THE ABC's OF MSOs

How and why to form a compliant, lasting and profitable Management Services Organization

EXECUTIVE SUMMARY

Management Services Organizations are, at their core, structures that allow money to flow between licensed professionals and non-licensed participants. They're complex structures that have, in the past, been abused. But when put together in a way that adheres to the spirit and the letter of the law, MSOs offer stunning opportunity for profit.

At their heart, MSOs provide a way for non-licensed entities to pay licensed physicians for services in a way that they wouldn't legally be able to do under a direct remuneration setup. What are the types of MSOs? What are the pitfalls? What do you need to know if you're investing? In this paper we'll discuss:

- The agnostic nature of MSOs
- Common MSO myths
- Why MSOs exist
- How MSOs work
- What laws govern compliance
- How to properly structure an MSO
- What to look out for if you suspect an MSO may not be on the level

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MSOs ARE A NEUTRAL CONSTRUCT

Chances are, if you're in private practice, you've heard of Management (or Medical) Services Organizations. Most likely, MSOs have been posited to you as a component of a business structure involving your practice.

MSOs provide services to a medical practice, plain and simple. They can be owned by physicians who may be in a position to refer to the medical practice they serve, so long as the physician-members who share in the MSO's revenue do so solely based on their investment, and not on the amount of referrals sent to the underlying practice.

Consider the following two MSOs:

> **MSO A**
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> Two non-licensed individuals form an MSO and a legally unrelated charitable foundation to work with military veterans dealing with chronic pain. The MSO offers marketing services to compounding pharmacies for a monthly fee. The charitable foundation initiates drug studies for military veterans, and offers nominal payments to patients and doctors to participate in studies regarding the efficacy of compounded medication in treating chronic pain. The charitable foundation directs both patients and physicians to use the compounding pharmacies contracted with the MSO for the study. The compounding pharmacies bill Tricare (which provides health coverage for active-duty and retired members of the military and their families) for the compounded medications and retains all of the billed fees.
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> **MSO B**
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> A Texas MSO is formed by partners without any education or licensing in the medical, nursing or pharmaceutical fields. The same partners form an affiliate company which is funded solely by the MSO. The MSO contracts with medical providers to "employ" the MSO partners for a percentage of the reimbursements collected from the business the MSO directs to providers. The MSO then directs the affiliate company to pay patients $250 per month for each visit from the provider and physicians $30-$60 per patient referred to the provider.

As you might expect, the owners of MSO B were federally indicted, along with the owners of the medical service providers involved, in a scheme that grossed over $65 million in fraudulent reimbursements. What you might not expect is that MSO A and MSO B are the same company.

The MSO is neither inherently good nor bad on its own. Yet despite being compliance agnostic, MSOs are routinely vilified. Like any other tool, it's how MSOs are used that makes the difference.

MSOs earn money by allowing non-licensed personnel to support those licensed to practice in a way that's similar in scale, but distinct from an actual equity holding.

MSOs, like the medical practices they serve, come in all varieties. Some are specialized, performing one specific function (e.g. billing). Others are comprehensive, fulfilling virtually all the non-clinical needs of a medical practice. The main goal, however, remains constant throughout – to bring efficiencies to the medical practice without violating the complex laws that govern both the practice of medicine and the business of medicine.

The most important takeaway here is how nuanced and challenging compliant MSO structures are, and why you should *absolutely* not attempt to operate one without the assistance of an experienced healthcare attorney. Like any tool, it's far more dangerous in the hands of someone who doesn't know how to use it properly. In other words, choose wisely before you hand over your chainsaw.

COMMON MSO MYTHS DEBUNKED

MSOs ARE A SCAM

This is a sentiment routinely expressed in public forums regarding the MSO structure, but it's no more true than saying LLCs are a scam. MSOs aren't a scam, but some scams have improperly used MSOs. Any proposed structure involving an MSO needs to be vetted by experienced healthcare counsel, but dismissing MSO opportunities out of hand is reductive and wholly unnecessary. There are tens of thousands of profitable, compliant, operating MSO structures across the country, as well as plenty of equity participants (physicians and non-physicians, alike) enjoying very healthy returns on investment.

MSOs ARE ALL THE SAME

There are as many types of MSOs as there are types of medical practices. To wit, when a practice is considering employing an MSO structure, it should always be customized for that practice. Using another practice's MSO structure and documentation is like wearing someone else's suit. It may cover you in some ways, but it's not going to fit, and it's definitely going to hurt after a while.

We'll get into the specifics in a bit, but in general, MSOs are differentiated primarily by two factors: the services they provide; and the relationship of the owners of the MSO to the practice(s) it serves.

MSOs ARE GOOD OR EVIL

Like we said, MSOs are a tool. Nothing more, nothing less. A chainsaw is terrifying when Leatherface is swinging it around, and a life-saving tool in the hands of a rescue worker after a hurricane. Regardless, the chainsaw itself has no predilection toward either.

