

**Health Law Section, The Florida Bar
Ad Hoc Legislation Committee
Final Report**

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Purpose of this Final Report:

Following is the "Final Report" of the Ad Hoc Legislation Committee ("Committee")¹ with respect to the review of the *Florida Patient Self-Referral Act of 1992 (Fla. Stat §456.053)*, *Patient Brokering Act (Fla. Stat §817.505)*, *Anti-Kickback (Fla. Stat §456.054)* and *Fee-Splitting (Fla. Stat §458.331)* laws.

The preliminary draft of this Report was posted on the Health Law Section website for members to provide specific comments by e-mail to The Florida Bar.

Purpose of Committee

To review the Florida Patient Self-Referral Act of 1992 (Fla. Stat §456.053), Patient Brokering Act (Fla. Stat §817.505), Anti-Kickback (Fla. Stat §456.054) and Fee-Splitting (Fla. Stat §458.331) laws and recommend to the Executive Council of the Health Law Section of The Florida Bar whether or not these laws should be made to conform to the federal Fraud and Abuse Act (§1128B of the Social Security Act; 42 U.S.C. 1320a-7(b)) and Stark Law (42 U.S.C. §1395nn) through amendment, or repeal and adoption of federal laws, enforcement, regulations and interpretation, or whether a "safe harbor" with respect to the Florida laws for actions which do not violate the federal laws should be enacted.

Since the intent of the Legislature is to protect the people of Florida from unnecessary and costly health care expenditures, this Committee considered whether having separate Florida laws has achieved this goal by prohibiting patient referrals between health care providers and entities providing health care services. This Committee considered whether the cost of enforcing these laws has actually added to health care expenditures rather than reduced them. The Committee considered whether the Federal laws fulfill the Florida Legislative intentions, thereby making the Florida Laws unnecessary.

¹ The Committee was created by the Executive Council of the Health Law Section of The Florida Bar, at its Mid-Year Meeting held on January 10, 2002, in Miami. Stephen G. Prom, Esq., was appointed to Chair the Committee. Elizabeth D. Shaw, Esq. was appointed to serve as Secretary to the Committee. Appointed Members of the Committee are: Stephen G. Prom, Esq., (Chair), Elizabeth D. Shaw, Esq., (Secretary), Allen R. Grossman, Esq., Jennifer L. Hammond, Esq., George F. Indest, III, Esq., Troy A. Kishbaugh, Esq., Valerie G. Larcombe, Esq., Nanette O'Donnell, Esq., Nancy A. Schlichting, Esq., Stephen H. Siegel, Esq., Gary J. Walker, Esq., and Augustine S. Weekley, Jr., M.D., Esq. Comments on the draft report were also specifically solicited from approximately fifty (50) health care attorneys who are recognized statewide for their knowledge of and experience with the subject matter.

Laws (Text)

Text of the Laws is attached hereto as Appendix A.

Laws (Summaries)

A Summary of the Laws is attached hereto as Appendix B.

Summary of Findings

1. The Summaries set forth in Appendix B are incorporated by reference.
2. The Anti-Kickback Law applies to all Florida health care providers and any provider of health care services. Enforcement is left to the various Boards which govern the respective providers. Some, but not all, of the statutes which govern the various Florida health care professions provide for disciplinary action for similar but not identically described conduct. [See e.g., Fla. Stat. §458.331(1)(i) (M.D.'s); 465.185 (pharmacy); 459.013(3)(c) (osteopaths); 395.0185 (hospitals)].
3. Per review of Board of Medicine index of disciplinary actions, few (if any) physicians have been disciplined directly for violation of Florida laws prohibiting patient self-referral/anti-kickback so that the cost of enforcing these laws is minimal compared to the costs incurred by health care professionals to obtain legal advice as to relationships and activities.
4. Prosecutions by Florida enforcing agencies for violations of self-referral and anti-kickback laws have been "indirect". The prosecution has been for the conviction of a "crime related to the practice of medicine" after conviction for violation of the federal laws.
5. According to informal discussions with representatives of applicable agencies, these laws are not enforced because few, if any, on the enforcement side fully understands them.
6. The Florida Patient Self-Referral Act is roughly analogous to Stark as reflected in the following comparison table.

DESIGNATED HEALTH SERVICE	STARK	FLORIDA PATIENT SELF-REFERRAL
Clinical Lab Services	X	X
Physical Therapy Services	X	X
Occupational Therapy Services	X	X
Radiology Services	X	X
Radiation Therapy Services	X	X

DME	X	
Parenteral and Enteral Nutrients, Equipment and Supplies	X	
Prosthetics, Orthotics, and Prosthetic Devices and Supplies	X	
Home Health Services	X	
Outpatient Prescription Drugs	X	
Inpatient and Outpatient Services	X	

7. Florida Fee-Splitting, Florida Anti-Kickback and Florida Patient Brokering laws are roughly analogous to the Federal Fraud and Abuse Act.

a) Florida Fee-Splitting:

i) Paying or receiving any commission, bonus, kickback, or rebate; or

ii) Engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies.

b) Florida Anti-Kickback: It is unlawful for:

i) any health care provider or any provider of health care services to offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients.

ii) violations of this section shall be considered patient brokering and shall be punishable as provided in s. 817.505 (Patient Brokering Act).

c) Florida Patient Brokering: It is unlawful to:

i) offer or pay, solicit or receive, a commission, bonus rebate, kickback, or bribe, directly or indirectly, in cash or kind, or engage in any split-fee arrangement to induce referrals.

ii) aid, abet, advise or otherwise participate in the above prohibited conduct.

8. Florida Fee-Splitting, Florida Anti-Kickback and Florida Patient Brokering laws apply to conduct with respect to health care services or items regardless of payor source.

9. Federal Fraud and Abuse² and Stark laws apply only to health care services or items funded by the federal government (For example, Medicare/Medicaid, Champus, etc.).
10. Although roughly analogous, the Federal and State schemes are in numerous instances inconsistent.
11. The AMA Code of Ethics makes little distinction between fee-splitting between physicians, labs or pharmacies.
12. Consideration should be given to harmonizing the State and Federal laws either through regulations, legislation, and/or Declaratory Statements of the various Boards.
13. The statutory scheme of anti-kickback and various fee splitting laws is inconsistent and confusing. Consideration should be given to consolidating the anti-kickback and fee splitting laws into one law that applies to all of the various health care professionals with uniform enforcement.
14. Consideration should be given to providing for a civil sanction in addition to, or as an alternative to the criminal sanctions provided for under Section 456.054(3) (providing for the criminal sanctions set forth under the Patient Brokering Act).
15. The Declaratory Statement process has been inconsistent between boards, resulting, in part, because the Boards may be trying to review matters of law, rather than questions of professional conduct. Consideration should be given to appointing one Board, made up of professionals and laypersons to issue regulations and declaratory statements regarding anti-kickback and fee splitting matters.

Analysis for Legislative Change

Florida's Anti-Kickback Law

Florida's Anti-Kickback Law (Fla. Stat. §456.054) is overbroad. The statute has not been refined by legislation, regulation, attorney general opinion or the Courts, since its original enactment. Conduct which was the object of its original legislative intent has since been addressed by Florida's Patient Brokering law and, in large part, by increased enforcement of Federal Anti-Kickback law, which, although limited in scope to conduct involving health care services or items which are funded by the federal government³, provides much more guidance to providers, third party payors, enforcement agencies and their counsel by means of the statutory language, regulations, rules, advisory opinions, agency position statements. Similar to the limiting proviso contained in the

² In 1996, the Health Insurance Portability and Accountability Act ("HIPAA") broadened the scope of the Fraud and Abuse Law to include prohibited conduct related to all health care services or items, however, funded, See 18 USC S. 1347, but enforcement efforts or guidance have not been forthcoming.

³ But see, footnote 1, supra.

Patient Brokering Law⁴, a "safe harbor" would be a rational alternative to repeal, and could either be limited to conduct involving health care services or items which are covered thereby, or expanded to apply to any health care services or items, regardless of funding source. Accordingly, three (3) alternatives obtain:

1. Repeal
2. Amendment to include either one of the following "new" "safe harbors", to be included as subsection (4):

Alternative #1

Practices not prohibited by 42 USC s. 1320a-7b(b), or regulations promulgated thereunder shall not be deemed an unlawful "kick back" for purposes hereof.

Alternative #2

Practices which are not or would not be prohibited by 42 USC s. 1320a-7b(b), or regulations promulgated thereunder if funded by the federal government, shall not be deemed an unlawful "kickback".

Discussion

Repeal of the Anti-Kickback Law, alone, would not remedy the problem(s), since some, but not all, of the statutes governing the various healthcare professions provide that conduct prohibited by language similar to the Anti-Kickback Law as grounds for disciplinary action⁵. Since violation of the Anti-Kickback Law could, by applicable Board Regulation, be grounds for provider disciplinary action, even if not specifically provided by in the statute creating the governing Board, repeal of the Anti-Kickback Law would: (1) arguably, deprive those Boards of the sanction; and (2) not remedy the problems inherent to the language used in the statutes specifically applicable to the various Boards. The more useful approach, then would appear to be to amend the Anti-Kickback Law as provided in Alternative 1 or 2, and similarly amend the specific Board Statute's specified grounds for disciplinary action. The difference between Alternatives 1 and 2 lie in the limitation (Alt. #1) or non-limitation (Alt. #2) of the funding source. That is, under Alt. #1, the "safe harbor" would only be available with respect to conduct related health care services or items funded by federal governmental sources, whereas under Alt. #2, the "safe harbor" would be available with respect to conduct related to health care services or items regardless of funding source. In any event, some

⁴ Section 817.505(3)(2) provides, "This Section shall not apply to...Any discount, payment, waiver of payment, or payment practice not prohibited by 42 USC S. 1320a7b(b), or regulating promulgated thereunder."

⁵ See "Finding" #2.

actions which can erode the public trust in the medical professions, regardless of whether they result in an actual increase in health care costs, may be better addressed with civil sanctions. Consideration should be given to providing for a civil sanction in addition to, or as an alternative to the criminal sanctions provided under Section 456.054(3) (providing for the criminal sanctions set forth under the Patient Brokering Act).

Florida's Patient Brokering Act

Enacted in 1992, the Patient Brokering Act is better written than the Anti-Kickback Law, and better describes the conduct unlawful thereunder. Notwithstanding the foregoing, the Patient Brokering Act is largely duplicative of the federal Anti-Kickback law to the extent that the subject health care items or services are federally funded. Accordingly, to eliminate or reduce costs of duplication of compliance, analysis and/or enforcement efforts, three (3) legislative alternatives obtain:

1. Repeal.
2. Amend Section 817.505(3)(a) to read as follows:

This Section shall not apply to:

- (a) Any discount, payment, waiver of payment, or payment practice which is not or would not be prohibited by 42 USC s.1320(a)-7b(b), if payment for such health care services or items were funded by the federal government.
3. The legislature could amend Section 817.505(3)(a) to clarify the state's position *whether* the Act is intended to supplement or parallel federal laws.
4. Regulation(s) could be adopted clarifying the state's position as to section(3) above.

Discussion

Repeal, alone, would result in a lack of State sanction authority for both: (1) the Anti-Kickback Law (which provides that violation thereof is enforceable as a violation of the Patient Brokering Law); and (2) conduct which is outside the scope of the Patient Self Referral Act but within the scope of the Fraud and Abuse Law. The Amendments provided in Sections (2) and (3), above, however, would provide considerable guidance to both providers and state enforcement agencies. The Regulation suggested in Section (4) above, would require guidance from the legislature.

Florida Fee Splitting Law

Florida's Fee-Splitting prohibitions are contained in the Patient Brokering Act and in statutory

provisions setting forth grounds for disciplinary action by the various Boards⁶ Included in the litany of grounds with respect to medical doctors is "engaging in any split-fee arrangement with any other person, including other physicians, for patients referred to providers for health care goods or services." The statutes which apply to other providers are similarly worded. Section 458.331(1)(i) provides the Florida Board of Medicine with the authority to discipline medical doctors who violate this section. Penalties include a fine and possible medical license revocation.

The Florida Legislature has failed to define "fee-splitting" and has provided no purpose or intent within the Fee-Splitting Statute's language. Therefore, it is not surprising that the Florida Board of Medicine has been inconsistent in its review and interpretation of what constitutes a prohibited split fee arrangement.⁷

Proposals:

1. Delete the clause: "or engaging in any split-fee arrangement in any form whatsoever." The effect of removing this clause would be that physicians would still have to comply with the Patient Brokering Act which addresses split-fee arrangements. However, without a clear definition of "fee-splitting," it will still be difficult for the Florida Board of Medicine to interpret this statute consistently.

2. If it is desired to retain the split-fee arrangement clause, then amend the statute(s). Possible alternatives include:

i) Define "fee splitting." The Florida legislature could adopt a definition similar to the template found in Minnesota's Fee-Splitting Statute.⁸ Following is a recommended version:

(1)(i) Fee splitting, includes without limitation:

(1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, for the referral of patients or the prescription of drugs or devices;

(2) dividing fees with another physician or a professional corporation, unless

⁶ See, e.g. Fla. Stat. §458.331(1)(i) (M.D.'s); 465.185 (pharmacy); 459.013(3)(c) (osteopaths); 395.0185 (hospitals).

⁷ The history, problems and inconsistency of the Board of Medicine's interpretation and application of the Fee-Splitting Statute are well documented. See Marshall R. Burack, Special Issue: Health Law Symposium: Article: *Florida Board of Medicine Resists Change*, 7 U. Miami Bus. L. Rev. 485 (1999); Allen R. Grossman and R. Andrew Rock, Feature: *Fee Splitting and the Management of Medical Practices: A History of the Board of Medicine Declaratory Statements*, 72 Fla. Bar J. 48 (1998), Richard O. Jacobs, *Splitting Fees or Splitting Hairs? Fee Splitting and Health Care - The Florida Experience*, September 1999.

⁸ See Richard O. Jacobs, *Splitting Fees or Splitting Hairs? Fee Splitting and Health Care - The Florida Experience*, September 1999.

the division is in proportion to the services provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;

(3) referring a patient to any health care provider as defined in section 456.053(3)(i) in which the referring physician has a significant financial interest unless the physician has disclosed the physician's own financial interest; and

(4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest; and

(5) the provisions of this paragraph shall not be construed to prevent a physician from receiving a fee for professional consultation services.

Similar to the Minnesota Rules which provide a guide for the medical board to review the reasonableness of a division of fees, rules could be adopted by the respective professional Boards pursuant to which the Board would consider, among other things, the value of the professional services, overhead costs, time and distance traveled, and the availability of the service of the product elsewhere in the local trade area. It has been suggested that the wording of Minnesota Statute is too "loose" and should be clarified to include such behavior between any referring *person*, including family members, other non-physicians, and non-provider entities.

ii) Include a "safe harbor" for compensation that is fair market value and provides for the ability to reduce a payment to defray the costs of overhead or billing and collections related to the value of the service.

iii) Include a "safe harbor" for payment on a percentage basis for bona fide billing and collection services.⁹

iv) Define the difference between full-time employee, part-time employee and independent contractor. Provide for an exception for full-time bona-fide employment arrangements. Since part-time employment arrangements could be created as sham arrangements, only full-time arrangements would be allowed.

v) Allow the Board of Medicine or for similar statutes, the respective licensing board, to determine whether the proposed arrangement would have a significant impact on health care costs. If the impact would be de minimis, then the arrangement would be allowed.

