KSDB Health Law INSIGHTS

Kalogredis, Sansweet, Dearden and Burke, Ltd.

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Things to be wary of in a practice sale or purchase

By Vasilios J. Kalogredis, Esquire

We are still seeing many medical and dental practices being sold in today's healthcare environment. In negotiating a transaction such as this, there are the obvious points related to price and payment terms, whether and how the Seller doctor(s) will be employed by the Purchaser, and when the closing of the transaction would take place. This article will focus on a few points that often are not given a lot of focus until late in the game, if at all.

What is and is not part of the deal?

Too often I have been asked to review documents which do not clearly set forth exactly what is and is not part of the sale. For example, are all tangible and intangible assets of the Practice being transferred to the Purchaser? Although every transaction is certainly different and subject to negotiation, it is not unusual for the Seller's cash and accounts receivable to not be part of the transaction. In addition, many Sellers have certain Practice assets which they would like to retain. This might include things such as art work, automobiles, diplomas, and some items of "sentimental value." Besides clearly defining what assets are part of the deal, it is important to clearly set forth what, if any, debts, equipment leases, maintenance contracts, yellow page listing costs, personnel obligations (for example, unused sick time and/or unused vacation) are going to be assumed by the Pur-

— continued on page 2

Front row: *Jeff, Bill* ***Back row:*** *Karilynn, Mike, Dave*

Bill Kalogredis named a Pennsylvania Super Lawyer

Bill was listed in the June 2008 issues of Philadelphia Magazine and Pennsylvania Super Lawyers magazine as a Pennsylvania Super Lawyer, for the fourth consecutive year. The honorees were selected by Pennsylvania attorneys. Only five percent of Pennsylvania attorneys received this distinction.

Be wary

— continued from page 1

chaser. The key thing here is to clearly define in the documentation what is and is not being transferred by the Seller to the Purchaser. Vagueness only increases the chances for unpleasant surprises.

Read the fine print

It is important that the parties clearly understand what it is they are signing. It is not the most exciting part of the Agreement, but there are potential traps in what some might consider the "legal mumbo jumbo" of an Asset Purchase Agreement. For example, it is not unusual for the parties to make "Representations and Warranties" within the document. A Seller may "rep and warrant" that it has had no litigation (be it malpractice or otherwise) over the past five years. Unfortunately, some Sellers gloss over that and do not set forth all such matters. By doing so, they open themselves up to problems and a potential argument by the Purchaser later on that they misrepresented things. Another aspect of this relates to carefully, critically and fully completing all Schedules/Exhibits of the contract. This is indeed mundane stuff. However, before one signs on the dotted line, it is important that what is signed is complete and correct to avoid unnecessary legal and pragmatic hassles.

Handling accounts payable and prepaid expenses

No matter what date is selected for Closing there will be some bills coming in after that Closing Date, some portions of which will relate to activities when the Seller was the owner of the Practice and some to when the Purchaser was the owner. In addition, there often are certain expense items which the Seller may have "prepaid" and which would benefit the Purchaser post-Closing.

The important thing here is not so much to try to "nickel and dime" the other party for every penny. It is more to be sure that everyone understands what exactly is going on economically. The numbers should be shared. The items should be discussed. With all the facts on the table, the parties can then agree as to what, if any, economic adjustments should be made relative thereto. For example, it is not uncommon for the Seller agree to pay for all expenses relating to pre-Closing activities, even if the bill for those items comes in after the Closing. Generally, the Purchaser will agree to pay all bills that relate to the post-Closing activities. Things such as utilities, supplies, and the like are examples of this.

Prepaid items might include things such as insurance and lease payments. For example, if a practice were sold mid-month, and the Seller had paid a $5,000 lease payment for the entire month, it would be usual to have the Purchaser reimburse the Seller for one-half of that ($2,500).

Handling accounts receivable

Whether the accounts receivable are part of the sale or not, it is not unusual for the Purchaser to assist in the collection of those receivables. If they are "part of the sale," the receivables monies collected belong to the Purchaser. If they are not part of the sale, but the Purchaser has agreed to help collect those receivables on behalf of the Seller, the parties have to determine whether there will be any "fee" charged to the Seller for this activity.

It is not unusual for some patients who owe money to the Seller to also very quickly after the sale owe money to the Purchaser. In many Agreements we state that there will be a defined mechanism for determining where the money gets allocated upon payment in such circumstances. If it is clear from the payor (for example, an insurance company payment or a patient's payment which is clearly designated for a particular service) then there is no issue. If a patient makes a partial payment and does not so designate or the amount of the payment is not clearly applicable to any particular service provided, the contract should provide how that would be allocated. One approach is to have it go on a "first-in first-out" basis. In other words, any "not clearly designated" payment would be first used to satisfy the oldest obligations. Another approach is a "last-in first-out." That

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would first designate the payment towards the most current service provided and still outstanding from a billing standpoint. The important thing here is to discuss things and clearly set forth in the document what it is the deal is.

Real estate complications

Unfortunately, it is not unusual for the parties to come to an agreement relative to the sale of the medical or dental practice and then have major hang-ups regarding the related real estate. This can be true either in a situation where the practice's space is rented from an outsider or is owned by the Seller or an entity with which he has an equity interest.