MSOs ONLY NEED TO PROVIDE MARKETING

Probably the most common improper use of the MSO structure is where the only substantive service it provides is marketing, i.e. directing patient traffic to the underlying practice. This explicitly violates the Anti-Kickback Statute, and is the clearest example of an illusory structure. A quick review of MSO fraud case studies reveals a surprising number of MSOs who ignore this easily avoidable error. As a general rule, if you determine this is the only real service that an MSO provides (even despite lip service to other services), run away and don't look back. Do, however, look for that particular MSO on the news, as that's the place you're most likely to see it next.

HOW MSOs WORK

Before we get into the nuts and bolts of MSOs, let's discuss why the government requires medical practitioners to obtain proper licensure before they practice medicine. The Corporate Practice of Medicine Doctrine (CPOM) was created in response to public outcry against the peddlers of often harmful 'patent medicines,' and the acts and abuses caused by untrained healers. The widespread injury of the public by these snake-oil peddlers prompted both state and federal governments to adopt laws to ensure that only trained and competent practitioners could be licensed to practice medicine. *Garcia v. Tex. St. Board of Med. Exam.,* 384 F. Supp. 434 (W.D. Tex. 1974). Modern CPOM is structured to prevent any encumbrances, especially economic, on the physicians' independent medical judgment.

In general, an MSO is perhaps easiest to define by understanding what it is not. Though you, like us, have probably heard someone say they've set up an MSO to provide healthcare services, that is the precisely the one thing an MSO cannot legally do. An MSO specifically does not, and cannot, engage in the practice of medicine because an MSO *is not a medical practice*. MSOs provide non-clinical services to professional practices (medical, dental, or otherwise). An entity that engages in professional practice, according to the law, is defined by its core function. Each state defines these practices slightly differently. For example, in Nevada, it is defined by NRS 630.020:

NRS 630.020 "PRACTICE OF MEDICINE" DEFINED. "PRACTICE OF MEDICINE" MEANS:

To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality, including, but not limited to, the performance of an autopsy.

To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions. (...).

MSOs earn money by allowing non-licensed personnel to support those licensed to practice in a way that's similar in scale, but distinct from an actual equity holding.

As detailed herein, the MSO structure is chiefly driven by CPOM, which advises on what constitutes an entity "practicing medicine." Most jurisdictions have definitions of the practice of medicine similar to NRS 630.020. Additionally, most jurisdictions (including Nevada) have provisions for "professional" corporations and limited liability companies. NRS 89.040 provides as follows:

NRS 89.040 FILING REQUIREMENTS; REQUIRED PROVISIONS OF ARTICLES; NAME.

> One or more persons may organize a professional entity in the manner provided for organizing a corporation (...). Each person organizing the professional entity must (...) be authorized to perform the professional service for which the professional entity is organized.

The definition of an entity "practicing medicine" is based on these statutes. First, a professional entity is one that is exclusively owned by professionals licensed to perform the service. Second, the entity is "practicing medicine" if the entity employs professionals licensed to practice medicine, or engages licensed independent contractors to perform medical services. This definition is important because it helps us define how a business can avoid practicing medicine – primarily by *not employing or otherwise paying licensed physicians to practice medicine*.

So what does that leave? Literally, everything else. Think for a moment of all the things that a medical practice does besides paying the doctors: leasing/buying space and equipment, paying non-clinical staff, bookkeeping and accounting, billing and collecting, record-keeping and storage, patient and general administration, and the list goes on and on. An MSO has no affirmative duties, only proscribed activities. Therefore, the MSO can be a single-source provider to a medical practice of all non-medical services.

The MSO typically has an omnibus service agreement called a Management Services Agreement. The MSA lists all of the provided services and the terms and conditions therefor. MSOs are not required to directly provide the services they offer, and can be outsourced to third party providers.

It is important to remember that all services must be provided for fair market value. Determination of fair market value for commoditized services can be straightforward. Other services, specifically those which do not have a strong comparables, may require a third-party valuation to determine what the fair market value is. Even more, special attention should be taken with the licensure of intellectual property (e.g. brand name, logos, service marks, patents, etc.) and consulting services, as these may be especially difficult to value.

Importantly, an MSO should never contract for a service that it will not actually, provably provide. Illusory services are one of the easiest ways that regulators prosecute and penalize errant MSOs. A good MSA should provide itemized, monthly invoices, and

receive regular payments therefor. These omnibus bills should be detailed and precise, and the practice should always pay them promptly with a check.

WHY MSOs EXIST: THE BENEFITS

If you're new to MSOs, you're probably thinking: "This is a lot of trouble to go to just to get all your administrative services from the same company." You wouldn't be wrong. However, MSOs exist as a tool to move money in a compliant manner to parties that can't get it directly from the practice. Non-licensed individuals are prohibited by the CPOM doctrine from sharing in earnings of the practice, but a non-licensed individual may share in the earnings of the MSO.

