Deal or No Deal? Acquisitions of Small Practices by Hospital Systems and Academic Medical Centers: Aligning Two Cultures

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In recent years, it has become increasingly common for academic medical centers and other hospital systems (hereafter, AMCs) to acquire small medical practices at sites not necessarily close to the large practice's main campus or facility.[1] If done correctly, such acquisitions can have numerous benefits to both the parties and the surrounding community. For example, such arrangements may enable the academic practice or hospital system to establish teaching or outreach sites for some of its programs, thus providing benefits of more sophisticated health care programs to smaller communities. In turn, the acquired physicians may gain the benefits of centralized management, flexibility in work schedules, improved technologies, and more stable compensation and benefit programs, among other benefits.[2] Finally, there is the lessened compliance risk afforded by employment relationships.[3]

Most practitioners and compliance professionals understand the general nature of these types of transactions, including the type of due diligence advisable and other considerations and documentation necessary prior to closing.[4] Although there may be "nothing new under the sun" in this regard, each transaction brings with it unique business and cultural issues stemming from the type of acquisition, nature and personalities (corporate or individual) of the parties to the deal as well as the location of the practice(s). If not managed appropriately on the front end, these business and cultural issues could become compliance and management problems on the back end. In other words, it is possible that parties operating separately in an entirely legal and compliant manner prior to an acquisition could face compliance issues after closing without adequate care and attention.

Although each acquisition differs as to the factual and legal considerations involved,[5] this article examines some of the perhaps less obvious but common business and cultural structures that need to be examined and managed as part of the acquisition process and suggests an approach to manage due diligence for such proposed acquisitions. It is imperative that parties manage these risks and issues early and as part of the due diligence process and continue to monitor them through closing and post-closing.

Contracting

The AMC and the small practice will likely have very different contracting processes. In the small practice, there probably will be no formal acquisition requirements; however, the AMC is likely to be either governmental or not-for-profit in nature and, as a result, may elect or be required to comply with certain legal or regulatory contracting requirements, including potentially, competitive bidding requirements.[6] The compliance or legal professional will have to determine not only which contracts of the small practice are necessary to retain and assignable but also whether any assignment process comports with the AMC's purchasing requirements and, if so, for how long.[7]

Excluded Vendors

It is also possible that the small practice is currently doing business with a company that the AMC would be prohibited from engaging. This can occur if there have been past problems between the AMC and the vendor or if the vendor has become listed on some type of excluded list due to past issues. If this is the case, the compliance review must include determination of whether it is appropriate and allowable to engage with the vendor in the proposed relationship. Initial questions would include whether the contract is actually necessary for the practice and whether waivers could or should be obtained.[8]

Valuation

To the extent that there are contracts between a physician practice and a third party that would be subject to fair market value and commercial reasonableness requirements, additional attention may be required to the contracting process.[9] For example, in the context of medical director contracts with potential referral sources, the due diligence review should not only include a review of whether the current rate can be justified as of the time of entry into the contract but also whether becoming a part of the AMC now changes that calculus. This determination will likely depend upon how the original determination was obtained, but if the physician or practice now has a different compensation arrangement or changed duties and compensation or duties were factors in determining the original fair market value, then there should be a reassessment. Certainly, the mere potential impact of the physician now being part of an AMC's staff, with its attendant professional prestige, is sufficient to justify an updated review.

Other Risks

Are there real risks associated with the above problems in the context of the new business structure? Obviously, if there now is a fair market value or commercial reasonableness issue with respect to any contract, the contract's continuing compliance with Stark[10] or the Anti-Kickback Act (AKA)[11] may be an issue; however, the compliance professional should not forget that both the AKA Personal Services and Management Contracts Safe Harbor[12] and the Stark Personal Service Arrangements Exception[13] include requirements that the contract must "not involve the counselling or promotion of a business arrangement or other activity that violates any Federal or State law."[14] If the continued arrangement would violate state procurement or ethics laws after closing, the agreement may lose regulatory protection. Thus, it is possible that continuing a contract, even

if it originally was legally compliant, can become problematic if, due to changes in circumstance, the contract now violates a state law. The prudent course of action is to reexamine all contracts in view of the structure of the acquisition.

