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The Role of the Florida Board of Medicine and the *Bakarania* Decision

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VI. THE ROLE OF THE FLORIDA BOARD OF MEDICINE AND THE *BAKARANIA* DECISION

TIM RAVICH: [. . .] The next segment is entitled "The Role of the Florida Board of Medicine and the *Bakarania* decision." And [our panelists] will explain the terms in that title [. . .]. Let me introduce the panel from left to right.

We will start with **ALBERTO HERNANDEZ** seated closest to me. Mr. Hernandez is a shareholder in the Miami office of Greenberg, Traurig. Mr. Hernandez graduated from the University of Miami School of Law and focuses his practice on health care transactions, as well as corporate and regulatory matters. He represents physician practice management companies, hospitals, health maintenance organizations, outpatient treatment facilities, integrated health care delivery systems, long term health care facilities, physicians and other health care providers.

To Mr. Hernandez's left is **ROBERTO PUPO.** [. . .] Bob Pupo began his legal career with Greenberg, Traurig in 1992 [and works] in the firm's health department. His practice concentrates on corporate and regulatory matters relating to health care providers, including physician practice management companies, hospitals, HMOs, integrated delivery systems and other managed care entities. Bob has had extensive experience in the representation of publicly traded and privately held physician practice management companies. Serving as both transactional and regulatory counsel in a wide range of matters involving individual physicians, physician groups and physician networks, Bob also concentrates on the representation of hospitals including numerous not-for-profit entities, HMOs, integrated delivery systems and other managed care entities. Bob received his law degree from Harvard Law School in 1992 and a Bachelor of Science in Foreign Service from Georgetown University in 1989 graduating *magna cum laude*. In law school Bob was a member of the *Harvard Journal of Law and Public Policy* and helped prepare the 1991 supplement to *Fundamentals of Securities Regulations*. We are [delighted] to have you with us . . . thank you.

To Robert's left is **MARSHALL BURACK** a shareholder in the Miami firm at Akerman Senterfitt & Eidson. Mr. Burack [did his] undergraduate [study at] Princeton University and graduated *magna cum laude*, and then went to Harvard Law School. Mr. Burack represents physicians, ambulatory surgery centers, pharmacies, and imaging centers. He has written numerous articles and presented at numerous seminars. Mr. Burack's reputation in the legal community is such that he was among the first group of practitioners I contacted and was encouraged to contact when arranging this Symposium.

Next is **DAVID WINKER.** Dave Winker is an associate in the health law department of McDermott Will & Emery's Miami office. Dave's practice concentrates on counseling providers with third party payors and on transactional and regulatory matters in the health law field. This representation has included federal and state regulatory matters including anti-kick back and self-referral laws and federal and state reimbursement programs. He has represented clients in criminal and civil investigations and reimbursement litigation. Mr. Winker is admitted to the Florida, Georgia, and District of Columbia Bars. He received his law degree with honors from the University of Florida in 1994. I gladly turn the forum over to all of you.

DAVID WINKER: Good afternoon. My name is David Winker and I wanted to talk about the way we are going to conduct the panel today. I am going to begin by giving you a little bit of background on the fee splitting statute in the state of Florida. It's a statute that has had a great impact on structuring deals in this state. We have a very active Board of Medicine. I will speak to some of those terms. Robert [Pupo] will then talk about the *Bakarania* decision and also give us some background as to why we are even talking about *Bakarania*.[1] We know that the decision is before [Florida's] first district court of appeal, — the end of this month, actually the end of next month, the decision will be made as to whether that's upheld.[2] A lot of people are wondering whether it's still relevant. The P[hysician] P[ractice] M[anagement] ("PPM") industry has been in a bit of a retreat and is reforming itself. [. . .] — The question as to the relevance of the *Bakarania* decision to that retrenchment. Next Marshall [Burack] will speak to trying to get a kind of — get a synthesis of some board decisions, — looking at this body and how they are making decisions and they are looking for some trends in what's going on. And finally Al [Hernandez] will speak to what do we do after *Bakarania*, where do we go from here, what's going on with fee-splitting statutes, how we are structuring deals.