Florida Patient Self Referral Act

⁹ Florida Medicaid prohibits a billing company from being paid on a percentage basis (deemed fraud); however such arrangements are permitted under Federal Medicaid and Medicare.

The interplay between the 1992 Florida Patient Self Referral Act, as amended, (the “Florida Act”) and the federal Stark law has created confusion for individuals seeking to structure business relationships in the health care field. To some extent, the Florida Act is duplicative of the Stark law. For example, both laws apply to certain types of ownership interests in facilities to which physicians refer patients. To some extent, the Florida Act is narrower: it applies only to investment interests and not to other financial arrangements, such as employment or independent contractor relationships. The scope of services subject to the act is also different. Under the Florida Act, all health care services are subject to its provisions. Under the federal act, only certain services are subject to its provisions. Finally, although the federal Stark law applies only to services paid for by governmental programs, the Florida Act applies to specific services regardless of payor. In other words, the Florida Act applies to services reimbursed by private payors and governmental payors. The Florida Act includes two additional provisions, the "15% rule" and the "direct supervision" requirement. The 15% rule prohibits solo providers or group practices who provide diagnostic imaging services from accepting more than fifteen percent (15%) of their patients from outside referrals. If the provider or practice accepts outside referrals, then they must register with the Agency for Health Care Administration ("AHCA") and provide AHCA with annual reports. This reporting mechanism is overly burdensome to providers, especially solo providers, who generally have limited support staff. The Act also requires these services be provided under the "direct supervision" of the referring provider or group practice, which means the physician must be present in the office suite while the services are provided. This level of supervision is inconsistent with Medicare supervision requirements. Since Medicare recently relaxed their supervisory requirements, there does not appear to be a valid reason for Florida to require a higher level of supervision. This higher level of supervision increases the costs of providing these services and has the effect of increasing health care costs, which is in direct opposition to the original intent of the Act which was to "protect the people of Florida from unnecessary and costly health care."¹⁰

In any event, many counselors agree that the Florida Act has largely been supplemented by the Federal Stark law. The inconsistencies lead to a counseling conundrum, whether considering and planning business models limited to the State of Florida or interstate.

The following amendments could be made in order to eliminate or reduce the cost of duplication of compliance, analysis and/or enforcement efforts.

1. Repeal the statute. The effect of this repeal would be that physicians would only have to comply with the federal Stark law, and only services paid for by Medicare or Medicaid would be subject to scrutiny.
2. If it is desired to have the Florida Act apply to all payors, then amend the statute to include a “safe harbor” for any referrals by physicians with an ownership or investment interest in entities to which they refer patients for health care services, which referrals would not be prohibited under the federal Stark law if the payor were a governmental payor and if the services in question were designated

¹⁰ Fla. Stat. §456.053(2)(2002).

health services under the federal Stark law. To that end, subsection (o) would be amended by adding the following as new paragraph (m)

(m) by a health care provider for any health care item or service, including a designated health service, if the referral would not be prohibited by 42 U.S.C. 1395(nn) and regulations promulgated thereunder if payment for the services rendered were made by Medicare or Medicaid and if the services in question were “designated health services” as such term is defined in 42 U.S.C. 1395(nn) and regulations promulgated thereunder.

3. Amend Section 456.053(3)(0)3f by deleting the third (i.e. last) sentence thereof (i.e. "15% rule"). The provision eliminates from the definition of "referral," referrals of patients for diagnostic imaging services for which the sole provider or group billed both the technical and professional components, so long as the sole providers or member of a group do not accept more than fifteen percent (15%) of their patients receiving diagnostic imaging services (excluding radiation therapy services) from outside referrals.

4. Amend Section 456.053(3)(0)3f by deleting the following part of the first sentence: "and that are provided or performed by or under the direct supervision of such referring health care provider or group practice." The effect would be that physicians would only have to comply with Medicare supervision requirements. Medicare supervision requirements are more reasonable and cost effective because the level of supervision varies according to the complexity of the procedure.

Appendix A
State Law Text

The 2002 Florida Statutes

Title XXXII

REGULATION OF PROFESSIONS AND OCCUPATIONS

Chapter 456

HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

View Entire

Chapter

456.053 Financial arrangements between referring health care providers and providers of health care services.--

(1) SHORT TITLE.--This section may be cited as the "Patient Self-Referral Act of 1992."

(2) LEGISLATIVE INTENT.--It is recognized by the Legislature that the referral of a patient by a health care provider to a provider of health care services in which the referring health care provider has an investment interest represents a potential conflict of interest. The Legislature finds these referral practices may limit or eliminate competitive alternatives in the health care services market, may result in overutilization of health care services, may increase costs to the health care system, and may adversely affect the quality of health care. The Legislature also recognizes, however, that it may be appropriate for providers to own entities providing health care services, and to refer patients to such entities, as long as certain safeguards are present in the arrangement. It is the intent of the Legislature to provide guidance to health care providers regarding prohibited patient referrals between health care providers and entities providing health care services and to protect the people of Florida from unnecessary and costly health care expenditures.

(3) DEFINITIONS.--For the purpose of this section, the word, phrase, or term:

(a) "Board" means any of the following boards relating to the respective professions: the Board of Medicine as created in s. 458.307; the Board of Osteopathic Medicine as created in s. 459.004; the Board of Chiropractic Medicine as created in s. 460.404; the Board of Podiatric Medicine as created in s. 461.004; the Board of Optometry as created in s. 463.003; the Board of Pharmacy as created in s. 465.004; and the Board of Dentistry as created in s. 466.004.

(b) "Comprehensive rehabilitation services" means services that are provided by health care professionals licensed under part I or part III of chapter 468 or chapter 486 to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis.

(c) "Designated health services" means, for purposes of this section, clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic-imaging services, and radiation therapy services.

(d) "Diagnostic imaging services" means magnetic resonance imaging, nuclear medicine, angiography, arteriography, computed tomography, positron emission tomography, digital vascular imaging, bronchography, lymphangiography, splenography, ultrasound, EEG, EKG, nerve conduction studies, and evoked potentials.

(e) "Direct supervision" means supervision by a physician who is present in the office suite and immediately available to provide assistance and direction throughout the time services are being performed.

(f) "Entity" means any individual, partnership, firm, corporation, or other business entity.

(g) "Fair market value" means value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes, not taking into account its intended use, and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

(h) "Group practice" means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:

1. In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;

The 2002 Florida Statutes

817.505 Patient brokering prohibited; exceptions; penalties.--

(1) It is unlawful for any person, including any health care provider or health care facility, to:

(a) Offer or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage from a health care provider or health care facility;

(b) Solicit or receive any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in return for referring patients or patronage to a health care provider or health care facility; or

(c) Aid, abet, advise, or otherwise participate in the conduct prohibited under paragraph (a) or paragraph (b).

(2) For the purposes of this section, the term:

(a) "Health care provider or health care facility" means any person or entity licensed, certified, or registered with the Agency for Health Care Administration; any person or entity that has contracted with the Agency for Health Care Administration to provide goods or services to Medicaid recipients as provided under s. 409.907; a county health department established under part I of chapter 154; any community service provider contracting with the Department of Children and Family Services to furnish alcohol, drug abuse, or mental health services under part IV of chapter 394; any substance abuse service provider licensed under chapter 397; or any federally supported primary care program such as a migrant or community health center authorized under ss. 329 and 330 of the United States Public Health Services Act.

(b) "Health care provider network entity" means a corporation, partnership, or limited liability company owned or operated by two or more health care providers and organized for the purpose of entering into agreements with health insurers, health care purchasing groups, or the Medicare or Medicaid program.

(c) "Health insurer" means any insurance company authorized to transact health insurance in the state, any insurance company authorized to transact health insurance or casualty insurance in the state that is offering a minimum premium plan or stop-loss coverage for any person or entity providing health care benefits, any self-insurance plan as defined in s. 624.031, any health maintenance organization authorized to transact business in the state pursuant to part I of chapter 641, any prepaid health clinic authorized to transact business in the state pursuant to part II of chapter 641, any prepaid limited health service organization authorized to transact business in this state pursuant to chapter 636, any multiple-employer welfare arrangement authorized to transact business in the state pursuant to ss. 624.436-624.45, or any fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632.

(3) This section shall not apply to:

(a) Any discount, payment, waiver of payment, or payment practice not prohibited by 42 U.S.C. s. 1320a-7b(b) or regulations promulgated thereunder.

(b) Any payment, compensation, or financial arrangement within a group practice as defined in s. 456.053, provided such payment, compensation, or arrangement is not to or from persons who are not members of the group practice.

(c) Payments to a health care provider or health care facility for professional consultation services.

(d) Commissions, fees, or other remuneration lawfully paid to insurance agents as provided under the

The 2002 Florida Statutes

Title XXXII

REGULATION OF PROFESSIONS AND OCCUPATIONS

Chapter 456

HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

View Entire

Chapter

456.054 Kickbacks prohibited.--

(1) As used in this section, the term "kickback" means a remuneration or payment back pursuant to an investment interest, compensation arrangement, or otherwise, by a provider of health care services or items, of a portion of the charges for services rendered to a referring health care provider as an incentive or inducement to refer patients for future services or items, when the payment is not tax deductible as an ordinary and necessary expense.

(2) It is unlawful for any health care provider or any provider of health care services to offer, pay, solicit, or receive a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients.

(3) Violations of this section shall be considered patient brokering and shall be punishable as provided in s. [817.505](#).

History.--s. 8, ch. 92-178; s. 2, ch. 96-152; s. 79, ch. 97-261; s. 8, ch. 99-204; s. 78, ch. 2000-160.

Note.--Former s. 455.237; s. 455.657.

The 2002 Florida Statutes

Title XXXII

REGULATION OF PROFESSIONS AND OCCUPATIONS
MEDICAL PRACTICE

Chapter 458

View Entire Chapter

458.331 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(a) Attempting to obtain, obtaining, or renewing a license to practice medicine by bribery, by fraudulent misrepresentations, or through an error of the department or the board.

(b) Having a license or the authority to practice medicine revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions. The licensing authority's acceptance of a physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the physician's license, shall be construed as action against the physician's license.

(c) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of medicine or to the ability to practice medicine.

(d) False, deceptive, or misleading advertising.

(e) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department or the board. A treatment provider approved pursuant to s. 456.076 shall provide the department or consultant with information in accordance with the requirements of s. 456.076(3), (4), (5), and (6).

(f) Aiding, assisting, procuring, or advising any unlicensed person to practice medicine contrary to this chapter or to a rule of the department or the board.

(g) Failing to perform any statutory or legal obligation placed upon a licensed physician.

(h) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the capacity as a licensed physician.

(i) Paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. The provisions of this paragraph shall not be construed to prevent a physician from receiving a fee for professional consultation services.

(j) Exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity. A patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his or her physician.

(k) Making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine.

Appendix B
State Law Summary

This memorandum¹¹ provides a brief summary of the legislation under review by the Ad Hoc Committee.

1. Florida's Patient Self-Referral Act of 1992 – Fla. Stat. § 456.053:

Florida's Patient Self-Referral Act of 1992 (the "Act") prohibits a health care provider from referring a patient for the provision of certain designated health services, or any other health care item or service, to an entity in which the health care provider is an investor or has an investment interest. The Act defines "designated health services" as: clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic-imaging services and radiation therapy services.

The Act provides certain exceptions to the self-referral prohibition for orders, recommendations or plans of care that do not constitute a referral. Some of these exceptions include, services furnished by a sole provider or group practice; lithotripsy services by a urologist; services provided by an ambulatory surgery center licensed under Chapter 395; renal dialysis services and supplies by a nephrologist; and diagnostic-imaging services by a radiologist.

The Florida Legislature enacted this statute because it found that a potential conflict exists when a health care provider refers a patient to a provider of health care services in which the health care provider has an investment interest. According to the Legislature, these referral practices could limit or eliminate competitive alternatives in the health care services market. This, in turn, could result in overutilization of health care services which could increase health care costs. Nonetheless, the Legislature found it appropriate for health care providers to make referrals for health care services to an entity in which the health care provider has an investment interest if certain safeguards were established. Within the Act, the Legislature provides guidance to health care providers regarding prohibited patient referrals.

The Act has been through several, mostly technical, revisions over the past decade. However, the Act has only been interpreted on a few occasions. The two most notable include the Florida Board of Medicine Declaratory Statement *In re: The Petition for Declaratory Statement of Alan Levin, M.D. and Ameripath, Inc.*, 19 FALR 4525 (Fla. Bd. of Medicine 1997); and the Florida First District Court of Appeal decision in *Agency for Health Care Administration v. Charles W. Wingo, M.D., and Tallahassee Orthopedic Clinic, P.A.*, 697 So. 2d 1231 (Fla. 1st DCA 1997). Due to *Wingo*, the Florida Legislature modified the statutory exception for solo practitioners and group practices concerning outside referrals of diagnostic imaging services. There has been limited comment or literature written on the Act in journals or law reviews. One law review

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article which mentions the Act is: Marshall R. Burack, *Special Issue: Health Law Symposium: Article: Florida Board of Medicine Resists Change*, 7 U. Miami Bus. L.Rev. 485 (1999).

2. Florida's Anti-Kickback Statute – Fla. Stat. § 456.054:

Florida's anti-kickback statute ("AKS") prohibits any health care provider or any provider of health care services from offering, paying, soliciting or receiving a kickback, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients. "Kickback" is defined as remuneration or payment back pursuant to an investment interest, compensation arrangement, or otherwise, by a provider of health care services or items, of a portion of the charges for services rendered to a referring health care provider as an incentive or inducement to refer patients for future services or items, when the payment is not tax deductible as an ordinary and necessary expense.

The AKS was also enacted in 1992 and has been, like the Act, through a few modifications over the past 10 years. One of the most notable changes is that a violation of this statute is considered a criminal violation and is punished under the terms of Florida's Patient Brokering Act (to be discussed below).

Research records no published judicial court opinions, law review articles or any other sources which discuss or interpret the AKS.

3. Florida's Patient Brokering Act of 1996 – Fla. Stat. § 817.505:

Florida's Patient Brokering Act of 1996 (the "Brokering Act") is a criminal statute which makes it unlawful for any person to offer, pay, solicit or receive any commission, bonus, rebate, kickback or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, in exchange for patient referrals to a health care provider or health care facility. The Brokering Act also prohibits any person from aiding, abetting, advising or otherwise participating in a prohibited referral scheme. Violations of the Brokering Act are punishable as a third degree felony.

Like the Act, the Brokering Act provides certain exceptions to the referral prohibition. Some of the exceptions include: payments to a health care provider or health care facility for professional consultation services; commissions, fees or other remuneration lawfully paid to insurance agents as provided under the insurance code; any discount, payment, waiver of payment or payment practice not prohibited by the Federal Anti-Kickback Statute (or regulations promulgated thereunder); and any payment, compensation or financial arrangement within a group practice as defined in the Act.

The Florida Legislature enacted the Brokering Act due to unscrupulous practices by mental health professionals in the early 1990s. Specifically, mental health providers would pay "brokers" to travel along Florida's streets searching for homeless people to bring to the provider's hospitals for "treatment". After paying the "broker" a fee, the provider would complete an application for, and submit claims for reimbursement to, Medicaid on behalf of the

homeless person.