Ethics Laws/Conflicts of Interest

The AMC also likely will have to comply with either ethics laws, conflict of interest rules, or both due to its governmental or not-for-profit status.[15] This requirement can also result in contractual relationships becoming compliance issues. For example, often one or more of the physicians may own the building in which he, she, or they practice. This is permissible in the small practice context and may constitute good tax planning;[16] however, if there are restrictions or prohibitions on contracting with employees or faculty,[17] the legality of leasing from the physician or practice could be an issue post-closing. If the AMC is not planning to purchase the building as part of the acquisition, an analysis needs to be conducted of potential risks from such a relationship. As set forth above, if the lease with an interested party is not legally allowable, there could be other compliance issues as well regarding the overall transaction.

A personal service contract that is continued or assumed as part of the acquisition with a person or company prohibited from such contracting under state ethics laws also could violate the Stark law, as described above.[18] For example, if the son or daughter of one of the key physicians in a small practice owns the billing service that performs billing services for that practice, that person would be considered to be part of the physician's immediate family[19] under the Stark rules. The continuation of the contract might be a Stark violation since it is not legal under state ethics laws to have such a contract; thus, the Stark exception would not be satisfied.[20] Moreover, since the company owner is part of the physician's immediate family, the value of the contract could be considered part of the total remuneration paid to the physician.[21] Key questions to consider as part of the analysis would be if continuing of the contract is actually necessary and whether the service charges could be justified as commercially reasonable and at fair market value.

Nepotism and Employment Restrictions

Small practices usually have no limitations upon the persons they can hire other than those included in the excluded person prohibitions. Certainly, there will be issues aligning the practice's compensation structure to that utilized by the AMC. In addition, there may be issues that arise because certain of the practice employees are on the AMC's do-not-hire list. AMCs, however, frequently also have anti-nepotism prohibitions or other conflict of interest restrictions that can be violated through the acquisition process.[22] This is so because in a small practice there will likely not be any significant hiring restrictions. Thus, hiring a spouse as a nurse or office manager may ensure both loyalty and competence. Indeed, a common situation in such small practices is for the practice to employ one or more relatives of the physician; however, if there are prohibitions or restrictions on employment of relatives of supervisory employees or faculty, the legality of continuing the employment must be reviewed.

Even assuming that anti-nepotism rules can be navigated successfully, the employment of close relatives of the physician can pose compliance risks. First, if the person to be employed is within the Stark definition of an "immediate family member,"[23] a further analysis of the relationship must be conducted examining referral patterns and total compensation paid to both the physician and the immediate family member. Could the employment of an immediate family member cause the overall compensation paid under a contract or employment arrangement to no longer be commercially reasonable or at fair market value? Although there does not seem to be

a reported case on point, employment of a relative of a physician, who was either not fully qualified or compensated at an inappropriate rate, could result in potential Stark violations.

Tax Issues

After the resulting acquisition, the practice likely will be subjected to tax rules that were not encountered in the private practice context. If the AMC is a not-for-profit entity, will any of the contractual relationships that result from or are continued as part of the acquisition, such as a lease of the practice space from one or more of the physicians, potentially result in private inurement,[24] or otherwise subject the parties to intermediate sanctions under the tax laws?[25]

If the small practice is joining a not-for-profit AMC or hospital system, an analysis needs to be conducted to determine if any of the joining physicians or management personnel will be disqualified persons[26] in the not-for-profit context. Although many types of disqualified persons are determined by position, there are some that are determined under the facts and circumstances of the situation.[27] If such a person had the ability to exercise substantial control over a key component of AMC, it is possible that the person would meet that definition and thus potentially subject transactions to intermediate sanctions. For example, if a physician that was newly hired as part of an acquisition became the head of that local practice area, with significant management authority, the definition might be satisfied. In such an event, continuing an otherwise valid and compliant lease for office space owned, in whole or in part, by that physician, could result in excise taxes and sanctions.[28]