I think I'll start by saying I'm a health care attorney. When people ask me what that is, I begin by saying health care is one of the most regulated industries in this country. Otherwise economically or commercially reasonable activities are restricted in this industry. The idea [of] anti-kickback and self referral is foreign in most industries. If they are still listening, — I talk about kind of going on how we attempt to structure transactions within that. One of the things that recently people discovered: physicians are

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[1] In Re: The Petition for Declaratory Statement of Magan L. Bakarania, M.D., 20 FALR 395 (Fla. Bd. of Medicine 1997).

[2] Subsequent to this Symposium and during publication, such decision was, in fact, upheld. *See* Phymatrix Management Co, Inc. v. Bakarania, 24 Fla. L. Weekly, D1500 (Fla. 1st DCA June 25, 1999).

economically rational actors. Their decisions are affected by economics. The first time people actually focused on this was, actually, in Florida — looking at referral rates for, I can't remember the industry, but I think it was clinical labs — looking at utilization rates for labs that physicians owned. It was something like [physicians were] 80% more likely to refer to labs they owned than to a lab they don't own. That was the genesis of a lot of activity in this area, a lot of regulation.

Why *Bakarania* decision and fee-splitting? The reason people split fees is that a lot of these arrangements align the incentives of the parties. So at the margin, when Dave Winker makes the decision as to whether to refer the patient, — if I'm going to get a certain amount of that money it may affect my decision and it aligns my incentives to both — perhaps make that referral or engage in that conduct and in many cases reduce the cost. The PPM industry really picked up on this and I think another example of this is capitation. Where you down risk, you take risks on a pool of patients and you have every incentive at that point to efficiently deliver care and to reduce cost.

The statute in Florida is a fee splitting statute.[3] This statute is approximately 20 years old at this point. It was put into place long before PPMs came along, long before managed care was on the scene. The statute provides that . . . ". . . paying, receiving any commission, bonus, kickback, or rebate, or engaging in any split fee arrangement in any form whatsoever with a physician [. . .] either directly or indirectly for patients referred." That's the language we are dealing with. Most states have these prohibitions. They're incredibly broad. It's almost like the antitrust statute; [for] any contract is a detriment of free trade. You are restricting people's choices. The point of [. . .] concern is, — it's like a speeding law, [in that it may be or] is selectively enforced. If everyone is breaking the law, then certain enforcement decisions have to be made. That's what we are going to talk about today.

The Board of Medicine has, in my personal opinion, selectively enforced this statute. In this area, when you have uneven enforcement, I think, hand-in hand with that goes uneven reasoning. In the outline I wrote [an] articulation of reasoning in the event of enforcement is hard to find and when found, unclear. I think in a couple of the cases I'm going to go through to introduce the *Bakarania* case you will see that. What we are talking about is the Board of Medicine's ability to declare choice statements under Florida law; administrative boards can render statements to parties, who are engaging in an activity, on the legality of the arrangement. There are a number of decisions that led up to the *Bakarania* decision which essentially prohibit certain

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[3] FLA. STAT. §458.331 (1999)

percentage-based management arrangements. I'm going to go through just a couple of them.

I'm going to start with the *Lundy*[4] case. The *Lundy* case was a 1987 decision — so almost 11 years before *Bakarania* — where the Board approved an arrangement which is very similar to modern PPM arrangements. It was a turn-key management operation. Basically all the doctor had to do was show up at his office. The staff was there, the equipment was leased, the energy was on, and everything was ready to go. And it also included marketing. The quote from the final order in the *Lundy* case was that "the corporation would also provide advertising for the facility including but not necessarily limited to newspaper, radio and television advertising." The corporation then would split the fee 60% - 40% with the practice. The Board declared this was not a violation of the fee splitting statute. We went along for three years under that.

And in a case called *Zeterburg*,[5] the Board objected to a contractual arrangement that provided for a physician to split practice revenues with a management company. But in this case there is a twist. The management company was required to develop a referral network. What the management company was required to do was setup a circuit of clinics where this guy would go to each place the patients would be there; he would see them and get a percentage. The court in that case said "No, we are not comfortable with this split. The development of a referral network we believe is a split fee arrangement." Now, the difficulty and the importance of the Board of Medicine, — and I think one of the things Marshall [Burack] is going to talk to you about more, — is how there's no reasoning behind this; they basically said this [is the way it was, in] a one paragraph order.