Research records one relevant published judicial opinion on the Brokering Act, specifically, *Medical Management Group of Orlando, Inc., v. State Farm Mutual Automobile Ins. Co.*, 811 So. 2d 705 (Fla. 5th DCA 2002). This case provides an example where a particular “leasing arrangement” violates the Brokering Act. In *MMGO*, the Court determined that a management company, since it is not a medical services provider, violated the Brokering Act by leasing space, equipment and services from a diagnostic imaging center, and then billing for the services. The management company paid the diagnostic imaging center \$350 for the service, and then, in turn, billed the insurer \$1,400. The Court agreed with the trial court that this arrangement was nothing more than a fee-splitting scheme to compensate for prohibited referrals under the Brokering Act.

Another case, *NuWave Diagnostics, Inc. v. State Farm Mutual Automobile Insurance Co.*, Case No.: 97-09175(53) Broward County, Florida, is the only unpublished opinion found on the Brokering Act. *NuWave* is a County Court case wherein the Court granted summary judgment against NuWave Diagnostics and found that NuWave violated the Brokering Act. The County Court certified this case to Florida’s Fourth District Court of Appeal as a matter of great public importance, however, the Fourth DCA has not opined on this case to date.

The Florida Board of Medicine refused to interpret the Brokering Act in *In re: The Petition for Declaratory Statement of Magan L. Bakarania, M.D.*, 20 FALR 395 (Fla. Bd. of Medicine 1997). No law review, or other, articles were found on the Brokering Act.

4. Florida’s Fee-Splitting Statute – Fla. Stat. § 458.331(1)(i):

Florida’s Fee-Splitting Statute (the “FSS”) prohibits a physician from, among other things, engaging in any split-fee arrangement with any other person, including other physicians, for patients referred to providers for health care goods or services. Penalties for violating the FSS include a fine and possible medical license revocation.

The Florida Legislature has failed to define “fee-splitting” and has provided no purpose or intent within the FSS’ language. Nonetheless, the Florida Board of Medicine has exhaustively reviewed and interpreted the FSS. Unfortunately, the Florida Board of Medicine has been inconsistent in its review and interpretation of the FSS. There are numerous Florida Board of Medicine Declaratory Statements on the FSS, too numerous to include in this summary.

In addition, there are two notable court decisions on the FSS. The first is *C. Robert Crow, M.D. v. Agency for Health Care Administration*, 669 So. 2d 1160 (Fla. 5th DCA 1996); and the second is a very weak “PCA” decision by the First District Court of Appeal in *Phymatrix Management Co., Inc. et. al. v. Magan L. Bakarania, M.D., et. al.*, 737 So. 2d 588 (Fla. 1st DCA 1999).

Finally, there are quite a few newsletters and law journal articles on the FSS. Included with this summary are the following: Allen R. Grossman and R. Andrew Rock, *Feature: Fee Splitting and the Management of Medical Practices: A History of Board of Medicine Declaratory Statements*, 72 Fla. Bar J. 48 (1998); Marshall R. Burack, *Special Issue: Health Law*

Symposium: Article: Florida Board of Medicine Resists Change, 7 U. Miami Bus. L.Rev. 485 (1999); and Richard O. Jacobs, *Splitting Fees or Splitting Hairs? Fee Splitting and Health Care – The Florida Experience*, September 1999.

Federal Law Summary

The following attached summary is included in this report for educational purposes only:

Fee-Splitting Articles

Splitting Fees or Splitting Hairs? Fee Splitting and Health Care -- The Florida Experience

Wednesday, September 01, 1999

		
<u>Richard O. Jacobs</u> St. Petersburg		

Reason is the life of the law; nay, the Common Law itself is nothing but reason. William Blackstone: Comments on the Laws of England, 1765.

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain money for referral of services or to induce further referrals. Advisory Opinion 98-10, D. McCarty Thornton, Chief Counsel to the Inspector General.

It is our conclusion that references to "division of services" clearly indicates intent to disavow "division of fees" for mere patient referrals. That is, the conventional understanding of what constitutes "fee splitting." The contrary interpretation, if carried to its logical conclusion, would lead to absurd results. Presumably, all of Dr. Blickensderfer's gross income consists of "fees for services." If he were not permitted to "divide" those fees to pay such necessary expenses as secretarial salaries, office rent, and telephone charges, his practice would not long survive. Practice Management Associates, Inc. v. Blickensderfer, 630 So. 2d 1147, 1148 (Fla. 2nd D.C.A., 1993).

Introduction

In this paper we examine fee splitting under Florida law. This evolving body of health-care law is driven by administrative rule making and interpretations of statutory law aimed at prohibiting doctors and other health care professionals from paying for a patient referral. In those simpler days in early England, Blackstone could not have foreseen today's regulatory proliferation, and with it, what some view as at least the momentary death of common sense.

We say "momentary" because of our experience with other applications of statutory law and rule

making. For example, early court decisions under the Retirement Income Security Act of 1974 ("ERISA") denied medical plan participants damage claims against insurers withholding benefits or care for any reason. The courts viewed the preemption provisions of ERISA as the basis for denying even the most egregious claims for malpractice or treatment denial damages. Only with time, and the persistence of insured plan participants and their attorneys, has reason reentered the ERISA arena.

Until recently, the traditions and ethics of the learned professions universally exhibited a strong disdain for marketing and advertising. With that disdain came the prohibition against fee splitting -paying for patient or client referrals. However, as lines blurred between the businesses and the professions and as professionals became pressured to promote their practices to survive in face of growing complex, global competition, promotional rules eroded and marketing freedom prevailed - at least among some of the professions. For example, accountants licensed in Florida are now permitted to offer insurance and investment products to their clients and charge commissions. Lawyers are now permitted to pay referral fees to other lawyers when the fees are disclosed to clients.

For health care practitioners, however, the freedoms granted to other professionals do not exist. Perhaps the rationale arises from the idea that our government must pay for health care and micro-management of medicine is necessary to control costs. Perhaps the rationale comes from the ideology that marketing, over-utilization and fraud and abuse go hand in hand. Perhaps the rationale is based on today's technological complexities and the difficulty in determining what is or what is not reasonable and necessary health care worth paying for.

Whatever the rationale, as managed care plans and provider networks grow, as Wall-Street-financed physician practice management companies ("PPMC") consolidate practice management and promotion, as federal and state governments increase their micro-management of the health care delivery system, fee splitting has evolved as a legal issue of gigantic proportions.

In Florida, fee splitting is center-stage as a result of the Florida Board of Medicine's 1997 advisory opinion given in the petition of Doctor Magan L. Bakarania. The Medical Board advised Dr. Bakarania that a practice management agreement between a physician group and a PPMC, PhyMatrix, violated Florida's fee-splitting statute. The management agreement provided that PhyMatrix was paid a percentage management fee in exchange for managing the practice and providing network development and other practice-enhancement services. The Board advised the percentage management fee was an illegal fee split. Dr. Bakarania's petition is currently on appeal.

In 1998, Dr. Bakarania's attorney requested an advisory opinion from the Office of the Inspector General ("OIG") of the Department of Health and Human Services on behalf of another physician. The OIG issued Advisory Opinion 98-4 indicating that a percentage fee PPMC management contract could violate the federal anti-kickback statute because percentage fees could encourage health care service over utilization and upcoding.

Corporate Practice of Medicine and Fee Splitting

Early writings about medical practice economics indicate that fee splitting was an ethical concern as early as the 1890s. Fee splitting arose as an issue because surgeons had developed the common practice of paying family practice doctors for patient referrals. In response, the American Medical Association developed ethical prohibitions. Additionally, between 1914 and 1953, twenty-two states passed laws making fee splitting illegal. Today, at least thirty-six states have laws prohibiting kickbacks or fee splits.

Until the mid-1950s, the practice of medicine in corporate form was viewed as injurious to medical science, individual patients and medical practitioners. The development of the corporate practice of medicine divided physicians into two camps. Most physicians opposed the corporate practice of medicine. They believed it would create a bidding war among physicians and would drastically decrease the level of reimbursement for physicians' services. Other physicians welcomed the stability of income they perceived the corporate practice would provide.

The courts deciding against the corporate practice of medicine reasoned that corporations were inherently incapable of practicing medicine because the corporation itself, as a legal entity, was incapable of meeting the state training and licensing requirements applicable to the practice of medicine. Courts expressed concern that interposing the interests of a third party, the corporation, into the doctor-patient relationship would cause the physician to be more interested in the needs of the corporation than in the needs of his patients. The interposition also resulted in a fee split between the corporation and the physician. As a further response to the growing corporate practice, several state legislatures passed legislation limiting the practice of medicine to natural persons.

As a corporate practice of medicine doctrine developed, it and associated fee-splitting issues were addressed by several health care professional associations, including the American Medical Association, American Osteopathic Association, American Dental Association and the American Podiatric Medical Association, the state health professional boards and the courts.

The change in attitude about corporate practice of medicine, from prohibition to permission, was tax-driven. At the time, only corporate employees could have the full benefit of tax-favored retirement plans. Professionals did not want to be excluded.

American Medical Association

In 1957, the House of Delegates of the American Medical Association ("AMA") approved of the practice of medicine through partnerships, associations, or other lawful groups. In a resolution, the House of Delegates stated that these methods of organization were acceptable as long as the practice management and ownership duties remained in the hands of licensed physicians. In 1961, the AMA took a leadership role on this issue. In that year, twelve states passed the first professional corporation acts. These laws were based on a prototype statute drafted by the legal staff of the AMA.

That same year, the AMA's Judicial Council issued a proclamation stating "physicians may take advantage of professional association laws and may also ethically do those things, which are necessary to reap the intended and proper advantage of such legislation." By 1971, all states

authorized professional corporations, associations or partnerships.

In 1968-1969 the AMA surveyed state medical societies regarding their positions on professional corporations. This survey asked whether or not the societies favored the practice and whether or not they had promulgated rules on the issue. Five of 47 responding state medical societies reported ruling on the issue. Of the respondents, one opposed professional corporations but four ruled in their favor. However, almost half of the state societies responded in favor of the idea of the corporate practice of medicine. In a repeat survey in 1973-74, there was little change on the subject.

In 1977, the AMA Judicial Council issued Opinion 4.61. This document authorized physicians to form professional service corporations and associations if formation was consistent with the laws of state in which they practiced. Opinion 4.61 required that professional service corporations and their physician employees observe the Principles of Medical Ethics applicable to individual physicians. Finally, Opinion 4.61 required that the ownership and management of these professional corporations remain in the hands of licensed physicians.

The issue of fee splitting evolved along a concurrent path. Initially, the AMA opposed any form of fee splitting. But, between 1946 and 1963, the AMA softened its position. At first, it took the position that the division of income among the members of a group must be associated with the services and contributions of the group's members. The AMA considered profit-sharing plans including lay employees as unethical. However, in 1964, the AMA Judicial Council modified their position:

A retirement plan classified under the Internal Revenue Code which also covers lay employees and which provides that the contribution made by a solo practitioner, a group of physicians, or a professional corporation will be based on a percentage of compensation of the participants is ethically acceptable even though the contribution: (1) is limited to a percentage of net income before taxes or (2) is payable only when net income exceeds a specified amount.

This position is now liberally construed to mean that almost any type of pension, profit sharing, or other retirement plan is now ethically acceptable.

The present position of the American Medical Association on fee splitting is expressed in 1998 AMA Policy Compendium H-140.991:

Fee-splitting arrangements between physicians and other independent practitioners in which payment is made *merely for referral of patients* are unethical; State boards of medical examiners are encouraged to address this significant issue and deal appropriately with those physicians in their jurisdictions who are involved in these unethical, and often times illegal, practices. (Res. 89, A-86; Reaffirmed: CEJA Rep. A, I-88)

This expression by the AMA is consistent with the Florida Second D.C.A. in *Professional Management Associates, Inc. v. Blickensderfer* which differentiated a fee allocation based upon services from a fee-split for a mere patient referral. It is inconsistent with the declaratory statements of the Florida Board of Medicine. We discuss later.

American Osteopathic Association

In 1970, the General Counsel of the American Osteopathic Association issued an opinion addressing the increase in the corporate practice of medicine by osteopathic physicians and other professionals. The General Counsel opined that because almost 70% of osteopaths engaged in a full-time general practice as opposed to 22% of medical doctors, the trend toward group practice by osteopathic physicians would not be as great as among medical doctors. In this opinion, the General Counsel further noted problems of unethical fee splitting involved in the progression of the corporate practice of medicine. The General Counsel reasoned that if the AOA Ethics Committee were called upon at that time to render an opinion, there might be some variation in opinion regarding whether additional compensation that does not reflect fees earned by the physician results in fee-splitting. He opined that this disparity could have been accounted for by the Committee's varying perspective concerning the increase in corporate practice by professionals and the advance of different methods of payment.

In 1972, the AOA Committee on Ethics issued a ruling holding that paying a radiologist employed by a professional corporation a percentage of his fees plus his expenses did not involve improper fee splitting even though his remaining fees were distributed among the other member-employees of the professional corporation.

In 1978, the AOA Ethics Committee issued a ruling interpreting Sections 19-22 of the AOA Code of Ethics. That document concluded that the group practice of medicine does not violate the AOA Code of Ethics as long as the division of income among the members is based on the relative value of the professional services and other services and contributions provided by the respective members to the group.

Today, Section 12 of the AOA Code of Ethics is consistent with that 1978 ruling. It states that any fee charged by a physician shall compensate the physician for services actually rendered and there shall be no division of professional fees for referrals of patients.

The position of the AOA is also consistent with the position of the Florida Second D.C.A. expressed above.

American Dental Association

In 1968, the Judicial Council of the American Dental Association (ADA) issued *The Principles of Ethics of the American Dental Association*. This document did not include a policy position on professional corporations but did allow reasonable arrangements involving partnerships and office sharing. Because the document failed to explicitly prohibit professional corporations, some practitioners viewed the practice as permitted. Section 9 of the 1968 Principles of Ethics prohibited fee splitting by dentists, defining prohibited fee splitting as any fee agreement between dentists that is not disclosed to the patient.

A survey conducted by the ADA in 1968-1969 revealed that several state dental societies showed a significant interest in professional corporations. During those years, the Michigan, Colorado, and Missouri societies issued rulings favorable to the practice while Arizona prohibited the corporate practice of dentistry.

Currently, Section 4 of the ADA Code of Professional Conduct states that dentists have a duty to be fair in their dealings with patients, colleagues and society. Subsection E. of Section 4 explicitly prohibits dentists from accepting or tendering rebates or split fees.

American Podiatric Medical Association

The Code of Ethics of the American Podiatric Association explicitly prohibits fee splitting, excepting from their definition of fee splitting the division of fees within a partnership. Section O of the Code of Ethics states:

It is unethical for podiatrist to pay or accept commissions in any form or manner on fees for professional services, references, consultations, pathology reports, radiograms, prescriptions, or on other services or articles supplied to patients. Division of professional fees or acceptance of rebates from fees paid by patients to x-ray, clinical or other laboratories, shoe stores, or other commercial establishments is unethical. It is unethical for a podiatrist to pay for the recommendation of patients. The division of revenue in a partnership is outside the scope and application of this rule.

The Continuing Conflict

By 1971, all 50 states permitted professional corporations. Today, many states including Florida, Alaska, Connecticut, Delaware and Indiana have no prohibition against the corporate practice of medicine regardless of whether the corporation is a profession or non-professional entity. For example, in Florida, the Board of Medicine has repeatedly ruled that Florida law permits the corporate practice of medicine. In those rulings the Board has deemed it acceptable for non-physicians, including corporations, natural persons and other legal entities, to own medical practices and employ physicians. However, a number of states including California, Texas, Arizona, Illinois and Idaho still prohibit the practice of medicine by "regular" non-professional corporations, partnerships and other legal entities.