Simply put, MSOs allow collaboration, incentives and synergies that are unavailable from vanilla structures. Indeed, there are many circumstances where a lay or non-licensed party contributes material economic value to a professional medical practice and might rightfully, then, expect some measure of participation in that entity's profitability. MSOs are designed to provide a legally compliant structure which addresses this economic inequity in a way which is consistent with the public policy concerns.

The MSO structure avoids "lay control over the physician's medical judgment" by separating the clinical functions of a practice from its administrative and business functions. Because these unlicensed parties cannot offer any contribution to the physicians' medical judgment, they are barred from participation.

However, there are many non-clinical factors in a professional medical practice which directly affect that practice's revenue and profitability. By limiting these non-licensed parties' affect to these non-clinical elements, no matter how much of the MSO the non-licensed parties own/control, the physician's medical judgment is not controlled by non-licensed parties. The money that the physicians received in consideration of his/her practice of medicine stays within the purview of an entity wholly owned/controlled by licensed physicians. Thus, there is no "divided loyalty" between the MSO (or its owners) and the patients he/she serves with respect to their clinical judgment.

The MSO structure (or those who employ it) cannot be held accountable for the commercialization of the medical profession. The MSO structure deals with only the non-clinical elements of the medical profession. The MSO allows the medical profession to reap the benefits of advancements and efficiencies in patient administration and other key business functions, without violating the spirit or the letter of the CPOM laws. If our doctors are spending their time dealing with the administrative functions of their practices, that takes valuable time away from patient care.

If MSOs didn't exist, professional medical practices would likely engage non-licensed parties anyway. This structure allows them to do so in a way that is consistent with the public policy and the CPOM doctrine.

MSO COMPLIANCE

Interestingly, Nevada has not codified the CPOM doctrine into law. In the alternative, it has been recorded primarily in written opinions from the state Attorney General. The first of these (which remains good law) was in 1977. Op. Nev. Att'y Gen. No. 77-219 (Oct. 3, 1977) states, in relevant part:

> Licensed professionals who have assisted a corporation to illegally practice medicine have had their professional licenses revoked by the appropriate licensing boards and such action has been upheld by the courts in *State Board of Dental Examiners v. Miller, 8 P.2d 699 (Colo. 1932), and Rockett v. Texas State Board of Medical Examiners*, 287 S.W.2d 190 (Tex. Civ. App. 1956). In Nevada, such conduct would probably constitute "unprofessional conduct" for "fee splitting" and "aiding any unlicensed person to practice medicine," (...).
>
> Although in each of the cases cited above, the incorporators or officers of the corporation were unlicensed laymen, we fail to see any legal significance or change in the legal rules in the event of a situation where some of the incorporators were professionally licensed while the remainder were laymen, (...).
>
> Based upon the foregoing medical and dental practice cases, it is the opinion of the Attorney General that no corporation organized under the General Corporation Law of Nevada, Chapter 78 of Nevada Revised Statutes, may lawfully engage in the practice of medicine, as that term is defined at NRS 630.020, subsection 1.

Because NRS 89.040 requires that all of the equity holders of a professional entity be so licensed, we can distill the requirement that all equity holders of a Nevada entity that purports to practice medicine *must* be licensed medical professionals.

This is further borne out in the AG's 1977 opinion:

> In brief, the Professional Corporations Act authorizes Nevada physicians licensed by the State Board of Medical Examiners under Chapter 630 of the Nevada Revised Statutes to incorporate individually or in a group for the purpose of practicing medicine; however, all the incorporators and all the corporate officers and "employees" must be licensed Nevada doctors. In addition, all the stockholders must likewise be licensed Nevada physicians.
>
> Incorporation under Chapter 89 of the Nevada Revised Statutes is deemed by law to have no effect on any law applicable to the nature of the relationship existing between

> a person furnishing professional services and a person receiving such services, including any liability arising out of such services. NRS 89.060. This provision of the statute is designed to insure the continuance of the long recognized personal, fiduciary, and confidential relationship which attaches to the practice of medicine or of the other learned professions, notwithstanding the existence of an impersonal corporate form.

Obviously, the AG's opinion has not and should not prevent these professional corporations from employing non-licensed personnel to perform ancillary functions, but this language does go to the other important position of what an entity "practicing medicine" does: it pays physicians to practice medicine on its behalf.

The subsequent Attorney General's Opinions echo and reflect these positions without modification. Op. Nev. Att'y Gen. No. 2002-10 (Feb. 26, 2002) holds:

> Since the issuance of Op. Nev. Att'y Gen. No. 219 (October 3, 1977), there have been no changes in Nevada statutes condoning the doctrine of corporate practice of medicine or vitiating the requirements of NRS chapter 89.

The AG's 2002 Opinion notes that the expansion and exceptions codified for entities offering laser refractive surgery and through a host of regulations surrounding Health Maintenance Organizations (e.g. NRS chapters 695B, 695C, 695F, and 695G), the CPOM doctrine in Nevada was expanded to include accountability to either state medical agencies or the State Commissioner of Insurance.