The next case we have is *Speiller*.[6] In *Speiller* the Board considered a petition of a physician who owned a multispecialist clinic. He wanted to avoid employing physicians. He wanted to have [an] independent contractor arrangement with these physicians to come in. He would basically provide the same thing, a turn-key arrangement. The doctors would show up, see the patient and they would split the fee. Basically he would be paid a flat fee for the services he performed. The Board looked to *Lundy* and distinguished the case and said that you could not keep a portion of the fees. What's so amazing about this decision is that it goes to, I think, a kind of fundamental, — like

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[4] In Re: The Petition for Declaratory Statement of Edmond G. Lundy, M.D., 9 FALR 6289 (Fla. Bd. of Medicine 1987).

[5] In Re: The Petition for Declaratory Statement of Joseph M. Zeterberg, M.D., 12 FALR 1035 (Fla. Bd. of Medicine 1990).

[6] In Re: The Petition for Declaratory Statement of Paul B. Speiller, M.D., P.A. d/b/a Multi Specialists of Deerfield, 14 FALR 3942 (Fla. Bd. of Medicine 1992).

those of us that work in a law firm; we are employees, obviously, but if you're an independent contractor the incentives of [my engaging] you at a certain cost and [taking] care of everything else [so that you just] do this service, — many people did not think this was a split fee service.

Finally, leading up to Robert's talk I want talk about the corporate practice of medicine in Florida. Florida is a state that does not prohibit the employment of physicians. And that is firmly established under Florida law. The Board does regulate the way that you can compensate a physician pretty closely. What type of incentive package you can give, etc. But they do allow the corporate practice of medicine and with that I'm going to turn it over to Robert to talk about the *Bakarania* decision.

ROBERTO R. PUPO: Thanks. Some of the cases David [Winker] mentioned created a regulatory setting in Florida. Those cases and other decisions by the Board of Medicine created a regulatory setting where percentage fee arrangements were commonplace and although no practitioner would tell his client that a percentage fee arrangement was entirely without risk, they were common industry practice in the state of Florida. This could change and has been affective in the interim while the *Bakarania* decision is still out there and could change permanently depending on what happens when the oral arguments are decided on the *Bakarania* matter.

The decision came about upon the filing of a petition for declaratory statement by Megan Bakarania. The doctor sought a determination from the Board of Medicine on the bases of his stated intent to join a medical group practice in Tampa, Florida. That practice was being managed by a Physician Practice Management company (a "PPM") — actually it was the Phymatrix Management Company — that was the manager for that practice. As stated in the petition, the doctor sought the determination because he was going to be part of the practice and was asked to join this agreement. The agreement was rather typical in the industry in terms of offering comprehensive management services to the practice. The services included office equipment, included personnel, included a series of other office management services including billing and collection services. More importantly, for purposes of the Board decision, the contract included a series of contracting services, which included among that category the establishment of relationships with managed care entities with provider networks. This was contained in this agreement; it is the type of provision that is commonplace. It's more than just commonplace — it was part of the selling point or part of the attraction that these type of arrangements have with doctors.

With the wave of managed care, and I think in talking to panel members, — and I think we all agree, — that managed care is really the most important health care issue that we're tackling now in the health care industry. In order

to remain competitive in this new wave of managed care, doctors felt that, many of them anyway, — that joined these types of arrangements felt that they needed professional help. And this is the type of assistance, not just establishing the contract, evaluating them and negotiating these contracts that doctors have sought and it's been, like I said, one of the principle reasons why doctors joined into these types of arrangements. Now, in return for these services that are being provided, this agreement in particular included three forms of compensation, or three types of fees that were being paid. The first fee was the basic pass-through fee where cost of the manager would be reimbursed. The second fee was a general fee, it was a flat fee, in this particular case it was $450,000 a year that the practice would pay. Finally, and what caught the Board's attention was the performance fee which was a 30% fee based on net income, on an historical net income of the practice once the practice net income reached a certain threshold — this fee would kick in.

On the bases of these facts, combining the level of comprehensive services and the fees, the Board determined that the arrangement violated the fee splitting statute. It did so on two separate bases. The first, the Board declared that the net income percentage fee violated the statute because it did not reflect the cost of services being provided. In this ruling, the Board relied on the prior Board decision in the *Green Clinic*[7]. I will talk about the applicability of the *Green Clinic* in a few seconds. The second bases for the decision was that the percentage fee arrangement combined with services that would enhance the practice also resulted in a fee split. In this regard the Board determined that the activities of the practice management company in obtaining managed care, contracts for the practice could result in the practice compensating the management company for these referrals that are being brought in to the practice pursuant to the managed care agreements.