The growth of the corporate medical practice introduced different fee-splitting issues. Despite growing liberalization in the corporate practice and employee profit sharing, the regulatory boards continued to oppose fee splitting between a physician and a layman or between independent physicians. This position was justified under the principle that physician judgement could be tarnished by financial considerations. Fee splitting was viewed as unethical because it interferes with the proper professional relationship or increases fees.

Despite these positions, however, in states where the corporate practice of medicine was authorized, regulation did not prohibit non-physician corporate owners from sharing in the corporation's earnings even though those earnings represented, at least in part, the fees generated by employed physicians.

Today, the distinction between corporate ownership of a medical practice and traditional fee splitting still confronts practitioners and regulators alike. The issue was recently addressed by the Florida Board of Medicine in its Answer Brief in the pending case of *PhyMatrix Management, Inc. v. Magan L. Bakarania*, Case No. 97-4543, (1st D.C.A.). In describing their interpretation that a management contract paid on a percentage basis constitutes an inappropriate fee split the

board states:

PhyMatrix suggests to the court that its agreement is simply the corporate practice of medicine with a different 'structure.' It is in fact this difference in structure that distinguishes this agreement from the corporate practice of medicine. In the corporate practice of medicine, the corporation owns the medical practice and carries all the liabilities and responsibilities of ownership. The owner-corporation legally employs physicians and at the end of business retains its corporate earnings. The PhyMatrix agreement seeks to avoid ownership, but still provides PhyMatrix a share of the earnings.

The Board draws a distinction between fee splitting among members and employees of a corporation and fee splitting between professionals and third-party contractors. The Board fails to distinguish between the use of fees to pay for legitimate business services from the use of fees to pay for patient referrals. There is a definitional problem, which we address next.

Definitional Lack of Clarity

Most states have enacted legislation or rules prohibiting physician fee-splits and other payments for referrals. However, *referral* and *fee split* are rarely defined in the fee-split context.

What is a "Patient Referral?"

Though state laws usually lack a definition of referral, referral is defined under the Social Security Act. For purposes of section 1877(h)(5) of the physician-referral provisions of the Social Security Act, a "referral" includes:

- The request by a physician for an item or service for which payment may be made under Medicare Part B, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician).
- The request or establishment of a plan of care by a physician that includes the furnishing of designated health services.

In its 1998 proposed "Stark II" regulations, however, the Health Care Financing Administration ("HCFA") adopts the view that a referral to oneself is a referral:

Section 1877(a)(1) prohibits a physician from referring Medicare patients for the furnishing of designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. The statute encompasses any entity that provides designated health services, without qualifications or limits. We attempted to reflect the breadth of the concept in the August 1995 final rule at § 411.351, where we defined an "entity" as a sole proprietorship, trust, corporation, partnership, foundation, not-for-profit corporation, or unincorporated association. ... We wish to clarify that we regard an individual physician or group of physicians as referring to an "entity" when they refer to themselves, or among themselves. The concept of a "referral" under section 1877(h)(5)(A) and (B) covers the request by a physician for an item or service under Part B, or the request or establishment of a

plan of care by a physician that includes the provision of a designated health service. This statutory definition does not exclude in-office referrals, nor does it specify that a referral occurs only when a physician refers to an outside entity.

HCFA's "I'm-my-own-grandma" approach adds little help in the context of defining a prohibited referral for fee-split purposes. The search for a definition is also exasperated by judicial interpretations of the Federal anti-kickback statute. The courts have adopted the government's position that the anti-kickback statute makes illegal arrangements where *any one purpose* of the remuneration is for referral of services or to induce further services.

Let us end this section with the definition of referral from the Random House Dictionary:

A person recommended to someone or for something.

What is a Fee Split?

Similarly lacking is a definition of fee split separating a payment for patient referrals from a payment for professional services. Adopting either HCFA's definition that a self-referral is a referral, or the *when any purpose of a payment is a referral* approach supported by some courts under the federal anti-kickback statutes, makes any payment to any person making a referral (including to oneself) for any good reason illegal.

Consider HCFA's view that such common business practices as hospitals providing parking for physician staff members can be an illegal payment for referrals. The proposed Stark II regulations provide:

We have also been asked about parking spaces that a hospital provides to physicians who have privileges to treat their patients in the hospital. It is our view that, while a physician is making rounds, the parking benefits both the hospital and its patients, rather than providing the physician with any personal benefit. Thus, we do not intend to regard parking for this purpose as remuneration furnished by the hospital to the physician, but instead as part of the physician's privileges. However, if a hospital provides parking to a physician for periods of time that do not coincide with his or her rounds, that parking could constitute remuneration.

With a similar unsettling broad-brush, consider Florida's Board of Medicine view that a global fee split is an illegal fee split, expressed at its April 1998 board meeting:

The Board voted to issue an opinion letter regarding certain financial arrangements between specialists and imaging centers. The Board stated that an arrangement which calls for the specialist to refer patients to an imaging center, then receive a portion of the global fee for performing the read of the study, is prohibited by law. The Board referred the matter to their Rules Committee for development of clarifying language.

As of this date, the Rules Committee has not issued a rule.

The Florida statute interpreted by the Board of Medicine was adopted in 1979. Section 458.331(1)(i) of the Florida Statutes provides that the Board of Medicine has the authority to discipline a physician for:

ypaying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee

arrangement in any form whatsoever with a physician, organization, agency or person either directly or indirectly, for patients referred ... for health care goods and services. ʏ

Similar statutes apply to each of the Florida's professional health-care licensure classifications.

A related Florida Statute makes it a crime to:

ʏoffer or pay any commission, bonus, rebate, kickback, or bribe, directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of patients or patronage from a health care provider or health care facility.

Court interpretations of the Florida fee-splitting statutes are sparse. Most of the interpretations have come from the Board of Medicine and other regulatory bodies.

The only cases are a series of related cases from the Florida Second District Court of Appeal. The Second D.C.A. addressed fee splitting in a series of cases relating to a Florida chiropractic practice management company, Practice Management Associates. The chiropractic fee-splitting statute is identical to the Florida fee splitting statute applicable to medical doctors. The Court found that a percentage-fee arrangement in which Practice Management Associates provided services to chiropractors in Illinois and Minnesota did not violate Illinois, Minnesota or Florida law. The Court interpreted "splitting fees" under the statute "... in the traditional meaning of dividing a professional fee with another person, professional or non-professional, for the referral of patients."

The Court held that marketing efforts of Practice Management Associates did not amount to a referral of patients; thus, there was no fee split between the company and the chiropractors. The Court distinguished *compensation paid for the division of services* from a *division of fees paid for mere patient referrals* in a companion case. The division of fees, it held, is legal; the payment for referrals, illegal.

In its published April 1998 board minutes referred to above, the Florida Board of Medicine did not explain the reasoning behind its holding that a division of a global fee is illegal. Clearly, the Board did not follow the Second D.C.A.'s differentiation between a division of fees for services performed and fee-splits for the *mere referral* of a patient. The Florida Board of Medicine clearly rejected the opinion of the Florida Second D.C.A. in its briefs filed in *Bakarania*.

The Board's view that a division of a global fee for services rendered is an illegal fee split overlooks business reality. For the most part, physicians have not sought global fees. Global fees have been impressed on the health care system by managed care plans, not physicians or patients. Global fees result because of the bargaining power of managed care payers who insist on paying providers global fees with the caveat: "You provide the entire service for the global fee and you split up the fee between service providers."

The result is a fee allocation among providers, a split-fee for services rendered, demanded by the payers with superior bargaining power. Demanded by payers who monitor results with utilization review and quality control procedures.

Physician Practice Management Companies, such as PhyMatrix or Practice Management

Associates, do not refer patients. They arrangement business contracts - including managed care contracts with hard-nosed, bottom-line oriented managed-care customers who insist on tough contracts monitored by utilization review and quality control systems.

Today's rapid reorganization of laissez-faire medical practices into financially and professionally managed clinics is demanded by the market place. Physicians who cannot compete economically and professionally, who do not join provider networks, which cannot differentiate themselves from competitors, find themselves out of business. Survival demands that professional skills be augmented with organization, capital, marketing, and sophisticated management, elements lost in the typical medical practice. Contractual services like those provided by PPMC's are becoming necessary for survival. Paying for those services on a percentage basis is good business; payment is performance-related.

Ironically, a RAND Journal of Economics study published almost two decades ago examined the welfare effects of fee splitting paid by one physician to another. The study concluded:

...in the principal-agent context it is possible for fee splitting to offer incentives which actually improve patient welfare. Fee splitting occurs when there is a divergence between price and the referral partner's marginal opportunity cost. ... It is shown that fee splitting may induce the first-contact physician to refer instead of performing a lower quality procedure himself. ...

Thus, missing is a fee-splitting definition distinguishing legitimate fee allocations and payments for services from payments which are payments for mere referrals.

Florida Board of Medicine on Fee Splitting

The Florida Board of Medicine has issued a series of opinions related to fee splitting. These opinions can be classified in five issue-based categories:

1. employment agreements,
2. independent contractor relationships,
3. management contracts between physicians and other entities,
4. leases and
5. equipment and facilities ownership.

Before examining Board of Medicine decisions, we review the scope of authority delegated by the legislature to an administrative agency charged with statutory interpretation and enforcement.

The Measure of Administrative Agency Authority

- C No agency as the authority to impose rules unless granted the authority by legislation.
- C An agency may interpret statutes through practice, agency rules, or as issued in a declaratory statement. However, the administrative interpretation of the statute must be consistent with the legislative intent of the statute:

A grant of rulemaking authority is necessary but not sufficient to allow an agency to adopt a rule; a specific law to be implemented is also required. An agency may adopt only rules that implement, interpret, or make specific the particular powers and duties granted by the enabling statute. No agency shall have authority to adopt a rule only because it is reasonably related to the purpose of the enabling legislation and is not arbitrary and capricious, nor shall an agency have the authority to implement statutory provisions setting forth general legislative intent or policy. Statutory language granting rulemaking authority or generally describing the powers and functions of an agency shall be construed to extend no further than the particular powers and duties conferred by the same statute.

- C If the legislature has granted rulemaking power to an administrative agency, that grant must be accompanied by identifiable standards governing its exercise, so that the power to make the law is not unlawfully delegated
- C Agencies are given wide discretion in the interpretation of statutes they administer. The agency's interpretation need not be the sole possible interpretation or even the most desirable one; it need only be within the range of interpretations. However, an agency's interpretation will be rejected when it "has no basis either in the statute, rules of the agency, sound business practices, or common sense."
- C Although a court must follow the agency's interpretation not the court's preferred interpretation, the discretion of an agency is "somewhat more limited where the statute being interpreted authorizes sanctions or penalties against a person's professional license. Statutes providing for the revocation or suspension of a license to practice are deemed penal in nature and must be strictly construed, with any ambiguity interpreted in favor of the licensee."
- C An agency rule or interpretation cannot enlarge, modify, or contravene the provisions of law it implements, nor can it implement a statutory provision stating only general legislative intent. Implementation must be of specific statutory provisions.
- C An agency may issue a declaratory statement only on the "applicability of a statutory provision, or of any rule or order of the agency, as it applies to the petitioner's particular set of circumstances." If the declaratory statement has the potential for affecting the "substantial interests of persons other than the petitioners" it has the effect of a rule, and the declaratory statement procedure cannot be used.

Employment Arrangements

The fee split issues raised by the compensation of an employed physician were addressed by the Board of Medicine in *In re: The Petition for Declaratory Statement of C. Robert Crow, M.D.* In *Crow*, a physician sold his practice to a corporation. Dr. Crow continued to work for the corporation as an employee. He was paid on a flat salary basis. Dr. Crow sought a declaratory statement from the Board of Medicine regarding a proposed change in his compensation arrangement. Under the proposal, he would receive a base salary plus 35% of all practice revenues generated during the previous year by him or by individuals under his supervision and

40% of all practice revenues in excess of a certain target level. The Board held that both the salary arrangement and the bonus which was based, in part, upon fees generated from referrals by the physician for ancillary services, constituted a prohibited fee split.

The Board went on to state that if the arrangement were limited solely to fees generated by the physician from his own professional services and those services provided by individuals under his own direct supervision without reliance on fees generated from ancillary services, the arrangement is legal.

This case was later affirmed by the Fifth DCA in, *Crow v. Agency for Health Care Administration*. In affirming the Board's ruling, the Court discussed the Board's motivation in prohibiting physicians from receiving payment based on ancillary revenues stating:

It is ... clear that the Board was concerned with the possibility that an employee physician's medical judgment might be skewed where that physician benefits financially from overutilization of ancillary tests and services even if performed by IHHC [the acquiring corporation].

A careful analysis of *Crow* raises several questions.

Florida's fee-splitting statute, Fla. Stat. § 458.331(1)(i) does not define fee splitting, and, particularly, does not distinguish between fees earned from ancillary services and personal services.

Did the Board of Medicine exceed its authority by making new law? Did it use its declaratory statement as disguised rule making? Did the Fifth D.C.A. give undo difference to the Board of Medicine's interpretation?

We think so. Why? The holding does not apply to proprietors and partners. If the Board has the right to prohibit physicians from being paid for ancillary revenues, the statute would say so and the prohibition would apply to all physicians, not just employed physicians. The Board, however, has not been granted the right and the statute does not say so. We suggest instead that the Board's position established an unreasonable classification among business entities.

Crow provides that an employed physician can be paid productivity compensation from professional services but not from ancillary services. What happens to compensation for ancillary services? The compensation belongs to the owner of the practice. The owner of the practice in Florida may be a physician - in fact *the physician rendering the ancillary services* - or any other person. Thus, if the physician practices as a proprietorship, the physician retains ancillary service revenues as proprietorship earnings. If the physician practices as a Limited Liability Company or general partnership, the earnings are retained as partnership earnings and distributions. If the physician is the sole owner of a professional corporation, the ancillary service revenues are retained as corporate earnings or distributed as S-corporation profits. In any case, the physician is legally paid ancillary service revenues.

The Board of Medicine *Crow* approach, which has the effect of a rule, creates an unreasonable classification. It prohibits ancillary service compensation being paid to employed-physicians. It cannot, and does not, deny proprietor and partner physicians the revenue from ancillary services

The deference granted the Medical Board's concern about utilization "abuse: expressed by the Fifth D.C.A. is beyond the authority granted the Board of Medicine in the enabling legislation.

The Court also fails to understand the distinction in organizational form and the limits of authority of the Board of Medicine. There is no statutory authority for the distinction. If statutory authority existed, it most likely would create an unreasonable classification since a classification prohibiting compensation to employees but not partner, proprietors or owners has nothing to do with the health, safety or welfare of the people of Florida.

For several years, the Internal Revenue Service challenged the form of business organizations, creating "corporate tests" and non-corporate" tests to determine taxation. Recently, the IRS has come to the conclusion that form versus substance was not a game it should play. The IRS has issued its "check-a-box" regulations providing latitude for taxpayers in determining their business form without regard to taxation effect.

The logic discovered by the IRS should be applied in health care regulation as well.

HCFA has attempted such an approach in its Stark II proposed regulations. HCFA proposes to preclude group practice physicians from being compensated for designated health services self-referred. HCFA would permit designated health service compensation when the services are performed after a referral from another physician. HCFA permits designated health service revenues to be distributed as part of the general profit share. But, alas, HCFA's regulations are limited to group practice physicians and do not deal with services performed by proprietors.