More recently, the AG addressed the doctrine in Nevada as it applies to hospitals, but also summarized the preceding opinions:

> In the two prior Attorney General opinions, the corporate practice of medicine doctrine was described to prohibit a corporation from employing physicians because, as its employees, the acts of the physicians are attributable to the corporation, which itself cannot be licensed. *See also Berlin v. Sarah Bush Lincoln Health Center*, 688 N.E.2d 106, 110 (Ill. 1997).

> The justifications for the doctrine center on three public policy concerns: (1) the possibility of lay control over the physician's judgment; (2) the division of the physician's loyalties between his patient and his employer; and (3) the commercialization of the medical profession.

Over the years, several other state and federal laws and regulations passed to correspond with different corollaries of CPOM.

The Federal Statutes include: (i) The Medicare and Medicaid Patient Protection Act of 1987, as amended, 42 U.S.C. §1320a-7b (the "Federal Anti-Kickback Statute");

The MSO structure avoids "lay control over the physician's medical judgment" by separating the clinical functions of a practice from its administrative and business functions.

(ii) Section 1877 of the Social Security Act, as amended, 42 U.S.C. §1395nn (the "Federal Stark Law").

The Nevada Statutes include) (i) NRS §439B.420(4) (the "Nevada Anti-Kickback Statute"); and (ii) NRS §439B.425 and NAC §§439B.5205 through and including 439B.5408 (collectively, the "Nevada Stark Law").

All of these laws deal with physicians receiving economic incentives for referring a patient to a specific medical facility. Physician self-referral is the practice of a physician referring a patient to a medical facility where the physician (or a close family member) has a financial interest. As is apparent from the definition, self-referral is an economic incentive for the physician which may interfere independent medical judgment. Similarly, if a physician receives some type of economic incentive (or kickback) for referring patients to a healthcare facility, this incentive will interfere with the physician's independent medical judgment. These laws were passed to strictly control the referrals in a way that their effect on the physician's independent medical judgment is minimal. When a medical practice utilizes the services of an MSO, it must ensure that the relationship, no matter what services the MSO provides, must comply with the all the laws and regulations mentioned above.

FEDERAL ANTI-REFERRAL LAWS

THE STARK LAW

The federal self-referral law is codified in the Social Security Act §1877; 42 USC §1395nn, and is commonly known as the "Stark Law" after California Congressman Pete Stark. The law was first included as a provision in the Omnibus Budget Reconciliation Act of 1989 ("Stark I"). Further amendments in 1993 ("Stark II") and 2007 ("Stark III") further broadened the scope and reach of the law. Regulatory agencies like the Department of Justice, Centers for Medicare and Medicaid, and the Department of Health and Human Services oversee its enforcement.

The federal physician self-referral proscribes physicians from ordering designated health services for Medicare (and to some extent, Medicaid) patients from entities with which the physician (or an immediate family member) has a "financial relationship." CMS has issued regulations and guidance interpreting the Stark Law; the regulations appear at 42 CFR §411.350 *et seq.*

The term "designated health services" includes:

- clinical laboratory services
- physical therapy services
- occupational therapy services

- speech language pathology services
- radiology and certain other imaging services
- radiation therapy services and supplies
- durable medical equipment and supplies
- parenteral and enteral nutrients, equipment, and supplies
- prosthetics, orthotics, and prosthetic devices
- home health services and supplies
- outpatient prescription drugs; and
- inpatient and outpatient hospital services

The term "financial relationship" includes both compensation arrangements, and investment and ownership interests. The term "referral" under the Stark Law is defined broadly, "the request or establishment of a plan of care by a physician which includes the provision of the designated health service." Stark Law also provides a number of exceptions, i.e. types of financial relationships which do not fall within its purview. In addition, there are a host of exceptions that apply to ownership and compensation arrangements.

MSO arrangements between providers with referral relationships, such as a physician or physician practice and a hospital, will generally constitute a "financial relationship." Accordingly, it is critical that the arrangements between these providers satisfy the requirements of the applicable Stark exceptions.

THE STARK LAW: EXCEPTIONS

If a compensation arrangement qualifies for any of the following conditions, the relationship will not be considered a 'referral' for the purposes of Stark law:

FAIR MARKET VALUE EXCEPTION

The fair market value exception was promulgated because it does not pose a risk to the program or patient abuse provided all of the following conditions are satisfied. It excepts compensation from an arrangement between an entity and a physician for the provision of items or services (other than the rental of office space) by the entity to the physician or group of physicians if ALL of the following conditions are met:

- The arrangement is in writing, signed by the parties, and covers only identifiable items or services, all of which are specified in the agreement.
- The agreement is for a specific term, and contains a termination clause, provided that the parties enter into only one arrangement for the same items or services during the course of a year. An arrangement made for less than one year may be renewed any number of times if the terms of the arrangement and the compensation for the same items or services do not change.

