not constitute a ground for disciplinary action against a health professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code by a licensing agency regulating a particular health care profession.”

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<sup>47</sup> 682 F.3d 1144 (9<sup>th</sup> Cir. 2012),

<sup>48</sup> Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program (June 2013), available at: <http://www.finance.senate.gov/library/prints/>.

<sup>49</sup> Id.

## V. INVESTMENT STRATEGIES

### A. Management Services Agreement and Management Services Organization (MSO)

An MSO or another corporate entity owned in whole or in part by laypersons that provides administrative services to licensed professionals is one way in which non-licensed persons can invest in professional practices. Often, licensed professionals may partner or independently contract with MSOs, which provide their practices with administrative services or practice management tools that may include billing, purchasing, accounting, office space, supplies, human resources services or leased nonclinical personnel. The practice pays the MSO to perform operational functions to the extent that those services do not interfere with the professional's medical judgment or otherwise result in MSO control over the medical practice. This line may not be brightly drawn in some states and management services contracts must be carefully structured to preserve the professional's independence consistent with state laws.

#### 1. *California*

The California Medical Board has published guidance on the type of services or behaviors that may constitute the unauthorized lay control over a medical practice and the health decisions over which a physician must retain control.<sup>50</sup> These are categorized as health care decisions or business or management decisions.

According to the Medical Board, only physicians, and not unlicensed persons, can make the following health care 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

The Medical Board defines business or management decisions and actions that they have determined must ultimately be made only by licensed California physicians and not delegated to MSOs or other unlicensed entities (although consultation with unlicensed persons in making the decision is acceptable):

- 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.

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<sup>50</sup> [http://www.mbc.ca.gov/Licensees/Corporate\\_Practice.aspx](http://www.mbc.ca.gov/Licensees/Corporate_Practice.aspx). See also 2013 Guide to the Laws Governing the Practice of Medicine by Physicians and Surgeons, at [http://www.mbc.ca.gov/About\\_Us/Laws/laws\\_guide.pdf](http://www.mbc.ca.gov/About_Us/Laws/laws_guide.pdf).

- Setting the parameters under which the physician will enter into contractual relationships with third-party payers.
- Decisions regarding coding and billing procedures for patient care services.
- Approving of the selection of medical equipment and medical supplies for the medical practice.

Finally, the Medical Board prohibits certain types of medical practice ownership and operating structures:

- Non-physicians owning or operating a business that offers patient evaluation, diagnosis, care and/or treatment.
- Physician(s) operating a medical practice as a limited liability company, a limited liability partnership, or a general corporation.
- Management service organizations arranging for, advertising, or providing medical services rather than only providing administrative staff and services for a physician's medical practice (non-physician exercising controls over a physician's medical practice, even where physicians own and operate the business).
- A physician acting as "medical director" when the physician does not own the practice. For example, a business offering spa treatments that include medical procedures such as Botox injections, laser hair removal, and medical microdermabrasion, that contracts with or hires a physician as its "medical director."

There is a long line of California cases and opinions of the state's Attorney General, which are cited as support for the Medical Board's guidance above.<sup>51</sup> These include *California Assn. of Dispensing Opticians v. Pearle Vision Center., Inc.* (1983) 143 Cal.App.3d 419, discussed in Section III.E.3 above.

## 2. New York

In New York, a court case<sup>52</sup> highlights the factors a court may consider in determining whether there is a violation of the CPOM. In the *Carothers* case, the trial court upheld a jury verdict that a professional medical corporation ("PC") that was managed by an entity that was not physician-owned was fraudulently incorporated (and therefore, not entitled to payment under no-fault insurance

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<sup>51</sup> See, e.g., *Parker v. Board of Dental Examiners* (1932) 216 Cal. 285, where the Board of Dental Examiners suspended a dentist's license where he and other dentists were employed by a corporation owned in part by unlicensed persons. The California Supreme Court did not accept the dentist's argument that the dentistry licensing requirements did not apply to the business side of the practice, and held that "The law does not assume to divide the practice of dentistry into such departments." ; *Blank v. Palo Alto-Stanford Hospital Center* (1965) 234 Cal.App.2d 377 – A contract between a hospital and a physician's group for operation of a radiology department did not violate the CPOM ban despite the percentage split of gross income from fees derived from the physicians' services (2/3 hospital; 1/3 physicians). Although the court considered factors related to the requirement that the hospital provide certain facilities, it noted that the doctors appeared to retain their independent professional judgment and that the fees retained by the hospital were proportionate to the hospital's expenses in furnishing the diagnostic facilities; *Garvai v. Board of Chiropractic Examiners* (1963) 216 Cal.App.2d 374, where chiropractors licenses were suspended for being employed by an unlicensed person and practicing under a fictitious name; *Steinsmith v. Medical Board* (2000) 85 Cal.App.4th 458, where unlicensed persons owned the clinic where the physician practiced medicine as an independent contractor, the physician was found to have aided and abetted the unlicensed practice of medicine.