The effect of the *Crow* decision and the position of HCFA in its proposed Stark II regulations which prohibit ancillary service revenues to physicians discourages formation of group practices, contrary to the requirements of today's health care environment. Why? If, for example, pulmonologists, radiologists and cardiologists who perform ancillary services, including designated health services, can be compensated for these services as proprietors, why should they join groups, or become employed, when ancillary service compensation as an employee or group practice member is restricted? When we lawyers advise these specialists that by joining a group practice, they give up ancillary revenues, their interest naturally disappears.

In re: Petition for Declaratory Statement of George G. Levy, the Board addressed an arrangement under which Dr. Levy employed a radiologist on a part time basis to provide professional interpretation of MRI's conducted on the Dr. Levy's patients. The radiologist was paid on a "per read" basis. That payment was some amount less than the full professional service fee paid to the practice for the professional interpretation provided by the radiologist. The Board declared the payment to violate section 458.331(1)(i) of the Florida Statutes, stating:

The Board of Medicine finds that Dr. Levy's retention of any portion of the professional fees billed for reading and interpreting scans and studies performed on his patients, without Dr. Levy actually performing any professional services is a "split-fee" arrangement and therefore prohibited by 458.331(1)(i) Fla. Stat.

The patients for whom services were rendered were Dr. Levy's patients; he owned the practice. The radiologist was an employee of Dr. Levy, and doctor Levy retained responsibility for actions

of Dr. Levy, including malpractice responsibility. Dr. Levy owned space and equipment, billed for the services performed and operational and administrative expenses.

The Board fails to attribute any value to these activities and non-professional services. Perhaps Dr. Levy did not ask. However, the logical conclusion from the Board's decisions in *Crow* and *Levy* are in conflict with its own ruling in those holdings permitting the corporate practice of medicine, such as *In re: The Petition for Declaratory Statement of John W. Lister*. In *Lister*, the Board held that Florida law does not prohibit a duly licensed medical doctor from practicing as an employee of a corporation. Thus, it is the corporate owner, not the employed physician, who owns the practice, determines who will be patients, what fees will be charged, and what is fair compensation for services rendered. It is the corporate owner in the position of a Dr. Levy who is entitled to the profits from services rendered by its employees.

Simply put, if the medical practice, its patients and accounts receivable are owned by an employer authorized to own a medical practice, the employed physician is not splitting fees. The owner already owns the fees. The physician employee is entitled to nothing but compensation for services rendered. If the physician provides unnecessary medical services, the Board of a Medicine has the power to discipline him, but the payment by the corporation for legitimate services is not a fee split for the referral of patients; the fee split is a legitimate payment for services. The patients belong to the practice owner, not the physician employed by the practice. If this were not true, corporate employers could not enjoin physicians from competition after employment terminates.

Ironically, the Board's advances and approves that a professional practice owner is entitled to compensation for the risks of ownership in its appellate briefs filed in the *PhyMatrix* case we noted previously. The position of the Board in its brief is worth restatement:

PhyMatrix suggests to the court that its agreement is simply the corporate practice of medicine with a different 'structure.' It is in fact this difference in structure that distinguishes this agreement from the corporate practice of medicine. In the corporate practice of medicine, the corporation owns the medical practice and carries all the liabilities and responsibilities of ownership. The owner-corporation legally employs physicians and at the end of business retains its corporate earnings. The PhyMatrix agreement seeks to avoid ownership, but still provides PhyMatrix a share of the earnings.

Medicare recognizes that practice owners own accounts receivable for professional services rendered. Florida law also recognizes practice ownership, distinguished from physician ownership, of patient charts and records. The Medical Board decisions in *Crow* and *Levy* are contrary to logic, statutory law and its own rulings and positions in other Board petitions.

Independent Contractor Arrangements

In *re: The Petition for Declaratory Statement of Edmund G. Lundy, M.D.*, the Board addressed a situation in which a physician engaged a corporation as an independent contractor. The corporation provided the physician with office space, advertising, billing and administrative services. The physician's fees were paid directly to the corporation. In exchange for the services rendered, the corporation retained 40% of the physician's fees, paying the physician the other

60%. The Board of Medicine ruled that this was not a fee split but "simply a charge for services rendered," because there was no referral relationship between the company and the physician.

However, the Board held that an additional arrangement under which the company was to be paid a percentage of the physician's fees for the referral of patients within a network developed by the company did constitute a prohibited fee split. The Board's concern over this arrangement centered on the fact that the percentage fee was only paid if both the referring physician and the receiving physician were members of the company's network. If, on the other hand, the referral came from someone out-of-network, or an in-network physician made a referral to an out-of-network specialist, no fee was due. The Board held that because of the disparity between in- and out-of-network referrals, the arrangement constituted a prohibited fee split.

The Board addressed the independent contractor status of a physician *In re: Petition for Declaratory Statement of Gary R. Johnson M.D. and the Green Clinic*. Under the arrangement, the Clinic provided the physician with supplies, support staff, equipment, and billing services. However, the physician maintained control over his professional services and the amount of the fees charged. Compensation was divided between the doctor and the Clinic, with the doctor receiving 46% of the fees charged and the Clinic receiving 54%. The Board found this arrangement to constitute a prohibited fee split because the Clinic was to receive the 54% of billings for services performed *both* within and outside of the Clinic.

Often organizations use revenue from various sources to measure compensation.

Negotiated compensation between independent parties usually results in fair market value for services provided. Carrying the Medical Board's view to its logical conclusion, the Clinic could have charged, say 60% from Clinic revenues and 0% from outside revenues. This mix may have produced the same compensation, as the formula found unlawful. Again, it appears the Medical Board reached beyond its statutory authority.

The petition also fails to clarify how the payment of a fee for management services is in fact a payment for referrals, the only issue the Board has the lawful authority to regulate. The holding does reflect the need for clearer statutory definition as to when a fee allocation is a fee split or a payment for services.

The case of *In re: The Petition for Declaratory Statement of Paul B. Speiller, M.D.*, addressed a similar arrangement. In that case, Dr. Speiller owned a medical clinic organized to engage physicians as independent contractors. Under the independent contractor agreements, the Clinic provided consultation rooms, equipment, labs, nurses, technicians and other attendants and administrative staff. The patients receiving services at the Clinic would "belong to the Clinic" and the Clinic would bill for all services provided to Clinic patients by the independent contractors both at the Clinic and at area hospitals. Unlike the *Green* case, however, in *Speiller*, the Clinic set the fees for all services rendered and the physicians would be paid a flat fee per procedure. In addition, physicians who served as independent contractors at the Clinic would be allowed to maintain separate, outside independent practices, the patients of which would belong to the physician and not to the Clinic. The Board also found this arrangement to constitute an improper fee split because, as in *Green*, the Clinic sought to bill for services provided to Clinic

patients both within and outside of the Clinic.

The Office of Inspector General considers Medicare-related compensation-arrangements between contractors in a different light than compensation arrangements with employees. Giving little credence to the long-standing *Respondeat Superior* body of common law holding a principal responsible for an agent, OIG views percentage contracts with independent contractors as suspect. OIG sees independent contractors as being less accountable than employees are. The OIG cites no authority or study for its position.

In OIG Advisory Opinion 98-10, cited above, HCFA advised that a commission payable to a manufacture representative for sale of diapers and other items to a hospital is subject to the federal anti-kickback statute. The OIG advised it would not take action since the commission was fair market value and there was no indication of referrals. A similar result was reached by Florida's Fourth D.C.A. in a case involving a commission due Medical Development Network, Inc. for its promotion of durable medical equipment sales by direct calls on nursing homes and physicians. The equipment was reimbursed under Medicare. The court held the commission was not due and payable.

The anti-kickback statutes have an exception for compensation paid to employees. Thus, the illegal result expressed in the OIG opinion and by the Florida court only occurs when the promotion is by contractors. Is that logical? We return to marketing later.

Management Contracts

The Board's management contract opinions divide between those that provide for straight management services and those that provide for management services including marketing or network creation. The Board has concluded that percentage management fees under a management agreement are illegal when the management company provides marketing, and particularly network development services, for the physician or physician practice. The Board equates marketing and network development (joining healthcare providers into units of service under contracts with insurers and other payers) as patient-referral activity.

However, the Board's rulings are not consistent.

In re: Petition for Declaratory Statement of Joseph M. Zeterberg, M.D., the petitioner sought Board approval for an arrangement under which a corporation bought substantially all of his practice assets and provided him with practice management services including office space, equipment, staff, practice supplies, medical transcription, and other support services. Additionally, the corporation developed a "circuit" of clinics in which the petitioner provided services.

The physician signed a no-competition agreement and was paid the greater of either a floor amount or a set percentage of revenues plus expenses, with the corporation retaining the remaining revenues.

The Board found this arrangement constituted a prohibited fee split. The Board distinguished this case from the facts in *Lundy* because the corporation established and operated a series of offices,

the "circuit." The Board found that:

...the contract does not cover simply an administrative charge factor, but includes the activities of the company in going out and marketing allergy care services. ... In addition, Petitioner emphasizes that the fee received by Petitioner is not split with the clinic directly. However, the fee is split indirectly. . Although none of the fees collected by the specialist would be shared with the general practitioner, they would be shared with AAC. The referral occurs by virtue of the fact that the Corporation develops the "circuit" and arranges appointments.

Contrasted is the Board's approach In *Department of Professional Regulation v. Vinger*. In this case, the Department of Administrative Hearings reviewed and accepted an order of the Board of Medicine. The Board held that a physician who, through a wholly owned corporation, arranged for the provision of ancillary health care services to nursing facility residents did not engage in an inappropriate fee splitting arrangement.

In this case, the corporation made arrangements to make ancillary services available to nursing facility residents. In exchange for facilitating these services, the corporation was paid a percentage of the performing physician's earnings for the services provided. The Board found that since the nursing home made the services available to the residents on a non-exclusive basis, there was no referral to the physician.

The Board ruled:

This percentage was for actual administrative services provided by Health Care Plus to the physician, including advertising the availability of services, making appointments, use of reception services, providing forms for patients and transcription services, providing assistance to the physicians at the nursing home, providing transportation for patients needing to go outside the nursing home for care, delivering reports to the nursing home for each patient seen, and other administrative services necessary to insure the operation of the program. Health Care Plus was providing valuable overhead and management services for the percentage it received.

The Board made clear that one of the reasons that the arrangement did not constitute a fee split was that the company was not paid on the basis of services delivered by the participating physicians outside of the nursing facility. The Board went on:

...the statute does not prohibit a corporation from providing administrative services to a physician for percentage fee. To hold otherwise would be to prohibit HMOs and other similar arrangements from operating, since patients visiting HMOs necessarily see physicians working with the HMOs which advertise their services and provide administrative and support services to the physicians who care for the patients within the HMO facility. A percentage of the fee the doctor is entitled to by virtue of the services he has rendered to a patient is remitted to the HMO for the administrative and overhead services provided by the corporation. On a smaller scale, the Respondent's relationship to Health Care Plus and its relationship to nursing home facilities is similar to that of an HMO, whereby the corporation advertises services, provides administrative support and collect a portion of the fee that a doctor receives for patient care in order to compensate the corporation for the services it provides.

However, *In re: Petition for Declaratory Statement of Magan L. Bakarania, M.D.* the Board

stated that a payment of a percentage management fee is an unlawful fee split under Florida law: Although payment of a flat fee in return for the provision of management services, including practice enhancement, is appropriate and allowable under Florida law, payment of a percentage of the revenue of the management services and practice enhancement generated is not permissible.

The PPMC in this case, PhyMatrix, provided:

- C general practice management,
- C relationships and affiliations with other physicians and specialists, hospitals, networks, health maintenance organizations and preferred provider organizations,
- C a provider network, integrated the practice into existing networks, and
- C strategic planning,
- C coordination of managed care relationships, and
- C consultation about fee schedules and other management services.

In addition, PhyMatrix provided the following operational services:

- C billing, collections and bookkeeping,
- C employing personnel, facilities and equipment, development and operation of the ancillary services, and
- C financial reporting.

PhyMatrix also purchased the practice assets and leased them back to the physician practice.

In exchange, the physicians paid PhyMatrix a three-tiered fee:

- C an operations fee for the actual third-party expenses incurred in providing the services listed,
- C a management fee of \$450,000 per year, and
- C a performance fee of 30% of the group practice's net income per year from all revenues, including ancillary services, supplies and pharmaceuticals.

The Board found:

...this agreement which requires petitioner or petitioner's group practice to pay a specified percentage of their net income without regard to the cost of providing services supplied by the company, and without regard to whether the income is from services performed either by petitioner or under petitioner's supervision or direction is a split fee arrangement that is in violation of Section 458.3311(i) Florida Statutes. Furthermore, payment of fees to the company, that are based upon revenue generated, at least in part, because of the referrals that the company

has helped to generate is in violation of Section 817.505(1)(a) Florida Statutes.

The Board further concludes that establishing networks of providers and marketing, a passive activity, is equivalent to the indirect referral of patients. Apparently, the Board sees a difference when an HMO performs the marketing and network activity, as it recognized and permitted in *Vinger*. The Board did not deal with whether or not the payment for services is reasonable or fair market value. The case is on appeal.

Leases

In re: Petition for Declaratory Statement of Barry Zaretsky, M.D., the Board addressed a case in which a specialist provided services in the office of various primary care physicians paying those physicians "rent" for the use of their office space. However, it appears from the context of the Board's opinion that the fee was paid only if Dr. Zaretsky used the space. And, that Dr. Zaretsky only used the space if the hosting physician referred a patient to him. As a result, the Board found that the arrangement constituted a prohibited fee split.

In a podiatric case, *In re: the Petition for Declaratory Statement of Robert N. Wayne D.P.M.*, the Board of Podiatric Medicine addressed an arrangement between a podiatrist and Doctor Shaw, a medical doctor. The podiatrist owned a machine useable by both professionals within their practices. When a podiatrist's patient required treatment using the machine that was outside podiatry, the podiatrist referred the patient to Shaw, quote the patient a range of fees and rental of the machine to Shaw for \$200 per hour. The Board held that as long as the podiatrist quoted a range of fees rather than Shaw's exact fee and made the machine available to others at the same price, the arrangement did not violate the fee splitting statute. Interestingly, however, the Board did not address whether or not \$200 per hour represented a fair amount for the rent of the machine or even if the fair market value of the machine's rental was an issue in interpreting the statute.

Equipment and Facility Ownership

In the case of *In re: Petition for Declaratory Statement of Melbourne Health Associates, Inc. and John Lozito*, the Board examined a transaction under which a limited partnership was formed to own and operate a rehabilitation center in which physicians would be limited partners. The Board found that the arrangement did not violate the fee splitting provisions because the return on investment by the limited partners will be solely through participation in the profits of the partnership based solely on the number of partnership units owned by that investor. The return on investment will not depend in any way on the number of referrals made by the investor to the entity.

The Board addressed the purchase of peripheral vascular study equipment *In re: Petition for Declaratory Statement of Gene E. Myers, M.D.* In *Myers*, the physician was a shareholder in a corporation that owned the peripheral vascular study equipment. The Board found that since the return on investment was based on the overall success of the corporation and not referrals to or from the corporation by the investors, the arrangement was not a violation of the fee splitting provisions. However, the Board held the fee splitting provisions are violated if "the ability of an

individual physician to participate in this investment opportunity were tied in any way to his ability or willingness to make referrals to the facility or the likelihood that he would do so.

Investment arrangements are now restrained under the Stark laws and under Florida Patient Self-Referral Act.