In addition, as a for-profit practice joins a governmental or not-for-profit AMC, there should be analysis of potential activities in the small practice that could result in unrelated business income.[29] In a small practice conducted on a for-profit basis, there likely was no concern about sales of incidental items as part of the practice or selling laboratory services to third parties; however, such activities have the potential to generate unrelated business income in the not-for-profit sector. The best course of action is to, as part of due diligence, consult a qualified tax professional concerning such potential issues.

Medical Practice Issues

The small group physician also will or may have to make modifications in the manner in which its physicians conduct their day-to-day practices. This is especially true if the acquired practice will be hosting student or resident training programs.[30] The typical small practice will not have experience with medical students or residents; however, supervision and billing rules are different from anything that the practitioners likely would have encountered in the small practice. In addition, having trainees in the practice may impact productivity. The small practice needs to recognize this potential change in its practice methodology, and the AMC needs to provide suitable training to the small practice as part of the acquisition process.

The change to a more complex system of electronic health records also may require significant modifications to the practice methods of the small practice. The small practice providers need to be informed about the new system. Adequate time for both training and adjustment to the new system needs to be set aside to assure as smooth a transition as possible.

Finally, the internal quality and compliance review programs may require a change in the practice habits of the providers in the small practice. Typically, the small practice will not have a particularly formal compliance or quality review program in place; however, such programs are customary and common in AMCs and hospital systems. The small practice providers should be advised of these requirements prior to finalization of

the acquisition transaction and provided appropriate training and orientation as soon as practicable.

Deal or No Deal?

Appropriate training to acclimate providers with the new culture and due diligence focused on the type of issues identified in this article are essential to the avoidance of potential legal and compliance problems, but they may not be enough. Thus, a practical question remains: Are such issues capable of being remedied, or will they render the proposed transaction unadvisable or untenable? Ultimately, the answer will depend on a number of factors, including how important the challenged or problematic contract or relationship is to successful continuation of the small practice; the availability of waivers or exceptions to the policy; and the ability to utilize alternative methods of completing the transaction. Each situation will need to be evaluated according to its unique facts and circumstances.

For example, if the potential problem is an internal policy, such as an anti-nepotism policy, is waiver a possibility? If the proscription is statutorily based, then perhaps waiver will not cure the problem. Internal policies, especially those not based upon a statutory restriction, often can be the subject of such waivers. If the problem is based in contract, does the AMC have a related entity, not subject to such restrictions, with which the contract could be obtained? Could an employee whose continued employment poses a problem be reassigned or given a different supervisor? If the relationship is essential to maintain, there may be ways to accommodate such a continuance.

In any event, care must be taken to assure that any waiver of change of assignment does not create a compliance problem. For example, if the entity having the authority to grant the waiver never or rarely grants one, it may be difficult to justify that the waiver was appropriate. In any event, documentation of a compliant business reason for such a waiver is essential to its justification. A written determination should be made, reviewed by counsel and, if approved, retained in the contract file.

For these reasons, the first step in managing such acquisitions should always include an overview of the culture, legal and other policy requirements of the acquiring entity early on as part of the overall due diligence process. This will help identify potential issues and provide the acquiring entity an opportunity to explain the nature of and reason for any potentially problematic requirement.

After this overview is provided, to assist in decision making, an analysis should be conducted of the following factors:

1. Has a potentially problematic relationship been identified?
2. Is the potentially problematic relationship identified essential to the continued operation of the practice?
3. Are there legal or policy restrictions that preclude or limit the ability of the acquiring practice to continue the relationship?
4. Are waivers available? If so, can such waivers be justified as commercially reasonable and otherwise compliant?
5. If waivers are not available, is there an alternative means of continuing the relationship in a legally complaint manner?
6. Does the alternative means of continuing the relationship create a different set of compliance problems?