The writing specifies the compensation that will be provided under the arrangement. The compensation must be set in advance, consistent with fair market value, and not determined by the volume or value of referrals, or other business generated by the referring physician. Compen-

sation for the rental of equipment may not be determined using a formula based on (i) a percentage of the revenue raised, earned, billed, collected, or otherwise attributable to the services performed or business generated through the use of the equipment; or (ii) per-unit of service rental charges, to the extent that such charges reflect services provided to patients referred by the lessor to the lessee. The arrangement is commercially reasonable (taking into account the nature and scope of the transaction) and furthers the legitimate business purposes of the parties.The arrangement does not violate the anti-kickback statute (section 1128B(b) of the Act), or any federal or state law or regulation governing billing or claims submission.The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates a federal or state law.

The Stark III guidance explicitly acknowledged that the amendment to "the text of the exception for fair market value compensation in §411.357(l) [was] to permit application of that exception to arrangements involving fair market value compensation to physicians from DHS entities, as well as to arrangements involving fair market value compensation to DHS entities from physicians."

RENTAL OF OFFICE SPACE AND EQUIPMENT

While not as common as MSOs that exclusively provide administrative services, some MSOs lease property, office space, and/or equipment to physicians. This service relieves the physician of the administrative and time-consuming burden of locating and maintaining space. However, it is vital that the arrangement meet the requirements for this Stark exception.

This exemption protects arrangements for the use of premises which fulfill *all* of the following conditions:

- The lease is set out in writing, signed by the parties, specifies the premises (which must be used exclusively by the lessee), and is for a term of at least one year.
- The space rented or leased does not exceed that which is "reasonable and necessary" for legitimate business purposes.
- The lessee may make payments for the use of common areas if the payments do not exceed the lessee's pro rata share of expenses for such common space based on the ratio of space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using the common areas.
- The rental charges over the term of the lease must be set in advance, be consistent with fair market value, and not determined by *the volume or value of any referrals* or other business generated between the parties.
- The lease must be commercially reasonable even if no referrals were made between the parties.

The exception for equipment rental is similar to the space rental exceptions, and all of the conditions must be met:

- The lease must be set out in writing, signed by the parties, and must specify the equipment covered by the lease.

- The equipment must be used exclusively by the lessee.
- The lease term must be at least one year, and the equipment rented or leased must not exceed that which is ''reasonable and necessary" for legitimate business purposes.
- The rental charges over the term of the lease must be set in advance, consistent with fair market value, and not determined by *the volume or value of any referrals* or other business generated between the parties.
- The lease must be commercially reasonable even if no referrals were made between the parties.

PAYMENTS BY A PHYSICIAN FOR ITEMS AND SERVICES

This exception is only available where none other applies. It allows for to payments made by a physician (or an immediate family member) to an entity as compensation for any other items or services that are furnished with a price that is consistent with fair market value, and that are not specifically addressed in another provision. In the context of this exception, "services" means any kind of services, not exclusively those defined as "services" for purposes of the Medicare program.

THE ANTI-KICKBACK STATUTE

The federal Anti-Kickback statute provides criminal penalties and civil monetary penalties for individuals and entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business for which payment may be made under a federal healthcare program. The type of remuneration covered by the AKS includes but is not limited to kickbacks, bribes, and rebates. The statute applies to any such remuneration whether made directly or indirectly, overtly or covertly, in cash or in kind. Prohibited conduct includes not only remuneration intended to induce referrals, but also remuneration intended to induce the purchasing, leasing, ordering, or arranging for any goods, facility, service or item paid for by a federal healthcare program.

In recognition of the fact that the prohibition contained in the AKS has the potential to affect legitimate arrangements, a number of exceptions have been enacted, and are known as "safe harbors." According to public statements made by representatives of the OIG and the Department of Justice, as well as the preamble to the safe harbors, if an arrangement meets one of the applicable safe harbors, it is fully protected from both criminal and civil liabilities under the AKS. However, failure to meet all of the requirements of an applicable safe harbor does not make the conduct *per se* illegal. Rather, the preamble to the final safe harbor regulations indicates that the conduct outside the current safe harbor should be judged on a case-by-case basis.

THE ANTI-KICKBACK STATUTE: SAFE HARBORS

SPACE, EQUIPMENT, AND PERSONAL SERVICES AND MANAGEMENT CONTRACTS

Just as it is important for the MSO relationship to comply with the Stark Laws with regard to the provision of leased premises or equipment and the provision of services (as discussed above), the relationship should also be structured in light of the AKS safe harbors.

There are an unlimited number of scenarios where a non-licensed party contributes materially to that practice, and for which remuneration is equitable.

The OIG has created three separate safe harbors for certain contracts related to space rental, equipment rental, and personal services and management contracts. These safe harbors share common requirements.