Marketing Activities and Split-Fee Arrangements

The Board of Medicine's rulings address the fee splitting implications for marketing and marketing-related activities. With the increasing competitiveness of the health care industry, marketing tools necessary to generate business. The health law question is whether these requirements can be satisfied.

Marketing has been defined as the analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives. Marketing in a general sense relies heavily on designing an organization's offering, here health care services, in terms of the target markets needs and desires and on using effective pricing, communication and distribution to inform, motivate, and service the markets.

A distinction can be drawn between two different types of marketing: (1) direct or active marketing, and (2) indirect or passive marketing. The OIG has employed this distinction in its description of those activities that would be subject to prosecution under the federal anti-kickback statute. The OIG has taken the position that the anti-kickback statute:

on its face prohibits offering or acceptance of remuneration, *inter alia*, for the purposes of 'arranging for or recommending purchasing, leasing, or ordering any ... service or item payable under Medicare or Medicaid.' Thus, we believe that many marketing and advertising activities may involve at least technical violations of the statute."

Media advertising, for example, may be technical violations of the anti -kickback laws, they do not warrant prosecution. OIG considers passive marketing activities as activities that do not involve direct person-to-person solicitation of Medicare and Medicaid beneficiaries or providers.

Despite drawing this distinction, in Advisory Letter 98-4, the OIG concluded that a PPMC management services contract which included passive marketing duties and paid the PPMC on a percentage basis implicated the anti-kickback statute since the percentage management fee could encourage overutilization and upcoding.

The American Bar Association also employs the distinction between direct or active and indirect or passive marketing in respect to attorney advertising. The ABA defines direct or active marketing as selling directly through a consumer without the use of a middleman. Examples include mail orders, cold calling, telephone sales, and door to door sales. Indirect or passive marketing occurs when the potential client must initiate the contact with the law firm. Examples include brochures, published articles, billboards, and newsletters. The ABA Code of Professional Responsibility forbids direct advertising. Like the medical profession, the solicitation of business

by a lawyer through direct, in-person communication with a prospective client has long been viewed as inconsistent with the profession's ideal of an attorney-client relationship and as posing a significant potential for harm to a prospective client.

The Rules regulating the Florida Bar which define permissible advertising permit passive marketing. For example, an attorney may advertise through the use of public media, such as a telephone directory, legal directory, newspaper or other periodical, billboards and other signs, radio, television, and recorded messages the public may access by dialing a telephone number, or through written communication not involving direct solicitation.

The Supreme Court has held that states have the power to discipline lawyers for direct client solicitation. The Court rationalized that active, in person-solicitation differs substantially from passive advertising. Additionally, states have a stronger interest in prohibiting "pressure-laden", in-person solicitation than they do in prohibiting passive advertising of routine legal services. The difference between public or indirect advertising and in-person or direct advertising is the requirement that the recipient make an immediate decision about representation without time to compare the "availability, nature, and prices" of other legal providers. Direct solicitation is a one-side process because it allows an attorney, trained in persuasion, the opportunity to manipulate an uninformed lay person. Therefore, because in-person attorney solicitation is usually done in private, it is not subject to the public scrutiny that advertising receives. The Court concluded that state solicitation regulations are preventative measures. These regulation "reduce the likelihood of overreaching and the exertion of undue influence on lay persons ... protect the privacy of individuals, and ... avoid situations where the lawyer's exercise of judgment on behalf of the client will be clouded by his own pecuniary self-interest."

The Board of Medicine has not distinguished between active and passive marketing with the clarity expressed by the Florida Bar. Although the OIG has recognized the difference, OIG 98-4 raises concerns that the difference is not clearly recognized. An argument can and should be made that the distinction is applicable in fee-splitting cases. A percentage payment for marketing services should not universally be viewed as a fee split regardless of the services provided.

The direct result of such a broad pronouncement is to preclude incentive based payments to entities providing services as basic to a successful medical practice as managed care contracting and the development of passive marketing materials such as brochures and print advertisements. This distinction goes well beyond the intent of the fee splitting and patient-brokering statutes designed to preclude physicians and others from actively soliciting patients and referrals.

The restraints imposed by the approach of the Board of Medicine and the OIG may also be unconstitutional infringements on free speech. A 1998 decision from the U.S. District Court for the Northern District of Florida declared a Florida statute prohibiting dentists from advertising membership in or specialty recognition by an organization not recognized or accredited by the American Dental Association as unconstitutional. The Court confirmed that commercial speech enjoys First Amendment protection. Only commercial speech that is false, deceptive or misleading can be prohibited. The Court held that the Florida Board of Dentistry "may not rely on speculation or conjecture but must produce specific evidence to demonstrate that the harms ...

are real and substantial." The Board failed to meet that standard.

Certainly neither the Board of Medicine nor OIG considered the constitutional implications of its decision in regard to its concern about marketing activities by a PPMC. If a dentist or a doctor has the constitutional right to engage in commercial advertising, then the dentist and doctor have the constitutional right to employ professionals skilled in commercial free speech to assist them. Engaging professionals, including PPMC's, should be constitutionally protected and fair market value compensation should likewise.

The Minnesota Approach

Upon careful examination of the Medical Board approach, one can easily argue that the Medical Board has exceeded its interpretive authority. One can also easily argue that the courts have paid unusual deference to the Medical Board and its interpretations without careful analysis. Unfortunately, such arguments without legislative or further court support leave well-meaning physicians exposed to discipline, fines and penalties. What appears to be needed is a statutory revision providing clear guidance.

Minnesota Statutes 1997, section 147.091(p), provides:

(p) Fee splitting, includes without limitation:

- (1) paying, offering to pay, receiving, or agreeing to receive, a commission, rebate, or remuneration, directly or indirectly, primarily for the referral of patients or the prescription of drugs or devices;
- (2) dividing fees with another physician or a professional corporation, unless the division is in proportion to the service provided and the responsibility assumed by each professional and the physician has disclosed the terms of the division;
- (3) referring a patient to any health care provider in which the referring physician has a significant financial interest unless the physician has disclosed the physician's own profit interest; and
- (4) dispensing for profit any drug or device, unless the physician has disclosed the physician's own profit interest.

The Minnesota Rules provide a simple guide for the medical board:

5620.0160 DIVISION OF FEES.

In reviewing a division of fees ... the board may consider, but is not limited to, the following factors regarding the reasonableness of the proportional division of fees:

1. the value of the professional services;
2. overhead costs;
3. time and distance traveled; and
4. the availability of the service or the product elsewhere in the local trade area.

Conclusion

Lost on the Board of Medicine has been the clean, crisp holding of the Second D.C.A. that illegal fee splitting involves direct, patient-specific activity not any business activity. In reaching its decision, the court said:

Such an interpretation recognizes the complexities of marketing and management of professional services in today's competitive business environment without compromising the public policy behind legislation prohibiting or regulating the division of professional fees.

Sadly, even if the percentage fee management contract used by PhyMatrix is upheld on appeal, reversing the Board of Medicine in *Bakarania* unresolved issues remain because of *Crow*, *Levy* and other Board decisions.

The Minnesota statute cited above prohibits fee splitting when compensation is paid "primarily for the referral of patients or the prescription of drugs or devices." This approach is similar to the AMA's ethical rules defining fee splitting:

Fee splitting arrangements between physicians and other independent practitioners in which payment is made *merely for referral of patients* are unethical....

The statute reaches a result similar to the Florida Second D.C.A. holding which limits fee splitting to payments made for the "mere referral" of patients. The reference to "primarily" or "merely" reflects the reality and requirements of medicine today.

Minnesota also permits physicians to divide fees for services rendered, solving the global fee requirements of managed care. This is helpful. The complexity of the managed care environment requires patient referrals, often among providers in exclusive networks who must share global fees. The market place's insistence on global fee demands that fees be split - shared among those who do the work. The market place has the ability to dictate how those fees will be shared. PPMC's providing management, passive marketing and network organization may be survival-necessities. Statistics are abundantly available to those charged with managing the system.

Guidance on the distinction between payment for a "mere referral" and for goods and services is provided in the Real Estate Settlement Procedures Act ("RESPA"). RESPA prohibits kickbacks in connection with a real estate settlement service related to a federally funded loan. An exception to the definition of kickback is provided for fees for goods and services actually furnished. Kickbacks are resolved under RESPA by determining whether or not goods and services were furnished and whether or not fair market value was charged for the services. The Board of Medicine, at least in dicta, has on occasions noted that percentage fees exceed costs, but does not address the value of the services. Cost and value are not necessarily related, as any person in business can attest. Percentage fees, a form of productivity compensation, are often the fair market value for the services rendered. Percentage fees and productivity compensation are the norm in almost every business today,

Any legislation intended to fairly deal with kickbacks and referral fees should include an exception for goods and services provided at fair market value, as does RESPA.

Unstated in the Minnesota law is whether kickbacks occur between employer and employee.

The federal anti-kickback statute provides an employee exemption and excepts from the kickback law "any amount paid by an employer to an employee (who has a *bona fide* employment relationship with such employer) for employment in the provision of covered services." A similar provision should be part of any fee-split legislation.

With the variety of today's business organizations, selected for tax and other non-health care regulation reasons, the employee exception should, in reality, be expanded to Limited Liability Company members and partners. Logic also indicates that independent contractors paid fair market value compensation for other legitimate services should also be excluded as recognized in OIG Advisory Opinion 98-10.

Related is the issue of disclosure. Disclosure of inter-relationships and compensation arrangements has been an integral to securities offerings since the 1933 Securities Act became law. Disclosure allows patients and buyers of health care services to make informed decisions and set appropriate contractual terms for relationships. Most states have adopted requirements that physicians disclose investment interests in health care facilities to patients. Minnesota requires disclosure as part of its fee-split statute. Publicity stigmatizes inappropriate behavior. The requirement for disclosure should be a part of fee split regulation.

The Board of Medicine has approached fee splitting in an arbitrary fashion, as if the idea exists in a vacuum. Its decisions lack practical reality, and, as we have noted, may well exceed the Board's statutory and constitutional authority. Fee splitting demands definition and revision to fit today's environment.

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SPECIAL ISSUE: HEALTH LAW SYMPOSIUM: ARTICLE: FLORIDA BOARD OF MEDICINE
RESISTS CHANGE

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SUMMARY:

... During the 1990's, the health care industry has been experiencing revolutionary changes.
... Such provisions include, among others, the prohibition against "paying or receiving any commission, bonus, kick-back or rebate, or engaging in any split fee arrangement ... for patients referred to providers of health care goods and services. ...In this Order, the Board declared that the payment by a physician group practice of a management fee equal to a percentage of the group's net income violates Florida's prohibition against fee-splitting. ... Dr. Bakarania is a Florida licensed physician who was considering joining a group practice which had recently entered into a long-term management agreement with Phymatrix Practice Management Company, a national practice management company. ...The Bakarania decision casts a cloud of uncertainty over the physician practice management business in Florida, raising doubts about the legality of many existing and proposed management contracts. ...In November, 1997, when the Board issued its Order in Bakarania, the physician practice management industry was growing rapidly. ...The Self-Referral Act contains an exception from the basic prohibition for referrals by a member of a group practice for services provided solely for the group's patients and that are provided by or under the direct supervision of another member of the group. ...

TEXT:

[*485]

During the 1990's, the health care industry has been experiencing revolutionary changes. The growth of managed care, the consolidation of physician practices, and the development and growth of physician practice management companies have spurred the creation of new economic arrangements and alliances, as providers, payors, and managers struggle to survive and prosper in a changing health care environment. In the face of decreasing payments from managed care payors, health care providers are constantly seeking new sources of revenue and new ways to expand their patient base.

The economic arrangements which providers enter into to achieve these objectives often raise questions under federal and state anti-fraud and abuse laws, prohibitions against fee splitting, and prohibitions against "self-referrals." In the State of Florida, the Florida Board of Medicine is often called upon to issue a Declaratory Statement as to whether a particular economic arrangement is in compliance with applicable provisions of Florida law.

¹ The questions posed to the Board of Medicine in various requests for Declaratory Statements often involve a tension between innovative new ways to structure delivery of health care services in a changing health care industry and established prohibitions against fee-splitting, self-referral and other practices which are often associated with over-utilization of health care services. In weighing these competing values, the Board of Medicine has generally followed the more conservative road, favoring traditional ways of doing business and ruling that various new economic arrangements are in violation of applicable law.

The Florida Board of Medicine is one of several regulatory boards within the Florida Department of Business and Professional Regulation which are responsible for regulating the practice of various professions. The Board of Medicine consists of 15 members, 12 of whom must be licensed physicians. Although the principal function of the Board of Medicine is to review and [*486] adjudicate complaints against physicians alleging professional malpractice or other violations of the Medical Practice Act,

² the Board of Medicine is also responsible for enforcing various provisions of the Medical Practice Act relating to the business of practicing medicine. Such provisions include, among others, the prohibition against "paying or receiving any commission, bonus, kick-back or rebate, or engaging in any split fee arrangement ...for patients referred to providers of health care goods and services.

³ In the past several years, the Board has issued several orders, in response to requests for Declaratory Statements, declaring illegal certain business practices and relationships which have been developed by providers and practice management companies in response to changes in the health care industry. Seeking to prevent or delay changes in the way the business of health care is conducted, the Board has relied upon broad interpretations of Florida's statutory prohibitions against fee-splitting and kick-backs in declaring its disapproval of certain business arrangements.

Perhaps the most significant of the Board's recent decisions is In re: The Petition for Declaratory Statement of Magan L. Bakarania, M.D., issued by the Board on November 3, 1997.

⁴ In this Order, the Board declared that the payment by a physician group practice of a management fee equal to a percentage of the group's net income violates Florida's prohibition against fee-splitting.

In recent years, as physician practices have consolidated and grown in size, many physicians have turned to physician practice management companies to manage their practices and provide various other services. A wide range of compensation arrangements have been developed in connection with the provision of practice management services. In many instances, a physician group will pay its management company a percentage of the group's revenues or profits as consideration for management services provided by the company.

Dr. Bakarania is a Florida licensed physician who was considering joining a group practice which had recently entered into a long-term management agreement with Phymatrix Practice Management Company, a national practice management company.

⁵ Pursuant to the management agreement, the management company was to provide general management services, including but not limited to "practice expansion" services. The practice expansion services included creating a physician- provider network, developing relationships and affiliations with other specialists, hospitals, networks, [*487] HMOs and PPOs, developing and providing ancillary services, and evaluating, negotiating and administering managed care contracts.

6

As consideration for providing the specified management and practice expansion services, the management company would receive a management fee consisting of three separate components: (1) an operations fee equal to the company's actual out-of- pocket expenses for providing operational services; (2) a fixed annual fee, to compensate the company for providing general management services; and (3) a performance fee, equal to 30% of the group's net income.

⁷ Dr. Bakarania sought the Board's guidance as to whether the proposed compensation arrangement was in violation of the prohibition against fee-splitting, set forth in Section 458.331(1)(i) of the Florida Statutes.

⁸ That section prohibits the "paying or receiving of any commission, bonus, kick-back or rebate,

or engaging in any split- fee arrangement, in any form whatsoever with a physician, organization, agency or person, either directly or indirectly, for patients referred to providers of health care goods and services."

In its Order, the Board ruled that the payment of a performance fee which is equal to a percentage of the physicians' net income and which is payable without regard to the cost of the management services provided is a split-fee arrangement in violation of Florida law.

⁹ The Board found that the management company's practice expansion activities helped generate referrals, and that the payment of fees based on revenues generated by these referrals violated the prohibition against fee- splitting.