Now, I think it was the second prong of the decision that has caught everyone's attention and why this has been such a controversial determination in Florida. The reason for that is twofold. I think that the Board in so ruling redefined what the concept of "referral" for purposes of the fee splitting statute, that's number one. The second is that determination doesn't seem to fit in within Florida's corporate practice determination. In other words, the application of the corporate practice of medicine, here, doesn't seem to be consistent with the Board determination.

First, with the particular concept of referral, traditionally the Board had held that there needed to be a close nexus between the making of the referral and the payment for the making of that referral. There had been a case,

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[7] In Re: The Petition for Declaratory Statement of Gary R. Johnson and the Green Clinic, 14 FALR 3935 (Fla. Bd. of Medicine 1992).

Practice Management Associates, Inc. v. Orman,[8] out of [Florida's] second district court of appeals that basically adopted this traditional definition of referrals. This definition was subsequently also adopted by the Board. In one of the more recent decisions this definition was adopted in the Board determination in [*In Re: The Petition for Declaratory Statement of George G.*] *Levy*[, *M.D.*].[9] And this determination again, established a close nexus. The decision in *Orman* provided two examples. One of those examples is a fee earned by a specialist — was being divided with the referring physician that sent the patient over to the specialist. Another example provided in *Orman* was that the doctor that treated the patient and received a fee from the patient or through the patient's insurer, which split the fee with the sender of that patient with whoever sent that patient to the doctor.

Again the new concept the Board introduced here was that there was no such nexus between the practice in the *Bakarania* case and the manager. The manager's activities simply resulted in additional contracts, managed care contracts, or could result in additional contracts for the practice. The management company had no control over the patient, over the third party that might have assigned the patient to the practice — certainly had no control over what doctor the patient selected. Still, despite this factual background the Board ruled that there was sufficient nexus for the establishment of this relationship to constitute a referral and a fee split for that patient being sent to that practice. Now what the impact to this is, with respect to managed care, is the Board delving into the managed care arena. The eventual impact at this point and time is rather uncertain and is certainly open to discussion and I'm sure will be addressed depending on what happens with the *Bakarania* decision. What the most immediate impact is, is that it's probably going to restrict the ability of the physician to establish these types of relationships or, at least obtain, the assistance of a third party manager in connection with establishment of these relationships.

Now with respect to the corporate practice — the impact that the decision has had, as David [Winker] mentioned, in Florida, — it is well established a non-physician can employ other physicians and basically run [. . .] business on that bases. In that regard anyone sitting in this panel — a non-doctor can go out and hire a doctor [and] make money, make a profit derived by the fees generated by that doctor. It would be perfectly legal in this state. It's legal in other states but that's not the law here. This is something that has caught everyone's attention because the structure in that scenario is not substantially different from the structure that was created and had been so often created in

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[8] Practice Management Associates, Inc. v. Orman, 614 So.2d 1135 (Fla. 2d DCA 1993).

[9] In Re: The Petition for Declaratory Statement of George G. Levy, M.D., Unpublished Final Order, 97-0495 (Fla. Bd. of Medicine 1997).

the state of Florida in connection with these practice management arrangements. So, . . . since there is a certain importance given to the form and not as much as the substance of these relationships, the interesting question that this raises, and it's a question that right now there's no answer to is whether this decision indicates that the Board might embark on a new direction with the respect to the corporate practice of medicine and whether it's going to look closely at arrangements that seem to resemble the employment of doctors by non-physicians and challenge those arrangements.

Now as I said previously the other prong of the *Bakarania* decision relied on the *Green Clinic*. And among the reasons why the *Bakarania* decision established new law in Florida, at least that would certainly be the opinion of many observers of the Board of Medicine decisions, is that the *Green Clinic*, in most people's eyes, was the typical fee split case. There, you had a cardiologist that was providing service to various patients. Those patients were being referred to the cardiologist by other primary care doctors that were members of the Green Clinic. In return for these referrals the cardiologist agreed to pay a certain percentage over to the Green Clinic. In this situation, unlike the situation in the *Bakarania* case there was a very direct nexus between the referral and the payment for that referral — again one of the several reasons why *Bakarania* has been so controversial in the state.