All three safe harbors require:

- A written agreement
- A term of at least one year
- That the aggregate payment amount as well as the premises, equipment, or services covered be specified in advance
- That if the agreement does not contemplate full-time services, the agreement must also specify the schedule of intervals, their precise length, and the exact charge for such interval

To "preclude schemes involving the use of multiple overlapping contracts to circumvent the one year requirement," the OIG has added a requirement to all three safe harbors that the agreement cover all space, equipment or services for the term of the agreement. Payments must be based on fair market value and cannot vary based on the volume or value of any Medicare or state health care program-covered referrals or business generated between the parties.

SMALL INVESTMENT INTERESTS

With respect to the small entity safe harbor, each of the following eight standards must be satisfied:

- No more than 40 percent of the value of the investment interests of each class of investments may be held in the previous fiscal year or previous 12-month period by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for, the entity.
- No more than 40 percent of the gross revenue of the entity in the previous fiscal year or previous 12-month period may come from referrals or business otherwise generated from investors.
- The terms on which an investment interest is offered to a passive investor, who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity, must be no different than the terms offered to other passive investors.
- The terms on which an investment interest is offered to an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity must not be related to the previous or expected volume of referrals, items, or services furnished, or amount of business otherwise generated, from that investor to the entity.
- There may not be any requirement that a passive investor make referrals to, be in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity as a condition for remaining as an investor.
- The entity or any investor may not market or furnish the entity's items or services (or those

of another entity as part of cross-referral agreement) to passive investors differently than to non-investors.
- Neither the entity nor any investor (nor other individual or entity acting on behalf of the entity or any investor in the entity) may loan funds to or guarantee a loan for an investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity if the investor uses any part of such loan to obtain the investment interest.
- The amount of payment to an investor in return for the investment interest must be directly proportional to the amount of the capital investment of that investor.

NEVADA STATUTES

NEVADA ANTI-KICKBACK STATUTE

The Nevada Anti-Kickback law is simply stated in NRS §439B.420(4), which holds:

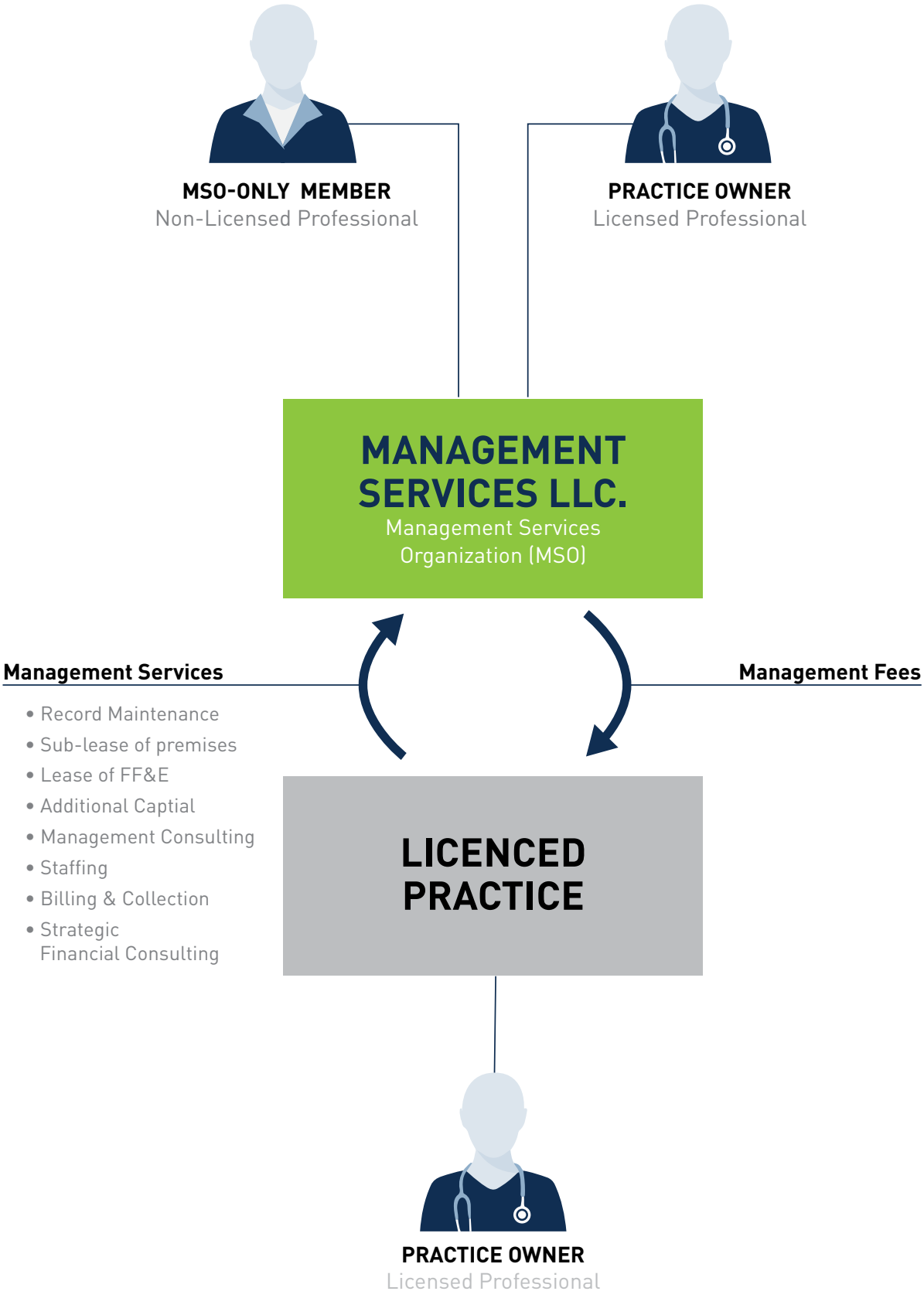
A health facility shall not offer any provider of medical care any financial inducement, excluding rental agreements (...), whether in the form of immediate, delayed, direct or indirect payment to induce the referral of a patient or group of patients to the health facility. (...).