¹⁰ In its decision, the Board was not influenced by the fact that the proposed compensation structure is widely used, in Florida and elsewhere across the country, and is an essential element of the business relationship between practice management companies and the practices which they manage.

11

In its decision, the Board sought to distinguish the Bakarania situation from the management agreements examined in a line of judicial decisions in Florida which hold that percentage fee payments to management companies [*488] do not violate the fee-splitting prohibition.

¹² According to the Board, the management agreements in the prior cases did not expressly require the management company to expand the physicians' practices or provide additional referrals of patients.

¹³ The Board concluded that the practice expansion activities performed by Phymatrix were equivalent to making referrals to the practice, and that payment of a fee for the practice expansion services based upon the practice's income amounts to prohibited fee-splitting.

¹⁴ The Board ignored the previously- accepted distinction between direct referrals from one provider to another provider, and practice expansion and network development activities which may develop additional business but do not result in referrals of specific patients.

Although the Board stated that its ruling was limited to the facts presented in the Petition for Declaratory Statement, and the decision was not intended to be construed as an absolute prohibition against percentage fees in physician practice management agreements,

¹⁵ it is difficult to determine from the decision what types of percentage arrangements would be permissible. It is possible that, in future management agreements, the management company could be compensated in different ways for the various services it provides. For example, the management company could receive a percentage-based fee for administrative management services and a flat fee for practice expansion and network development activities. This structure apparently would not violate the statutory provision against fee-splitting, as interpreted by the Board in Bakarania.

The Bakarania decision casts a cloud of uncertainty over the physician practice management business in Florida, raising doubts about the legality of many existing and proposed management contracts. According to persons associated with the practice management industry, a number of significant transactions were deferred, restructured or abandoned as a result of the Bakarania decision. Although not all physicians regard practice management companies favorably, such companies have provided valuable services and resources to many physician practices, and a management fee based on a percentage of revenues or income is usually an essential part of the contractual arrangement between the parties.

[*489]

The Board's decision in Bakarania was appealed to the District Court of Appeals by Phymatrix, and the Board agreed to stay its decision pending the outcome of the appeal. On June 25, 1999, the First District Court of Appeal affirmed the Board of Medicine's Order, stating, in a one paragraph per curiam opinion, that, because the appellant had not shown that the Board's interpretation of the law is "clearly erroneous," the Board's decision must be affirmed.

¹⁶

In November, 1997, when the Board issued its Order in Bakarania, the physician practice management industry was growing rapidly. As the spread of managed care threatened to erode physicians' patient bases and reduce fees, many physicians were being enticed to sell their practices to practice management companies which promised to reduce operating costs by managing practices more efficiently, and to create countervailing market power to negotiate favorable contracts with managed care companies. The practice management companies also offered the possibility of windfall investment gains. Many physicians received stock in the management company as part of the consideration for the sale of their practice, and, based upon the favorable valuations Wall Street was according to these companies, physicians expected significant appreciation in the value of their stock. These expectations were dashed in 1998, when severe problems started appearing in the practice management industry, as many companies failed to provide competent management services, and did not produce promised cost savings and revenue increases. The market value of many publicly-traded management companies plummeted. Several practice management companies filed for bankruptcy protection, and other companies, including Phymatrix, announced plans to abandon the physician practice management business entirely, to concentrate on other health care business activities.

At approximately the same time the Board's Order in Bakarania was affirmed, the Board issued its Final Order In re: The Petition for Declaratory Statement of Rew, Rogers & Silver, M.D.'s, P.A.

¹⁷ In this Order, the Board reaffirmed prior orders which found that a percentage management fee did not necessarily violate the prohibition against fee-splitting if the management company was not responsible for generating referrals. The Board distinguished the case presented from the facts in Bakarania, finding that the management company managing the Rew, Rogers medical practice was not responsible for expanding or growing the practice. Further, the percentage fee was capped at a maximum of \$ 10,000 per month, thus capping the [*490] management company's incentive to grow the practice. The Board held that, under these circumstances, the percentage management fee did not violate the fee-splitting provision. The Board did not specifically indicate whether the monthly fee cap was essential to its decision, or whether it was sufficient that the management company was not obligated to generate additional patients. for the managed practice. In either event, this recent ruling indicates that the Board is not completely averse to the changing financial arrangements which are occurring in the medical industry, and the ruling should provide some measure of relief to practice management companies which receive a percentage of the managed group's income as all or part of their management fee.

Two other Orders issued by the Board in 1997, although having a narrower impact than Bakarania, also demonstrate the Board's reluctance to accept new economic arrangements involving physicians who are seeking ways to adapt to and prosper in the changing health care economic environment.

On November 3, 1997, the same day it issued its Order in Bakarania, the Board also issued its Final Order In re: The Petition for Declaratory Statement of Jeffrey Fernyhough, M.D.

¹⁸ Dr. Fernyhough sought the Board's guidance with respect to his proposal to lease "prime" counter space in his office to a mail-order pharmacy, for the installation of the pharmacy's computer terminal. Utilizing the computer terminal, Dr. Fernyhough's patients could order medications prescribed by the doctor and would receive them the next day by overnight mail delivery. The computer would contain relevant patient data (which would be entered by the doctor's administrative staff), and the computer's sophisticated software would enable the doctor to determine whether any prescribed medication would cause an adverse interaction or be duplicative of any other prescribed medication. The presence of the computer terminal in the doctor's office would also provide increased convenience for patients in ordering and obtaining prescribed medications, Patients would not be required to use the mail-order pharmacy for obtaining prescribed medications, and all patients would be advised of their right to obtain medication from the pharmacy of their choice.

¹⁹

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The pharmacy proposed to enter into a written agreement with the doctor pursuant to which the pharmacy would pay the doctor rent for lease of the counter space and reimburse the doctor for administrative services performed by the doctor's staff in connection with inputting patient data into the computer. The rental payments were asserted to be consistent with the fair [*491] market value of the counter space being leased and with the cost of administrative personnel, as determined in an arm's length transaction, and would not be determined in a manner which takes into account the volume or value of any referrals or business generated between the doctor and the pharmacy.

20

The Board refused to accept the doctor's representations that the fair market value of the prime counter space in his office could be determined in such a manner as to avoid the doctor receiving a windfall from the lease of a few feet of counter space. The Board found that the arrangement is "simply put, a scheme to allow pharmacy to pay Petitioner in return for providing referrals to the pharmacy in violation of Section 458.331(1)(i), Florida Statutes." In making its ruling, the Board apparently did not consider potential benefits to patients arising from the presence of the pharmacy's computer terminal in the doctor's office, or the advances in computer technology which may support changes in the traditional relationships between physicians and pharmacies.

The Board's Final Order In re: The Petition for Declaratory Statement of George G. Levy, M.D., issued on May 2, 1997, represents another refusal by the Board to accept non-traditional economic relationships involving physicians.

²¹ In his medical practice, Dr. Levy had the need to order, from time to time, magnetic resonance imaging (MRI) studies for his patients. Dr. Levy sought to facilitate the prompt and efficient provision of MRI scans for his patients by engaging a qualified radiologist physician as a part-time employee, to interpret MRI scans performed for Dr. Levy's patients by an independent MRI center. The MRI center would perform the scans on Dr. Levy's patients and provide Dr. Levy with the MRI films, for interpretation by Dr. Levy's radiologist employee. Dr. Levy would utilize information contained in the radiologist's report to treat his patients. The MRI center would bill the patient's insurer for the "technical" portion of the scan. Dr. Levy's office would bill the patient's insurer for the "professional" portion or the interpretation. Dr. Levy would pay his radiologist employee on a "per-read" basis, paying him a specific amount for each interpretation. To the extent collections with respect to the professional component of the MRI service exceeded the per-read fees paid by Dr. Levy to his radiologist employee, Dr. Levy would retain the difference.

The Board ruled that Dr. Levy's retention of any portion of the professional fees billed for reading and interpreting scans and studies performed on his patients without Dr. Levy actually performing any [*492] professional service is a "split-fee arrangement," in violation of Section

458.331(1)(i) of the Florida Statutes. In reaching this restrictive result, the Board apparently ignored the employer-employee relationship between Dr. Levy and the radiologist, ruling, in effect, that referrals from an employer to an employee will be subject to the same scrutiny as referrals between separate entities, and that an employer may not retain a portion of the revenue generated from services provided by his employee to referred patients.

On the other hand, the conservative result reached by the Board in *In re: The Petition for Declaratory Statement of Alan Levin, M.D. and Ameripath, Inc.*

²², which dealt primarily with the Florida Patient Self-Referral Act of 1992,

²³ is consistent with applicable law, and the Board did not have to rely on an overboard interpretation of the statutory language to reach its conservative result. This case involved a proposal by Ameripath to provide pathologists to groups of dermatologist physicians, on a part-time basis, pursuant to independent contractor and employee leasing arrangements, so that the dermatology groups could provide clinical laboratory and pathology services for the groups' patients. The consideration to be paid by such groups to Ameripath would be less than the amount which the groups would be entitled to bill for the pathologists' services.

²⁴

The Board found that the proposed arrangements violated the Self-Referral Act. The Self-Referral Act prohibits a health care provider from referring patients for the provision of certain "designated health services" (including, among others, clinical laboratory services) to an entity in which the referring provider is an investor.

²⁵ The referral of patients to the pathologist for clinical laboratory services, and the fact that the dermatology group billed for the pathologist's professional services, triggers the prohibitions of the Self-Referral Act.

The Self-Referral Act contains an exception from the basic prohibition for referrals by a member of a group practice for services provided solely for the group's patients and that are provided by or under the direct supervision of another member of the group.

²⁶

The Board properly found that the proposed arrangement did not qualify for this exception.

²⁷ When the services provided by a part-time pathologist were considered as part of the services provided by a dermatology group, the group would not meet the Self-Referral Act's definition of a "group practice." [*493] The statutory definition of a "group practice" requires (i) that each member of the group provide "substantially the full range of services which the health care provider routinely provides ..., through the use of shared office space, facilities, equipment and personnel," and (ii) that substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group."

28

The Board found that, because a pathologist would be providing a limited range of services for a dermatology group, he would not be providing, on behalf of the group, the full range of services which he normally provides as part of his overall practice. Thus the dermatology group would not meet the first test set forth in the statutory definition. The Board also found that, because a pathologist would be employed on a part-time basis and would devote only part of his professional time to providing services through the dermatology group, in many instances, the requirement that members of the group provide substantially all of the services provided by such persons through the group would not be satisfied.

29

The prohibitions of the Self-Referral Act are set forth clearly and explicitly, and allow less room for interpretation than the prohibition against fee-splitting. The Board's Order in Levin involved the application of a fairly explicit law to a particular set of facts rather than a determination of the parameters of a more general law which is subject to varying interpretations. Curiously, after holding that the proposed arrangements in Levin violated the Self-Referral Act, the Board also ruled, using rather circular reasoning, that the arrangements also violated the prohibition against fee-splitting.

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Florida's statutory prohibitions against fee-splitting and self-referral are designed to control health care costs by discouraging unnecessary referrals induced by financial incentives. Proper interpretation and enforcement of these statutory provisions is essential to maintaining the economic integrity [*494] of the health care system. The prohibitions should not be interpreted so broadly, however, so as to thwart innovation and the development of new relationships or arrangements which may promote efficiency or better or more convenient service for patients. The Board of Medicine should recognize that the health care industry is changing rapidly. In reviewing proposed new economic arrangements, the Board should weigh the benefits which may accrue to patients and to physicians from such arrangements against the possibilities of abuse which may be inherent in such relationships.

¹ Section 120.565 of the Florida Statutes provides that each agency shall provide by rule a procedure for the filing and prompt disposition of petitions for declaratory statements as to the applicability of a specified statutory provision or rule to a particular set of facts. Although a declaratory statement applies only to the petitioner and the particular facts presented, the declaratory statements are published and put parties on notice as to how the agency or board issuing the statement interprets a particular statute or rule.

² Fla. Stat. ch.458 (1997)

³ Fla. Stat. §458.331(1)(i) (1997).

⁴ 20 FALR 395 (Nov. 3, 1997).

⁵ Id.

⁶ Id. at 398-99.

⁷ Id. at 396-97.

⁸ In most requests for Declaratory Statement, the petitioner is seeking a statement that a particular arrangement or transaction does not violate applicable statutes or regulations. In this particular instance, however, the physician group practice which Dr. Bakarania was planning to join was seeking to terminate its contractual relationship with Phymatrix. Thus, Dr. Bakarania was actually seeking a statement from the Board of Medicine to the effect that the subject management agreement was in violation of Florida law, and was, therefore, void or voidable.

⁹ In re Bakarania, 20 FALR at 398.

¹⁰ Id.

¹¹ Id.

¹² See e.g., Practice Management Associates v. Orman, 614 So. 2d 1135 (Fla. 2d DCA 1993); Practice Management Associates v. Gulley, 618 So.2d 259 (Fla. 2d DCA 1993); Practice Management Associates, Inc. v. Bitet, 654 So. 2d 966 (Fla. 2d DCA 1995). These cases, which are cited at note 4 of the Bakarania Declaratory Statement, involve language in Florida's Chiropractic Practice Act which is virtually identical to the language set forth in Section 458.331(1)(i) (1999) of the Florida Statutes.

¹³ In re Bakarania, 20 FALR at 398.

¹⁴ Id. at 399.

¹⁵ Id.

¹⁶ Phymatrix Management Co., Inc. v. Bakarania, 24 Fla. L. Weekly. D1500 (Fla. 1st DCA June 25, 1999).

¹⁷ As of August 20, 1999, the Board had approved the draft Final Order, but the Order had not yet been signed or filed with the Department of Health.

¹⁸ 20 FALR 4381 (Fla. Bd. of Medicine 1997).

¹⁹ Id. at 4382.

²⁰ Id. at 4383.

²¹ Final Order # AHCA-97-0495 (1997).

²² 19 FALR 4525 (Fla. Bd. of Medicine 1997).

²³ Fla. Stat. §455.236 Fla. Stat. (1992) (renumbered Fla. Stat. §455.654 (1997)).

²⁴ In re Levin, 19 FALR at 4526.

²⁵ See id. at 4527.

²⁶ Fla. Stat. §455.654(3)(k)3.f. (Supp. 1998).

²⁷ In re Levin, 19 FALR at 4528.

²⁸ Fla. Stat. §455.654(3)(f) (1997).

²⁹ Noting that the Self-Referral Act did not specifically define the term "substantially all," as that term relates to services provided by members of the group, The Board noted the similarity of the definition of "group practice" contained in the "Stark Bill" the federal statute prohibiting self-referrals -and borrowed the standard established by federal regulators implementing the Stark Bill, which require that at least 75% of the total patient care services provided by members of a group be furnished through the group.

³⁰ After finding the arrangements violated the Self- Referral Act, the Board stated:

Therefore, to the extent that such referrals would involve splitting professional fees between the referring entity of physicians and the Ameripath employed pathologists, such arrangement would result in a

violation of [the statutory prohibition against fee-splitting], because it would entail a split-fee arrangement. 19 FALR at 4529.

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FEATURE: FEE SPLITTING AND THE MANAGEMENT OF MEDICAL PRACTICES: A HISTORY OF BOARD OF MEDICINE DECLARATORY STATEMENTS

by Allen R. Grossman and R. Andrew Rock

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TEXT:

[*48] Over the past 10 years, the Florida Board of Medicine has issued a number of declaratory statements on the subject of fee splitting in the context of employment, management, and marketing arrangements between licensed physicians and business corporations and partnerships. The board's early declaratory statements addressed less than comprehensive business arrangements when private companies provided only space and basic management services. The board's most recent declaratory statement addresses overall management and marketing as provided by current physician practice management companies (PPMs). PPMs integrate physician practices into well organized networks for, among other things, the purposes of obtaining managed care contracts with health management organizations, insurers, and employers and of taking advantage of economies of scale.