<sup>52</sup> *In the Matter of Andrew Carothers, M.D., P.C.*, 888 N.Y.S.2d 372 (2009).

policies). Their decision focused on findings that: (i) the nominal physician-owner of the PC in question was not engaged in that PC's professional practice, and (ii) the non-physician owners of the MSO were the de facto owners of the PC and exercised substantial control over the PC.

The court in *Carothers* upheld a jury charge that the following non-exclusive list should be weighed in making a determination as to whether the MSO owners were de facto owners of the PC or exercised substantial control over the PC, including whether and the extent to which:

(1) the owners of the MSO and the MSO's dealings with the PC were arms-length, i.e. whether the agreements between the PC and the MSO were the products of arms-length transactions or whether the financial and non-financial terms were designed to give the owners of the MSO substantial control over the PC and to channel to the owners of the MSO the profits of the PC;

(2) the owners of the MSO exercised dominion and control over the assets of the PC, including the PC's bank accounts;

(3) the PC was capitalized by the nominal physician-owner(s) and the owners of the MSO, i.e. - the extent to which these individuals made capital investments in the PC;

(4) the funds of the PC were used by owners of the MSO for personal rather than corporate purposes;

(5) the owners of the MSO had the ability to bind the PC to legal obligations with third parties;

(6) the owners of the MSO were responsible for the hiring, firing and/or payment of salaries of the PC's employees and whether and the extent to which they dictated policy decisions;

(7) the day to day formalities that are part and parcel of the PC's corporate existence were followed by the PC, including the issuance of stock, election of directors, holding of corporate meetings, keeping of contemporaneous corporate books and records and the filing of corporate income tax returns;

(8) the PC and the MSO had common office space, addresses and telephone numbers;

(9) the physician owner of the PC played a substantial role in the day-to-day and overall operation and management of the PC;

(10) the owners of the MSO assumed the financial obligations of the PC as if they were their own;

(11) the funds of the PC and those of the MSO were commingled;

(12) the physician owners of the PC and the owners of the MSO shared the risks, expenses, and interest in the profits and losses of the PC; and

(13) the owners of the MSO played a role in the professional decision making of the PC.

In addition, the court noted in its opinion that there was evidence presented at trial that:

(a) all equipment used by the PC was leased from an affiliate of the MSO at exorbitant rates (and that through these leases, the bulk of the PC's profits were channeled to the MSO);

(b) the PC was not a named tenant on any of the office leases; and

(c) the only person who signed checks on the PC's bank accounts was an employee of the MSO and the physician-owner did not have knowledge about the amount of money in the bank accounts or the draws on the bank accounts.

### 3. *Internal Revenue Service ("IRS") Considerations*

Based on a recent private letter ruling from the IRS<sup>53</sup>, MSOs and friendly professional corporations (discussed in more detail below) could achieve tax savings and simplify tax compliance. The Ruling allows an MSO to include the professional corporations to which it provides services in its consolidated tax return. Effectively, since the MSO has control over the practice, the IRS has permitted it to include the practice on its tax return. However, MSOs in states with CPOM laws should carefully analyze whether consolidation of the practice with the MSO on its tax return will run afoul of those restrictions.

#### B. "Friendly" or Captive Professional Corporation

Hospitals, ancillary providers and other lay entities that cannot employ physicians often contract with friendly or captive professional corporations as a way to associate with and exert some influence over the professional's practice. Under this option, one or more licensed professionals who are friendly with the lay entity, set up a professional corporation (or other allowable entity), where they own all of the equity of the professional corporation. The lay entity then enters into one or more contracts with the professional corporation such as an administrative or management services agreement, whereby the lay entity can exercise certain financial and operational controls over the professional corporation. These often are established in conjunction with the friendly professional's contract as a medical director of a hospital or other facility, which may restrict the medical director's sale of shares of the professional corporation to another professional only with the lay entities prior approval. The stock transfer restriction may be disallowed in certain states.

This option is frequently used by hospitals and physician groups who seek alignment and integration in states where employment is disallowed. The professional's medical judgment is preserved while the physician group gets operational assistance through the management services it purchases from the hospital.