It is essential that such an analysis be conducted and these questions addressed satisfactorily before completion of the acquisition transaction, if a deal can, in fact, be made.

Conclusion

Acquisition of small practices by AMCs is becoming increasingly common and offers many advantages to the AMC, physicians being acquired, and potential patients;

however, a proposed transaction is often a joinder of two very distinct business cultures that, while being perfectly compliant in the original state, could result in compliance issues after acquisition if not managed appropriately. This is so because the new rules for the resulting organization are—and will continue to be—significantly different. This article has examined several of the potential "business cultural" risk areas parties should consider when deciding whether or not to finalize a deal. Although still presenting issues with which the due diligence team must contend, proper advance planning, analysis, and training can avoid or minimize such issues and lead to a better long-term relationship between the parties.

Endnotes

1. In fact, a 2016 study contends that hospital or health system ownership of physician practices grew by 86 percent from 2012 to 2015. *Avalere Health and PAI Physician Practice Acquisition Study: National and Regional Employment Changes* (2016). Another study shows that the number of physicians employed by hospitals has increased by 14,000 from July 2015 to January 2018. Overall, 44 percent of physicians were employed by hospitals in January 2018 compared to 25 percent in July 2012. Physicians Advocacy Institute, *Updated Physician Practice Acquisition Study: National and Regional Changes in Physician Employment 2012 -2018* (Feb. 2019), *available at* www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/021919-2016-PAI-Physician-Employment-Study_1-26-18_Final.pdf?ver=2019-02-19-162948-333.
2. Much has been written about the potentially harmful effects of consolidation among health care providers. Kathy Selker, "How Mergers And Acquisitions Are Affecting Hospital Marketing", *Forbes*, June 12, 2019, *available at* www.forbes.com/sites/forbesagencycouncil/2019/06/12/how-mergers-and-acquisitions-are-affecting-hospital-marketing/#5e86bb067eb2; Chad Terhune, "As California Hospitals Sweep Up Physician Practices, Patients See Higher Bills", *California Health Online*, Sept. 4, 2018, *available at* californiahealthline.org/news/as-california-hospitals-sweep-up-physician-practices-patients-see-higher-bills. However, if structured and managed appropriately, it is clear that AMC acquisitions may bring positive efficiencies, such as "reduc[ing] inefficient duplication of services, allow[ing] firms to combine to achieve efficient size, or facilitate[ing] investment in quality or efficiency improvements." Martin Gaynor, *Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets, Statement before the Committee on the Judiciary Subcommittee on Antitrust, Commercial, and Administrative Law U.S. House of Representatives* at 7, Mar. 7, 2019 [hereinafter, "Gaynor, *Diagnosing the Problem*"].; *see also* Pope, Thaddeus, *Point/Counterpoint: Perspectives in the Negotiation of a Hospital's Acquisition of a Physician Practice*, July 18, 2014, *available at* www.thaddeuspope.com/Images/Team-19-Memo.pdf (last accessed Aug. 26, 2019).
3. Both the Medicare and Medicaid Patient Protection Act of 1987, as amended (42 U.S.C. § 1320a-7b) ("Anti-Kickback Act" and, together with the applicable regulations, the "Anti-Kickback Law" or the "AKA"), and Section 1877 of the Social Security Act, as amended (42 U.S.C. § 1395nn) ("Stark Act" and, together with the applicable regulations, the "Stark law"), contain provisions that make bona fide employment relationships favored from a compliance perspective. As a result, employing physicians may minimize risk under the compliance laws and enable the hospital system to provide better technology and more efficient management. However, such consolidations may have other unintended consequences. *See, e.g.,* Gaynor, *Diagnosing the Problem*, *supra* note 1.
4. Kelley H. Rice, *Physician Practice Mergers: The Importance of Due Diligence and Mutual Trust for All Involved*, Aug. 8, 2018 (discussing in depth the significance of performing adequate due diligence during a merger to provide sufficient opportunity for all parties to weigh the pros and cons of a specific transaction); William B. Eck, *Physician Practice Acquisitions: Avoiding Legal Pitfalls*, April 18, 2019, *available at* www.lexisnexis.com/lexis-practice-advisor/the-journal/b/lpa/posts/physician-practice-acquisitions-avoiding-legal-pitfalls (discussing generally some of the legal and structural considerations relating to any physician practice merger).
5. *Id*.
6. According to the most recently published data, there are 6,210 hospitals in the United States, of which 5,262 are community hospitals. Of community hospitals, 2,968 are not-for-profit, and 972 are governmental. Am. Hospital Ass'n, *Fast Facts on U. S. Hospitals 2019*, *available at* www.aha.org/statistics/fast-facts-us-hospitals. Hospitals that are owned or operated by governmental entities are the most likely to have some type of purchasing law with which to contend. Purchasing and contracting requirements will vary significantly depending upon the jurisdiction. *See* Melissa Javon Copeland (Ed.), *Guide to State Procurement-A 50-State Primer on Purchasing Laws, Processes, and Procedures* (ABA Publications, 2d ed. 2016) (providing for a 50-state review of purchasing laws). In addition, local governmental hospitals may have other laws applicable to them.