With that, I'll end my portion of the presentation, — only to say we will be keenly attuned to what [Florida's] first district court of appeal have to say about *Bakarania*.

MARSHALL BURACK: What I would like to do in the few minutes allotted to me is try to put the *Bakarania* decision into an economic and political context and also talk about the Board of Medicine's decision-making process and how some of these decisions come to be made. In the next panel, you'll be hearing a little bit more about the physician practice management industry as a whole. And I'm sure they'll be telling you about some of the problems that that industry is experiencing. But in 1997, when the *Bakarania* decision was handed down, the practice management industry was in much better shape than it is in today. Publicly-held PPM companies were favorites of Wall Street. Their stocks enjoyed high multiples. The companies were growing quickly. They were acquiring practices quickly. Physicians looked to PPM companies to help them in their struggle against the managed care companies and the physicians were in many cases happy to sell their practices and take the cash and the potentially valuable securities that were offered by the PPM companies. Then comes the *Bakarania* decision in Florida declaring illegal certain of these physician practice management contracts, and it really threw a speed bump into the highway of PPM growth.

But the *Bakarania* decision was more than just an impediment to the PPM industry. I see the Board's decision in *Bakarania* as a good example of the tension that exists between the development of new and inventive ways to structure the delivery of health care services in a very rapidly changing health care industry, that's on the one hand. And then, on the other hand, you have the old way of doing things with certain established prohibitions, including the prohibition against fee splitting, which we have heard about. *Bakarania* was one of just several recent decisions made by the Board of Medicine which exemplify this tension. And before discussing just two of those other decisions I want to give you a little background on the Board of Medicine, which will help you understand how these decisions are made.

The Board of Medicine is one of several regulatory boards that are now within the Department of Health. The Board of Medicine obviously is responsible for regulating the practice of medicine. It consists of fifteen members, twelve of whom must be licensed physicians. This is important. This is a physician board. The members of the Board are appointed by the Governor. As you might imagine, most of [the] physicians who are appointed to this board by the Governor are probably older, they are prominent, they're probably very successful, and they probably have been successful under the old way medicine was practiced, because medicine is changing very rapidly and these physicians are probably more conservative than younger physicians. One of the principal functions of the Board of Medicine, we heard about earlier, is to review complaints regarding malpractice.[10] They also make determinations with regard to other violations of [Florida's] Medical Practice Act.[11] And as a physician board, it is probably reasonably-well qualified to interpret and enforce the statutes and rules that relate to the clinical practice of medicine. But the Board of Medicine really has a much broader jurisdiction. It also interprets statutes and rules that relate to the *business* of medicine. And as the business of medicine has changed very rapidly, this aspect of the Board's function has taken on increasing importance. As a board of physicians — a board of physicians that are used to more traditional ways of practicing — I question whether the Board of Medicine is really the most appropriate entity to deal with the broader economic questions that come up under the Medical Practice Act. Because they are not now deciding whether a particular physician has committed malpractice in a particular case, they are deciding on the future of an entire industry in the *Bakarania* case, — the PPM industry. They are deciding on the future of managed care in this state which is the most important medical issue or health care issue facing society. Should

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[10] *See* Section IV, Regulation of Health Care Professionals in Florida, *supra* p. 427.

[11] FLA. STAT. §358, et. seq. (1999).

we have a board of fifteen people, twelve of whom are physicians appointed by the Governor, deciding these issues which are probably more appropriately decided either by legislature or by a court, which is going to take much broader issues into consideration? So that's the court, if you will, that decided the *Bakarania* case.