In the retail context, the professional may operate a practice on the premises of a lay entity's store, thereby allowing patients to obtain prescriptions from the professional, which are necessary for

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<sup>53</sup> Internal Revenue Service Private Letter Ruling Number 201451009, released December 19, 2014.



the purchase of goods from the lay corporation, e.g., optometrists and optical companies, dentists. In addition to complying with any specific corporate practice limitations and requirements, both entities need to consider the application of referral and anti-kickback laws on the federal and state level.

### C. Foundations

Lay corporations also may establish or partner with clinics that are specifically exempt from the corporate practice bar. For instance, non-profit tax exempt organizations, including hospitals seeking to integrate and align with medical practices may be able to use non-profit foundations to contract directly with professionals for medical services or themselves enter into direct contracting arrangements with the professionals.

Although California excepts nonprofit medical foundations from its clinic licensure laws and thus, the CPOM ban, so long as the nonprofit tax-exempt medical foundation meets certain requirements. It can contract with a medical group composed of at least 40 physicians, 2/3 of whom are fulltime, which has at least ten board certified specialties and which conducts medical research.<sup>54</sup> The medical foundation typically owns the facilities, space and equipment, negotiate payor contracts and bill and collect for all services. The Medical Foundation then compensates the medical group at fair market value under a professional services agreement, which may include salaries, benefits, incentive payments for quality and performance. Importantly, the foundation may bear the costs of information technology (IT), among other things.

### D. Health Maintenance Organizations and Health Plans

Health maintenance organizations and state licensed health care plans may be another investment option available in certain states. In California, health care service plans can employ or contract with licensed professionals to provide services to their members.<sup>55</sup> This investment option is well-suited to organizations that wish to assume risk for patient health on a group, capitated basis or through the sale of individual health plan contracts.

This health care delivery option has been increasingly used in the retail and big-box setting to establish stand-alone health plan offices that can contract with and provide medical services directly to consumers – even on a walk-in basis. Like all other exceptions to the CPOM Doctrine, though, licensed professionals must retain their control over clinical decision-making.

The establishment and operation of an HMO or health plan is costly, though, due to state financial requirements. The ongoing regulatory burdens and agency oversight can also be hefty.

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<sup>54</sup> See, e.g., CA Health & Safety Code § 1206(l).

<sup>55</sup> CA Health & Safety Code § 1395(b). See discussion *infra* at Section E.3.

## CHECKLIST IN ANALYZING BUSINESS ARRANGEMENTS IN A CPOM STATE

- A. Define services involved – determine specifically what is provided or advertised by the professional and the lay entity (professional v. technical)
  
- B. Compare services to licensing laws (statute, regulations, agency actions and guidance, case law)
  - 1. Professional licensing laws
    - a. What is the scope of practice of the profession?
    - b. Do services involve diagnosis, evaluation, prescribing, care or treatment?
    - c. Does lay entity perform any services within the scope of practice?
    - d. Do laws specifically preclude lay ownership or employment of professionals?
  
  - 2. Corporation laws
    - a. Is the corporate form permissible?
    - b. Is professional ownership required, in whole or in part?
    - c. Can laypersons have any type of ownership interest?
    - d. Can laypersons or nonprofessionals have officer or board of directors roles?
  
  - 3. Facility, licensing and regulatory laws
    - a. Is the office/facility subject to licensure laws?
    - b. Does licensing of institution specifically allow layperson ownership or employment of professionals, thereby making corporate practice ban inapplicable?
    - c. Are medical services provided in a non-licensed facility owned by a layperson?
  
- C. Does the lay entity "control" the professional practice by making the following decisions and determinations (consider totality of circumstances)?
  - 1. The patient's diagnosis
  - 2. Whether diagnostic tests are appropriate for patient condition
  - 3. Treatment options appropriate for and available to patient
  - 4. Ownership of patient records
  - 5. Hiring and firing of medical and ancillary personnel
  - 6. Amount of fees charged by physician
  - 7. Number of patients physicians required to see in a defined time period
  - 8. Site/office location selection
  - 9. Approval of physician equipment
  - 10. Inventory (drugs, products)
  - 11. Need for patient referrals
  - 12. Final coding for services and procedures

D. Other considerations

1. Is physician paid a salary or on the basis of gross revenue?
2. Has lay entity contracted to provide medical services?
3. Is lay entity paid for physicians' services?
4. Does lay entity advertise medical services under its name?
5. Does the lay entity bill for medical services under the lay entity's name?
6. Does the physician receive fees proportional to the services provided?
7. Is the management fee based upon a percentage of net revenues – a division of profits?

E. Do exceptions apply?

1. Academic Medical Centers
2. FQHCs
3. Community clinics
4. Charitable institutions
5. Hospital foundations
6. Publicly owned entities
7. Non-profit institutions
8. State licensed facilities and treatment centers
9. Other