7. *See id.* For example, Kentucky law requires certain governmental agencies as well as certain "affiliated corporations" to adhere to its Model Procurement Code, which provides, *inter alia*, for competitive bids to be solicited for covered purchases of $20,000 or more. Ky. Rev. Stat. Ch. 45A. However, procurement laws differ significantly from one jurisdiction to another. Many statutes exempt professions services, *see* Tenn. Code Ann. § 12-4-106 (Tennessee), or have other exemptions for health care, hospitals, or certain medical purchases, *see. e.g,* Fla. Stat. § 287.057(5) (Florida); R.C.W. § 39.26.100(4) (Washington); Va. Code § 2.2-4345(1) (Virginia); N.J. Rev. Stat. § 40A:11-5(a)(1) (New Jersey). However, even if an exemption is afforded, usually certain purchasing procedures must be followed.
8. *See infra* note 9. Commercial reasonableness is a common requirement through most health care compliance issues. Whether a waiver can be granted in a compliant manner will depend upon a number of factors, including its availability, past practices, and if there is a valid and compliant business justification.
9. The requirements that contracts between health care providers and referral sources be commercially reasonable and at fair market value are included in various Anti-Kickback Act Safe Harbors and Stark Exceptions. *See e.g.,* AKA- 42 C.F.R. § 1001.952(b)(5) & (6) (Space Rental); 42 C.F.R. § 1001.952(c)(5) & (6) (Equipment Rental); 42 C.F.R. § 1001.952(d)(5) & (7) (Personal Services and Management Contracts); Stark-42 C.F.R. § 411.357(a) (Rental of Office Space); 42 C.F.R. § 411. 357(b) (Rental of Equipment); 42 C.F.R. § 411.357(c) (Bona Fide Employment Relationships). Indeed, these requirements can be found in the description of fair market value compensation. 42 C.F.R. § 411.357(l).
10. *See id*.
11. *See id*.
12. 42 C.F.R. § 1001.952(d).
13. 42 C.F.R. § 411.357(d).
14. 42 C.F.R. § 1001.952(d)(6); 42 C.F.R. § 411.357(d)(1)(vi).
15. A significant majority of hospital systems are governmental or not-for-profit in nature. In the context of academic medical centers, this percentage is even higher. Governmental entities frequently are subject to state or local ethics laws. Each specific system must be examined for which laws may be applicable, potentially if governmental, either state or local. *See, e.g.,* Fur, I-Pang (2015) "Favoritism: Ethical Dilemmas Viewed Through Multiple Paradigms", *The H Journal of Values-Based Leadership*, Vol. 8, Issue 1, Article 6 (reviewing examples of such restrictions and citations to surveys of certain ethics laws). Not-for-profit hospital systems are more likely to have policy-based restrictions.
16. By setting up a real estate lease, the physician may, among other benefits, (1) receive revenue (cash flow) from the lease; (2) generate depreciation; and (3) own an asset that is likely to appreciate, ultimately generating capital gains income to the owner. *See* I.R.C. § 61 (gross income), 26 CFR § 1.61-8 (rents and royalties); I.R.C. § 162 (depreciation); I.R.C. § 163 (capital gains); I.R.C. § 1250 (accelerated depreciation).
17. *See supra* note 15.
18. *See supra* note 14. A contract that is illegal under state ethics law is not likely to satisfy the regulatory requirements of not otherwise violating state or federal laws.