I just want to mention two other orders that were issued by the Board of Medicine right about the same time [the] *Bakarania* case was issued to show that there are a number of other nontraditional economic arrangements which the Board has considered. And in almost every case, they find those nontraditional arrangements to be in violation of the fee splitting prohibitions. And I think they go pretty far out of their way to find those arrangements are violations (of the fee splitting prohibition) or else they find them in violation without a whole lot of reasoning. One case is a case called *In: The Petition for Declaratory Statement of Jeffrey Fernyhough, M.D.*[12] that was decided by the Board the same day *Bakarania* decision came down. In this particular case, a physician, Dr. Fernyhough, wanted to lease counter space in his office to a mail order pharmacy. The pharmacy would put in a computer terminal on the doctor's desk so that the patients, before leaving the office, could order their prescription drugs and have them delivered mail-order the next day. They wouldn't *have to*, they could go to their pharmacy, but that was an option, that was a convenience to the patient. And it just wasn't just a dumb ordering terminal on the desk, it was a computer terminal and supposedly rather sophisticated software, which would assist the physician in determining whether prescribed medication was appropriate, — determine whether the medication might cause adverse effects in conjunction with other medicines that the patient was taking. Presumably this was to increase patient convenience. The pharmacy said that it would pay rent to the physician for the counter space it would be occupying. The pharmacy company would reimburse the doctor for administrative services, which would be performed by the physician's staff in inputting data into the computer terminal. The Board refused to accept the physician's assertion that a fair market value rent for the counter space could even be determined. In a very short opinion, the Board would simply ruled that this arrangement was [a] way for the pharmacy company to pay the physician for his referrals of patients for pharmaceuticals.

The other case I want to mention, decided in the same year as *Bakarania*, was an order issued by the Board *In re: George Levy, MD.*[13] This was another refusal by the Board to accept what I would say is a nontraditional relationship between physicians. Dr. Levy referred his patients, from time to time, for

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[12] 20 FALR 4381 (Fla. Bd. of Medicine 1997).

[13] *See supra* note 7.

MRI scans. Generally, if a patient of a physician needs an MRI, the physician refers the patient to an MRI facility or to a hospital. The patient is scanned at the MRI machine. The radiologist associated with that facility would read and interpret the film and will issue his report to the referring physician. Well, Dr. Levy wanted to provide more expedited service to his patients. He wanted to hire a radiologist as a part time employee of his practice. So he would send his patients to an MRI facility and the films would come back to the practice, and his part time employee-radiologist would read the film and give an interpretation. The MRI facility would bill for the technical component only of the service and Dr. Levy's practice would bill for the professional component. And Levy proposed to pay his employee radiologist on a fee-per-read basis. And naturally, since he is in business to make a profit, as well as to serve his patients, the amount he was going to pay his radiologist-employee was less than the amount he was going to bill for the professional services. That's why people are in business — to take in more revue than expenses. Well, the Board ruled Levy's retention of any portion of the professional fee billed by his employee was fee splitting in violation of the statute. And in this particular case, the Board seems to ignore the employer-employee relationship, in effect, ruling that a referral from an employer to an employee of a patient is going to be looked at just as any other referral between two separate entities. And if there is any compensation going to the party who is making the referrals, in this case, the spread that is being retained by Levy for referring a patient to his employee — that's illegal fee splitting in connection with the referral.

To me, another example of how the Board is stretching the definition of referral as they did in *Bakarania* and as Robert [Pupo] alluded to, — to come to a conclusion that these new and innovative ways of structuring the delivery of health care services are illegal. And although *Bakarania* is probably the most important of the recent decisions dealing with economic issues, it's really only one of several which I think apply the fee splitting statute overbroadly and are impeding innovation between participants in the health care industry. [. . .]

ALBERTO HERNANDEZ: [. . .] I'm going to briefly talk about what will be the long-term and short-term implications of *Bakarania*. For purpose of my discussion I am going to assume that *Bakarania* will be upheld in some fashion by [Florida's] first [district court of appeal] . . .[14]

Bakarania probably [has] two different interpretations. The broadest interpretation of *Bakarania* will be that all percentage arrangements between

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[14] *See supra* note 2.

a PPMC (a physician practice management company) and physician group will be seen as a fee split and therefore subject the physician to discipline. I think that holding will be unlikely. I think the most likely holding under *Bakarania* that the first district court of appeal may find is that percentage arrangements where the PPMC provides practice enhancement activities such as Robert [Pupo] mentioned, — creation of networks, bringing managed care contracts, bringing ancillaries into the practices, — those type of activities will be —and a percentage arrangement will be found to be a fee split [. . .] thereby subjecting the physician to possible disciplinary action. Having said that, — assuming that's the holding, what are the short term implications of *Bakarania*? Well, the first one and the obvious one is that the physician and the PPMC, those want[ing] to stay in the deal are going to come to the table and try to renegotiate their agreement so they can comply with what may become Florida law. And although not an easy fix I think there are certain arrangements that will be able to be entered into by these parties to preserve the economic viability of the agreement while at the same time maintaining the relationship. For example, and I will talk a little on this in just a moment, . . . the state of New York has a flat out bar [against] percentage arrangements between physicians and PPMCs. However the other short-term implication, which is probably not as widespread but it's getting all the publicity and all the notoriety in the industry, is the tool by which physicians may use *Bakarania* to get out of their existing agreements. By having that agreement declared void, — I mean that's a big topic and there is a lot of debate going on in the industry about that.