This restriction applies solely to the entity receiving the referral, and any "financial inducement" related thereto.

Under the NRS §§439A.015, 439A.017 and 439B.100, the licensed practice entity is a "health facility" for purposes of the Nevada Anti-Kickback Statute, and the MSO is not. The term "referral" is not defined in either NRS Chapter 630 or NAC Chapter 630 (i.e., the primary Nevada statutes and regulations governing physicians). However, under NAC §439B.540 (i.e., in the Nevada Stark Law regulations), the term "refer" is defined to mean "sending or directing any person to another person or business entity for the purpose of obtaining, consuming or purchasing, for consideration, goods or services related to health care."

The only potential avenue for finding a Nevada Anti-Kickback violation is to determine that the payments made by the practice to the MSO are, in fact, indirect payment to induce referrals since *one* of the services offered by the MSO for the practice may be "marketing" and/or "business development."

First, if the MSO doesn't offer such services, there isn't any avenue for a violation. Second, if those services are offered, they are being paid for at fair market value (as discussed, above), and the payments that the practice makes to the MSO are due and owing regardless of whether any business actually results from the MSO's marketing efforts. If the strictures set forth herein are adhered to, there is little possibility of a determination that the MSO structure violates the Nevada Anti-Kickback Statute.


MSO-ONLY MEMBER
Non-Licensed Professional
PRACTICE OWNER
Licensed Professional
MANAGEMENT SERVICES LLC.
Management Services Organization (MSO)
Management Services
• Record Maintenance
• Sub-lease of premises
• Lease of FF&E
• Additional Captial
• Management Consulting
• Staffing
• Billing & Collection
• Strategic Financial Consulting
Management Fees
LICENCED PRACTICE
PRACTICE OWNER
Licensed Professional

The MSO is not a professional medical entity, nor are any of its agents licensed physicians. Therefore, it is not a provider of medical care, and cannot provide a 'referral' per the applicable statute. As a result, its direction of patients has no more weight than a roadside billboard. This activity is thus not covered by the Nevada Anti-Kickback Statute.

NEVADA STARK LAW

Under the NRS §439B.425, a licensed physician is prohibited from referring a patient for a service or for goods related to healthcare to a health facility or any commercial establishment in which such licensed physician has a "financial interest." The term "financial interest" is defined in NAC §439B.530(2)(b) to include an "income-sharing agreement … that provides compensation based, in whole or in part, upon the volume or value of the goods or services provided as a result of referrals." NAC §439B.5404 delineates specific practitioner referral situations that are allowed and compliant with NRS §439B.425.

As with Nevada Anti-Kickback, a determined violation would require first that the physician owner(s) of the practice are also owner(s) of the MSO (true of some but not all MSO structures); that the MSO offers "marketing" and/or "business development" services; and it is determined that such services constitute "referrals" under Nevada law. The MSO can easily be structured in such a way to maintain compliance with Nevada Stark.

HOW TO MSO PROPERLY

You already know that the MSO market is rife with fraud. Dozens of high-profile cases highlight the many ways to form an MSO the wrong way. So, with all these examples of what not to do, how exactly should you employ this structure?

THE ORIGINAL

In its original configuration, the MSO model was used only to mitigate costs and deliver economies of scale in administrative and management functions to private practices who could not otherwise afford them. In this original model, none of the owners of the practice (or contributors thereto) were owners of the MSO. The market value of the catalog of services provided was a function of the practice's expected savings and gains based on outsourcing these services – because the MSO would be competing for the practice(s)' business with other service-only MSOs.

These MSOs are either large multi-practice organizations, or subsidiaries thereof, depending on the model of the parent MSO. As their primary value drivers are their economies of scale, their efforts are primarily devoted to cost savings (on the services they provide), and value-adding opportunities for their partner practices (e.g. negotiated payor contracts, ancillary services, referrals, etc.).