19. 42 C.F.R. § 411.351 defines "immediate family member" broadly to mean a husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, daughter-in-law, brother-in-law, or sister-in-law, grandparent or grandchild; and spouses of a grandparent or grandchild.
20. *See supra* note 14.
21. *See* 42 C.F.R. § 411.354. The Stark definition of compensation arrangement, 42 C.F.R. § 411.354(c) includes both direct compensation (42 C.F.R. § 411.354(c)(1)) and indirect compensation (42 C.F.R. § 411.354(c)(2)). Both definitions include compensation arrangements between the physician *or* a member of the physician's immediate family. *See supra* note 19 for the definition of immediate family member.
22. Nepotism restrictions are a subset of ethics considerations that may be statutory or policy based. Like other ethics issues, statutes are more likely to be encountered in the governmental context. The National Conference of State Legislatures has a compilation of some of these laws. *See* NCSL, *50 State Table Nepotism*, Aug. 13, 2019, *available at* www.ncsl.org/research/ethics/50-state-table-nepotism-restrictions.aspx. However, local ordinances should be reviewed also.
23. The compensation would be aggregated under the definition of compensation arrangement and immediate family discussed above. Thus, in order for the hire to be compliant, it would have to pass both the fair market value and commercial reasonableness tests applicable to compensation arrangements. Thus, an improperly high rate of compensation or an unqualified employee, or both, could result in additional, and arguably excessive, compensation being attributed to the physician.
24. 26 USC § 501(c)(3); Treas. Reg § 1.501(c)(3)-1(c)(2); *see also* IRS, *Overview of Inurement/Private Benefit Issues in 501(c)3s*; 1990 EO CPE Text; *available at* www.irs.gov/pub/irs-tege/eo topicc90.
25. 26 U.S.C. § 4958(f)(1); Treas. Reg. § 53.4958-3(3).
26. While some persons, such as directors and officers, are automatically defined as disqualified person (Treas. Reg. § 53.4958-3(b); *c.f.* Treas. Reg. § 53.4958-3(a)(1), (c)), a person who is in a position to exercise substantial influence over the affairs of a tax-exempt entity may be a disqualified person regardless of title (Treas. Reg. § 53.4958-3 (c). Accordingly, service on advisory boards or councils or titles such as a program director, medical director, or practice group

lead must be analyzed to determine if a particular individual might be a "disqualified person." The ultimate decision is based upon a facts and circumstances analysis, see Treas. Reg. § 53.4958-3(e). Factors that suggest that a person may have the ability to exercise substantial influence are enumerated at Treas. Reg. § 53.4958-3(e)(2). Factors suggesting otherwise are listed at Treas. Reg. § 53.4958-3(e)(3).

27. *See generally*, Treas. Reg. § 53.4958-3(3) (listing facts and circumstances tending to show no substantial influence, such as a person taking a bona fide vow of poverty, a person serving as an independent contractor, *i.e.*, an attorney or client, to name a few).
28. 26 U.S.C. § 4958.
29. 26 U.S.C. § 512.
30. *See generally*, Teaching Physician Services, Medicare Claims Processing Manual (Publication 100-14) at Ch. 12; *see also*, CMS Medical Learning Network, *Guidelines for Teaching Physicians, Interns, and Residents*, March 2018 (ICN 006347).

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