In fact, I think, to a certain degree, we are already feeling the effects of *Bakarania* on that front. For example, just recently an opthamologist in Pasco County has filed suit against his physician resource group, PRG to get out of his contract with PRG, alleging that their arrangement, as in *Bakarania*, is against Florida policy and results in the fee split and therefore the opthamologist is saying, "It's going to subject me to penalties under Florida law" And it's just not Florida. In North Carolina, for example, MedPartners is fighting various law suits at various fronts by the physicians who are unhappy with MedPartners. The arguments being used by the physicians in North Carolina are similar to *Bakarania* — that the percentage arrangements result in fee split under North Carolina law. But also since North Carolina, unlike Florida, prohibits the corporate practice of medicine, physicians there are arguing that MedPartners, in its arrangement with its physician, is engaging in the corporate practice of medicine, — which is somewhat interesting . . . I can see that argument — the fee split argument is a little easier to understand when you've got a [. . .] bar on the practice of medicine, which is heavily regulated.

The other argument, which I think is an interesting one, — I'm not sure how good it is — an argument that one of the physician groups has raised against MedPartners North Carolina [is] that MedPartners, by virtue of announcing that it is getting out of the physician practice management industry, [has by] that statement anticipatorily breached its agreement with the physician group as they've taken the position that MedPartners can't perform its obligations under the existing agreement if it's getting out of the business.

As I mentioned before, there are certain alternatives to a percentage arrangement that might be available to restructure some of these deals. However, percentage range, in my view, is the best way because it aligns the incentives of the physician with PPMC, but there are certain things you can do to fix an existing arrangement. One, which is the easiest fix, but not viable at all, is just have the practice enhancement activities provided by the PPMC cease. So if you're not providing practice enhancement activities, it's hard to argue fee split under Florida law, given what I expect will be the *Bakarania* holding. However, one of the main reasons physicians come to a PPMC is exactly for those practice enhancement activities, — managed care contracts, formation of networks, and ancillaries, and the like. So with that, together with access to capital, — so I don't think when the physicians come to the table they're going to be saying, "Don't provide the practice enhancement activities, just take your fee." The other alternative structure that's been discussed among some [. . .] — we were discussing it the other day at lunch — is restructuring the deal so that the practice enhancement activities are provided for a flat fee and have the other array of services provided to a percentage fee. On further reflection, I'm not sure that'll work, although [Dr.] Eddie Dauer [of] the [Florida] Board of Medicine has expressed previously that he might see that flying, but I think if the Board of Medicine finally sits down and thinks about it, it probably won't. The reason I feel it may not is because, notwithstanding that a physician group is compensating a PPMC on a flat fee-for-practice enhancement activities, — if the PPMC is receiving a percentage arrangement on the other end, who's to say that it was not the practice enhancement activities that were reimbursed in the flat fee resulted in the increase revenues on the other side? So, long story short, the PPMC will probably still share in the increased revenues of the practice notwithstanding that practice enhancement activities have been paid on a flat fee. Again, so the easiest fix is the flat fee arrangement, whereby the PPMC is paid X dollars for the life of the agreement and that no percentage arrangements. Again that is done in some states.

In New York flat fee is pretty common there. There [are] some deviations from the flat fee arrangement in New York, but by and large it's flat fee. The problem with that is two-fold. First of all, businessmen on the PPMC side have a really hard time in establishing a flat fee, — coming up with the true