THE CURRENT

The modern MSO is used to develop legally compliant structures that accommodate economic contributions to the practice that cannot legally be directly remunerated. The primary restriction

preventing these direct relationships is the CPOM doctrine. However, there are an unlimited number of scenarios where a non-licensed party contributes materially to that practice, and for which remuneration is equitable.

This "modern" MSO structure includes those non-licensed parties as equity members of the MSO entity. An MSA provides the MSO revenue from the services it provides to the practice, so that the members of the MSO (both licensed and unlicensed) may share in the MSO's profits. The primary obligation that the practice retains is to pay the professional staff's salary (doctor, dentist, nurse, etc.). Importantly, this compensation must also represent fair market value.

The primary value driver for this MSO structure is its ability to provide enough services to move sufficient cash flow to the MSO to be split amongst the MSOs putative partners.

OTHER STRUCTURES

The Ninth Circuit court in *The Hanlester Network v. Shalala*, 51 F.3d 1390 (CTA 9 1995) laid out a framework for physician's ownership interests that would not violate AKS, even though they do not specifically fit into a AKS safe harbor. Specifically, as long as the return on investment is based on each physician's ownership interest and not their referrals; the eligibility to invest does not depend on an agreement to refer; the size of the physician's investment is not based on referrals, and physicians who do not refer are not required or pressured to divest, then such physician ownership interest would not run afoul of AKS.

Therefore, in the Ninth Circuit, which Nevada is a part of, a variety of MSO structures can be implemented using the guidelines provided in the *Hanlester* case. For example, an MSO could provide services to a medical practice, and could be owned by physician(s) who may in a position to refer to the medical practice, as long as the physician-member(s) invest in the MSO and share in the MSO's revenue solely based on their investment, and not the volume or value of their potential referrals to the underlying medical practice.

HOW TO SPOT A BAD MSO: WHAT QUESTIONS TO ASK

THE PAPER

The first question to ask is always for the documents involved. It is well-settled law that what is spoken contemporaneously with the delivery of a document is not binding. In other words, you can be legally lied to verbally, so long as you are given time to read the underlying agreement. It simply doesn't matter what you're told; it only matters what's in writing. Also, since you're going to call your lawyer about this anyway, save yourself a step – we're going to ask for them before we do anything.

COMPLIANCE

It may sound simple, but anyone who's put together an MSO structure will have a comprehensive compliance analysis handy, so you might as well ask for it. MSO managers and architects are keenly familiar with the legal restrictions involved and build their structures and policies with compliance in mind. They should know it so well that they can explain it to anyone, especially a

potential investor/partner. If they can't, you can still run what they do have by your own compliance attorney — but it's a bad sign.

FAIR MARKET VALUE

The most important element of MSO compliance (i.e. the most common method of non-compliance) is the valuation of the services provided by the MSO to the underlying practice(s). You should ask about what services the MSO provides (this should be a discrete, written list) and how the fee(s) due and owing from the practice(s) were/are determined. Management fees that are listed as a *percentage* of gross or net revenues are likely to pose a significantly greater risk of non-compliance than flat/set fees. As a good rule of thumb, if the proposed fee(s) are such percentages, you should absolutely get a legal opinion.

FINANCIAL PROJECTION

An MSO is a complex corporate structure and how it makes money and how much money it makes are important elements for any potential partner/investor to consider. Obviously, homegrown projections that promise astronomical returns should be an immediate red flag. However, the faults in forward-looking financial statements are not always so obvious. If you are successful in obtaining these financials and there are no obvious flaws, it is worthwhile to have a financial professional review them. He/she can tell you almost immediately if they have been professionally prepared and can spot internal inconsistencies.

ASK A PROFESSIONAL

If nothing else, consulting with experienced healthcare professionals who have worked with MSO structures before is a great place to start if anything more detailed is overwhelming. MSO work is highly customized and specific and vetting a proposed structure can be nuanced and daunting even for those who work in the space. A good review should not be cost prohibitive and the potential savings (i.e. avoiding a bad and/or illegal deal) is well worth the investment.

CONCLUSION

Importantly, our examples above do not constitute all of the ways the MSO structure can be used. No amount of examples could. The MSO is a flexible tool that can be employed to accommodate desired business relationships in an endless number of ways. By serving the public policies surrounding healthcare regulation in developing compliant business structures, participants are ensured of not only meeting the letter of the law when using an MSO, but also the spirit of such laws, which can make all the difference in an audit scenario.

Just like the introduction of the limited liability company to corporate structures in 1977, the introduction of the MSO to healthcare structures has opened the door to an unlimited variety of formal business relationships for medical businesses – limited only by their imaginations (and the skills of their legal professionals). If you are a medical business owner and hear the term "MSO," we hope you will now be armed with the right questions to ask to determine whether the MSO you're considering is good or bad and, more importantly, the reasons why.

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Ideal Business Partners provides boutique-style focus on healthcare business success from a multidisciplinary background, including legal, financial and strategic advice from a team that is built to work together towards your goals - without wasting time on coordination and staking claims.