At a meeting in Tampa on October 17, 1997, the board made its most recent statement on the issue of fee splitting related to medical practice management. In its final order filed on November 10, 1997, the board declared that a management contract between Access Medical, Inc., a 15-physician internal medicine group, and a practice management company, Management Company, Inc., violates Florida's statutory prohibition on fee splitting³⁰. The management contract, described in the petition for declaratory statement, requires the group to pay Phymatrix a percentage of the group's net revenues, in addition to all actual operating costs and a flat fee of \$ 450,000 per year. In return, Phymatrix provides management services to the group that include physician network development, managed care contracting, and other efforts to increase the number of patient referrals made to the group. Phymatrix is appealing the board's final order and the board has agreed to stay the final order pending the outcome of the appeal³⁰. The decision has attracted substantial attention at the state and national levels, as it threatens the legality of the current popular trend toward similar management contracts between physician practice groups and PPMs.

The basis for the final order appears in F.S. § 458.331(1), which sets forth a list of acts or omissions for which the board may take disciplinary action against a physician's license. The list includes § 458.331(1)(i), which prohibits "paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services. ..."³⁰

Florida's Administrative Procedures Act³⁰ authorizes an agency, such as the board, to issue declaratory statements that provide explanations of the agency's opinion with regard to the application of a specific statute, rule, or order to a particular set of circumstances³⁰. The uniform rules of procedure require a petitioner to allege the potential impact upon the petitioner's interest in order to show the existence of a controversy, question, or doubt as to the application of the specific requirement or prohibition³⁰. Florida's courts have set forth the appropriate use and scope of agency declaratory statements. To be entitled to the issuance of an agency declaratory statement, a petitioner must demonstrate an actual present and practical [*49] need for such statement³⁰. Agency declaratory statements may determine issues not presented in a petition when they are related to the application of a particular statute, rule, or order to specifically stated facts³⁰. However, such statements may not be utilized by an agency for the purpose of setting forth broad agency policies³⁰.

Agency declaratory statements generally bind the agency and the parties to the action with regard to the specific facts set forth in the petition and relied upon in the final order. The board has been known to push the envelope in responding to petitions which set forth specific facts that arguably could apply to any number of physicians licensed by the board. Of course, licensees often are most anxious to have the board address the most prevalent factual scenarios. Issues related to fee splitting and permissible corporate structures have been the issues most frequently posed to the board.

One of the board's first declaratory statements on these issues was in *In re Lundy*, 9 FALR 6289 (1987), in which the board considered a petition that described a business entity which provided office space and equipment and also billing and collection services to a group of family practitioners. The business entity also provided newspaper, radio, and television advertising and promoted the group's services to prospective patients³⁰. In exchange, the business entity retained 40 percent of collections. The board held that this agreement was not prohibited under the fee splitting statute. It stated:

While the scenario establishes that the patients' fees would be paid to the corporation and sixty percent of the fee would be returned to the practitioner, the sixty percent of the fee is attributed to the payment for lease of the space and equipment and for the provision of advertising and administrative services. Since the fee is not in any apparent way, either directly or indirectly, tied to an arrangement whereby the corporation makes referrals to the physicians or the physicians make referrals to the corporation, the Board does not perceive the arrangement as being prohibited by the statutory provision at issue³⁰.

At about the same time as it rendered the *Lundy* decision, in *In re Lozito*, 9 FALR 6295 (1987)³⁰, the board declared that a limited partnership (which included physician limited partners) that was formed to own and lease a rehabilitation center could lease the center for a fixed rent plus five percent of operating profits. The board held that the return on the physicians' investment would be proportionate to ownership interest, and, therefore, would not violate the fee splitting statute. While the fast developing PPM industry may have taken comfort from these early declaratory statements, the board has held most recently that several other business arrangements constitute prohibited fee splitting. In 1990, the board ruled on a petition for declaratory statement that described

a business corporation providing office space, staff, equipment, billing services, and marketing services of Dr. Zeterberg, an allergist³⁰. The marketing services included creation of a "circuit" of physician's offices in which the management company would lease space and other services required for the allergist to visit and provide specialist services to patients of the practices included in the "circuit." As set forth in the petition for declaratory statement, the allergist was to be paid a percentage of revenues. The board held that this arrangement constituted indirect payments to the clinics in the "circuit" for referrals and, therefore, was prohibited under the fee splitting statute. The board distinguished this arrangement from that in *Lundy* because here, the allergist's agreement included marketing as well as administrative services. The provision of marketing services appears to be a "red flag" indicative of fee splitting [*50] concerns. Two years later, the board reviewed a petition for declaratory statement that described the petitioner as the owner and operator of a multispecialty clinic that provided space, staff, ancillary services, and advertising for independent contractor physicians who provided patient services on a flat fee basis per procedure performed³⁰. The board found that this arrangement violated the fee splitting prohibition because the patients "belonged to" the clinic that referred them to the physician independent contractors and in return kept part of the fee. In arriving at this decision, an important factor was that the arrangement included services provided by the independent contractor physicians in a hospital setting, as well as the services provided in the clinic. The board determined that this showed that the independent contractor physicians were paying the clinic for establishing a patient relationship, not just for goods and services provided to the physician independent contractors when they practiced at the clinic.

The fact that the arrangement included services provided outside of the clinic also was an important factor in another declaratory statement issued by the board in 1992³⁰. As described in that petition, the Green Clinic was a partnership that contracted with individual physicians to provide space, staff, supplies, billing, collection, and other administrative management services, as well as access to ancillary services such as diagnostic equipment. The partnership retained 54 percent of the physician's collections. The board held that this was "classic fee splitting," because it was based purely on billings for physician services without any relationship to the cost of those services, and because the deal included hospital as well as office services.

Subsequently, in Crow v. Agency for Health Care Administration, 669 So. 2d 1160 (Fla. 5th DCA 1996), the Fifth District Court of Appeal upheld a declaratory statement of the board. This statement involved remuneration from a company that had purchased a physician's practice to the physician as an employee subsequent to the sale. The board found the remuneration to be tainted because it was based upon the overall revenues generated by the physician including revenues generated by referrals for ancillary services³⁰. Ancillary services consist of such procedures as laboratory tests and diagnostic procedures ordered by a physician. In its opinion, the court stated that it was appropriate for the board to make it clear that selling one's practice to an HMO is not a loophole to F.S. § 458.331(1)(i). The court's ruling in *Crow* set the stage for the petition recently filed by Dr. Bakarania.

The board's most recent declaratory statement was initiated by a petition filed with the board on June 24, 1997. The initial petitioner was Magan L. Bakarania, M.D., a Florida physician, who stated that he was considering joining the Access Medical primary care physician group in Tampa. Access Medical had a management contract that requires the company to provide the group with administrative management services such as bookkeeping, billing, and collections, and providing facilities, staff, and equipment. The company also must provide more general management services, including the development of physician networks and the negotiation of HMO and PPO contracts on behalf of those networks and the group. In return, the group was required to pay the company three separate fees: an operations fee equivalent to the actual expenses incurred by the company in providing management services to the group; a general management fee of \$ 450,000 annually; and

an annual "performance fee" equal to 30 percent of the group's annual collections, net of the other two fees, and of the group's "profits" prior to its relationship with the company. The original petitioner, Dr. Bakarania, asked the board to declare whether this arrangement was lawful under F.S. § 458.331(1)(i) and F.S. § 817.505.³⁰

Dr. Bakarania apparently wished the board to declare the company's management contract illegal. His petition highlighted the similarity of the company's management contract to the contract described in *Green Clinic*, 14 FALR 3935. Similarities include the facts that the percentage payment is not related to the cost of the management services provided (in fact, the contract requires the company's direct costs to be compensated off the top of revenues) and that [*51] the payment covers revenues from all services, whether performed inside the physician's office or in a hospital. The board first addressed the *Bakarania* petition at its August 2, 1997, meeting. There, the chair expressed concern that, as in the *Crow* case, the company was providing ancillary services which might give a physician an incentive to order tests or procedures or supplies that may not be necessary for the care of the patient. The *Bakarania* petition asked whether "the incentive payment to the company. . .could be construed to be basically a kickback for referrals because the company is obligated contractually to basically generate business for the group"³⁰ and to facilitate relationships with managed care networks. The board considered the line of Florida cases out of the Second District Court of Appeal which uphold a percentage management fee. More specifically, this court has held that a 10 percent management fee chiropractors paid to Practice Management Associates, Inc., for marketing and consulting services furnished to chiropractors establishing their clinics was not unlawful either under the Illinois fee splitting statute³⁰, or under the Florida Chiropractic Act's fee splitting statute, F.S. § 460.413.³⁰ The board did not rule on the *Bakarania* petition at its August meeting. The discussion there indicated a likelihood that, despite the *PMA* line of Second DCA cases, the board would use an expansive interpretation of a "referral" to include provision of general marketing services resulting in patients "delivered" through networking and managed care contracts.

Indeed, the concept of "referral" is not very well defined, except within the Florida Patient Self-Referral Act, F.S. § 455.236. This act defines "referral" in a somewhat circular fashion to mean "any referral of a patient by a health care provider for health care services, including. . .the forwarding of a patient by a health care provider. . .and the request or establishment of a plan of care. . ." F.S. § 455.236(3)(m). The statute then continues and lists a number of specific referrals which are not "referrals" for purposes of the statute.

The PPM industry has taken a narrow view of "referrals," considering a prohibited referral as one where a health care provider refers an individual patient to a specific provider or supplier of health care goods and services in which the referring physician has a financial interest. PPMs may obtain contracts for physicians, indirectly leading to a flow of patients, but they are not licensed to practice medicine and have not considered their activities to be the "referral" of individual patients.

The board's proposed declaratory statement takes a much more expansive view on what constitutes a referral. The concept that the company's percentage compensation for managed care networking and contracting services could constitute illegal fee splitting threatened to upset the market-created status quo that has driven the proliferation of [*52] PPMs in Florida. PPMs were even more alarmed that, in response to Dr. Bakarania's inquiry, the board might declare that the company's contract violated Florida's new Patient Brokering Act.³⁰ This law, enacted in 1997, contains criminal penalties for unlawful "brokering" of patients, a term which is not well defined in the new law.

Prior to the board's October 17, 1997, meeting, the company and its medical director, Edward E. Goldman, M.D., filed a motion to join the *Bakarania* declaratory action as petitioners. They also

filed a memorandum attacking Dr. Bakarania's standing and arguing that the matters raised by Dr. Bakarania affect the industry generally and, therefore, should be the subject of formal administrative rulemaking, under F.S. Ch. 120, including an appropriate fact-finding hearing. The company and Dr. Goldman filed their own alternative petition for declaratory statement, noting that "the essence of the activity addressed in Dr. Bakarania's Petition is the business administration of managed care arrangements."³⁰ They also argued that what Dr. Bakarania was really seeking was to ban the "corporate practice of medicine," which is not prohibited by law in Florida.³⁰

Phymatrix argued that the Second DCA's *PMA* line of cases established Florida law on the issue of percentage management contracts, in a manner that permitted such relationships under Florida's fee splitting statutes. The company additionally asserted that the board had no jurisdiction to interpret or apply F.S. § 817.505, the Patient Brokering Act.

Also prior to the October 17 meeting, the 13 physician members of the Access Medical Group (whose management contract with the company was at issue) filed a motion to join as petitioners. Another PPM company, Med Partners, Inc., and its medical director also sought permission to intervene in the matter. At its meeting, the board granted the various motions to intervene³⁰ and heard argument from the parties. The board ultimately ruled that the company's management agreement with the group was unlawful under F.S. § 458.331(1)(i).³⁰ This was because the group was paying the company a percentage of the group's revenues that had no correlation to the actual cost of providing management services and appeared to be provided simply to compensate the company for management services intended to develop more "patient referrals" for the group.

The final order describes how the board previously interpreted F.S. § 458.331(1)(i) in the *Green Clinic* statement, "to prohibit an arrangement whereby a clinic retains a specified percentage (54%) of the physician's billings without regard to the cost of providing services by the clinic to the physician and without regard to whether the billings are for services performed by the physician in and out of the Clinic."³⁰ The board then declared that the company contract "is a split-fee arrangement that is in violation of § 458.331(1)(i), Florida Statutes."³⁰ The board went on to state that "Payment of fees to the Company, that are based upon revenue generated, at least in part, because of the referrals that the Company has helped to generate is a violation of § 458.331(1)(i) ...although payment of a reasonable flat fee in return for the provision of management services, including practice enhancement, is appropriate. "³⁰ However, "payment of a percentage of the

revenue the management services and practice enhancement generate is not permissible."³⁰ The board distinguished the Second DCA's *PMA* line of cases. In *PMA*, the contract did not require the management company to provide "more extensive referrals of patients."³⁰ The company's contract in *Bakarania*:

Specifically requires the company to create a physician provider network; develop relationships and affiliations with other physician networks; develop and provide ancillary services including pharmacy, laboratory, and diagnostic services; and evaluate, negotiate, and administer managed care contracts. Each of these activities is involved in the development of a greater number of patient referrals to Petitioner's practice.³⁰

The board declined to rule on the application of the Patient Brokering Act, a criminal statute. It wrote "It is clear that the Legislature intends that payment of fees or other remuneration directly or indirectly related to the referral of patients to health care providers is no longer to be permitted in Florida"³⁰ and that there is a similarity in language and intent between F.S. § 458.331(1)(i) and F.S. § 817.505.³⁰

In a separate order³⁰, the board granted the oral motion made by the company and Dr. Goldman to stay the board's final order pending review by the district court of appeal.

The significance of the Florida Board of Medicine's *Bakarania* declaratory statement for the PPM industry cannot be overstated. If Florida courts support the board's expansive definition of referrals and its holding that a percentage management fee violates fee splitting prohibitions, a large-scale restructuring will be necessary in Florida.

The impact may be more far reaching. Other states may be influenced by the reasoning of the Florida Board of Medicine. The Florida fee splitting statutory language is not dissimilar to that of Illinois and other states. National and regional PPMs such as the Phymatrix Company and MedPartners generally have made a strategic commitment to forming physician networks in order to contract with HMOs and other payors for managed care contracts. Many believe that PPMs seek to build revenues by managing as much of the health care dollar and the managed care market as possible. Moreover, many commentators stress the importance of aligning incentives among business partners for success in the managed care industry. Revenue sharing arrangements such as the company's management contract with the group align the incentives of the physicians and the PPM company. Both seek a greater share of the managed care market in an era in which the health care industry is consolidating rapidly and network initiatives often are seen as critical to success and survival. If the physicians and the PPMs can't share revenue because of fee splitting prohibitions, and PPMs must be paid a flat fee for their services, incentives of the PPMs and physicians will not be aligned closely and [*53] the PPMs' relationships with physicians may be altered fundamentally.

Pending the outcome of the company's appeal, the final order in *Bakarania* may serve as the board's attempt to slow the pace of PPM deals with physicians. It may cause the PPM industry to reevaluate and redraft its contracts, to find other ways to compensate PPMs for the marketing, networking, and contracting services performed for Florida physicians. The resolution of the *Bakarania* case promises to be a significant event for the health care industry.