value of their management services on a fixed basis, particularly given the long-term relationships that these PPMCs entered into with the physician groups. Some of theses relationships are as much as, or are as long as, rather, forty years. Obviously we can see a businessman's concern saying, "I'm going to establish my fee today which has to say the same within the forty years." They are going to struggle with that. Again, there are ways to deal with that. Like in New York, for example, sometimes what you'll do is you'll establish a flat fee; and you reconcile that fee on an annual basis taking into account the services that were provided by the PPMC, the growth of the practice, the growth of the locations, the number of physicians, and then all those factors are taken into account when you establish the fee for the following year. The problem with that is that as a PPMC you're at the beck-and-call of the physician to agreeing for a new fee for the upcoming year. They may never agree to that. The biggest problem with the, — and this problem is a problem for both parties — is that a flat fee does not align the economic incentives of the party — meaning that, if I'm a practice management company and I'm getting paid $100,000 a year for providing services, what's my incentive to grow the revenue of that practice, if I grow it by 15%, 20%? I'm still going to be paid the same fee regardless of what I've done as a manager of the practice. But, on the other side of the coin is that there's also — the PPMC is not going to really worry too much about lowering expenses of the practice, again because it's not sharing in any savings, because its being paid a flat fee. Again, the economic incentives of the parties are not aligned . . .

. . . [T]here's also one other type of fee that can be used, that's been discussed among health care practitioners is, for example, — this is also allowed in New York, is to base your fee on a percentage of the operating costs of the practice. But what I mean by that is if, for example, [you] establish your fee at 8 to 10 or whatever number, 8 to 10% of the operating cost of the practice, — but in New York, for example, that's been allowed because allowing the PPMC to base its value of its service on the expenses and not the revenues or profits of the physician practice has passed muster because, again there is not a sharing of the fees between the PPMC and the physician; — harder if you step back and look at that arrangement, if you're a physician you're going to say, "Wait a minute, I don't want to compensate a PPMC as a percentage of my operating costs because what's their incentive to lower my cost? If they lower my cost, they lower their fees." So again, the incentives here are not aligned. The PPMCs [are going to] want to increase [the] cost of the physician practice so it can increase its fee. Not a real viable option.

I just want to address this. What are long-term implications of *Bakarania*? And here I don't want to talk too much, because I'm sure that's

going to be spoken by Jay [Martus] and Jeff [Cohen] [and Marc Auerbach] in the next panel.[15] I don't want to get too much into that, but, one thing that's been asked of me "Is the PPMC industry gone, is it done?" And my opinion is absolutely not. I think it's going through some changes. I think some PPMCs, such as Phymatrix and MedPartners have announced that they're leaving the industry, but again I think some PPMCs are still thriving. Some of the single specialties such as Ameripath and Pediatrics are still pretty active in the acquisition market and we still have pretty active growth patterns. . . . [G]iven the amount of investment that's in the market place by these PPMCs, it's not going anywhere. It might reconfigure and become a different type of animal but it's not going away. Now again, the business models might change. There might be some PPMC's going to more creation of networks, which are less capital intensive, and managing the risk contracts and not investing heavily in physician practices. Because again it's not as capital intensive. But ultimately I think the PPMC industry it's going to be here and it's here to stay. Again it might reconfigure somewhat.

If nothing else, it's my opinion that *Bakarania* probably points to the need, — and this is what Marshall [Burack] was touching upon, — the need for legislative changes. The biggest problem we have here is that PPMCs are relatively new animals into the health care market. The PPMCs, together with managed care, have created relationships that are complex — relationships that are now created by and among PPMCs, physicians, managed care organizations, and hospitals are complex and I'm sure were not envisioned or even considered when the current legislative regulatory structure was formulated. Again, this goes back, — we're applying traditional fee split statutes to situations which have changed and are dynamic. And so I believe the end result will be that there will be legislative changes, there are going to have to be, that will address some of the unique relations that have be created, while preserving the economic viability of the parties who are involved in the health care delivery system. [. . .].

(*From the Audience*): Mr. Hernandez, as you started to touch on it, — are there any organized medicine or in the legal community anything starting to come together to get these legislative things put through or proposed at this point that you've heard?

ALBERTO HERNANDEZ: I personally was involved initially, — about a year ago, in having legislative change enacted to address the *Bakarania* case and that, at end of the day, the parties that I was involved decided not to go

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[15] *See* Section VII, Physician Practice Management, *infra* p. 466.

forward. But, I don't know of any trade associations or the like that have been actively involved in.

(*From the Audience*): . . . only the Florida Medical Association?

ALBERTO HERNANDEZ: Not to my knowledge. Not to my knowledge — which is interesting and you wonder why.

TIM RAVICH: Thank you.

(*Applause*).