If the office space is owned by an outsider, the issues relate to trying to get either a new Lease for the Purchaser or an assignment of the existing Lease between the Landlord and the Seller to the Purchaser. We have seen many a Landlord (depending upon the terms of the initial Lease document itself) cause real problems relative to any such assignment. Sometimes the Seller is stuck staying on the Lease and therefore having the ultimate responsibility vis-à-vis the Landlord on the Lease. In those situations, it is imperative that the Seller receive legal protections and indemnifications from the Purchaser. It can become a sticky issue.

If the owner of the building is the Seller, it is sometimes more difficult to negotiate the terms of the Lease and/or sale of the real estate to the Purchaser than was the transaction relating to the sale of the practice itself. In a recent transaction, which ultimately did not go through because of the real estate issues, the Purchaser was concerned about buying a practice without controlling the real estate for a long enough period of time at a reasonable rental rate. He also wanted the right to buy the real estate at his option at some point within the next five years. The Seller refused both requests. With the real estate market and the general economy having serious issues, it has caused many a Purchaser to be much more concerned about how the space issues will impact the overall economics of the practice purchase situation. ■

2009 Medicare fee schedule proposals related to Stark and diagnostic tests

By Michael R. Burke, Esquire

On July 7, 2008, the Centers for Medicare & Medicaid Services ("CMS") published the proposed 2009 Medicare Physician Fee Schedule ("Fee Schedule"). The 2009 Fee Schedule proposal contains several important changes related to the Stark regulations and the anti-markup rules for diagnostic tests that, if implemented in final, would impact many physicians and the manner in which they practice. Since these items are only proposals, they may be significantly revised before they are finalized, and this article will briefly summarize the highlights of these regulations and the impact that they could potentially have on physicians and others who deal with them.

The first substantive change that would impact physicians relates to proposed revisions to the regulations that are scheduled to be effective on January 1, 2009 with regard to the prohibition on marking up diagnostic tests. In the 2008 Fee Schedule, CMS developed regulations that clarified and amplified its long-standing prohibition on the markup of the technical component of diagnostic tests and proposed a rule prohibiting the markup of purchased professional components of diagnostic tests. As a result of the outcry from providers related to the significant effect that these rules would have on their practices, as well as the lack of clarity in these rules, CMS delayed the effective date of these rules to January 1, 2009 (except with regard to anatomic pathology diagnostic testing services, which rules are currently effective).

In the proposed 2009 Fee Schedule, CMS is seeking comment with regard to two alternative approaches for applying the rule prohibiting the markup of purchased diagnostic tests:

- The anti-markup rule would apply in all situations where the professional or technical component of a diagnostic test is either purchased from an outside supplier or performed or supervised by a physician who does not "share a practice" with the physician or group billing for the service.

A physician would only be considered to be "sharing a practice" with a billing physician or a group if he or she is employed or engaged by only one physician or physician group.

- The second alternative would maintain the existing rule as finalized in the 2008 Fee Schedule but would expand the definition of whether or not the diagnostic test is performed "in the office of the billing physician" so as to include diagnostic testing performed in the same building in which the physician or group regularly supplies patient care as opposed to including only testing performed in the same office. This alternative would more closely follow the existing in-office ancillary services exception to Stark.

CMS also proposed several alternatives in dealing with the definition of what constitutes an "outside supplier" in the anti-markup rule. One alternative proposed by CMS would not consider a technical component purchased from an outside supplier (and therefore not subject to the anti-markup prohibition) if the technical component is both performed and supervised within the office of the billing physician and the supervising physician is either an employee or independent contractor of the billing physician or group. CMS then proposed several alternatives to the foregoing proposal, including (i) a proposal that the technical component of a diagnostic test will be deemed to be purchased from an outside supplier regardless of the site of service or the status of the supervising physician if the technical component is conducted by a technician who is not an employee of the billing provider and (ii) if the technical component of a diagnostic test is conducted by a non-employee technician, the technical component will not be considered to be purchased from an outside supplier if the supervising physician is an employee or contractor of the billing physician or group and performs the supervision of this test in the office of the billing physician or group.

CMS also solicited comments on other provisions related to the anti-markup prohibition, such as the calculation of a supplier's "net charge," whether CMS should prohibit reassignment of payment altogether in these instances (thereby requiring physicians who supervise the technical component or perform the professional component to bill Medicare directly), and whether or not to delay the effective date of the anti-markup rules beyond January 1, 2009.

Another provision contained in the 2009 Fee Schedule that would significantly change the landscape of the performance of diagnostic tests is the proposal that physicians and non-physician practitioners who perform diagnostic tests be required to enroll with Medicare as an independent diagnostic testing facility ("IDTF") in all instances. CMS is concerned about the quality of services provided by physicians and non-physician practitioners who do not have to meet the detailed standards required of IDTFs, and therefore proposed that physicians and physician groups enroll as IDTFs and be subject to most but not all of the requirements currently applicable to IDTFs.

This rule would have a huge impact on physicians and non-physicians who perform diagnostic tests. Examples of requirements applicable to IDTFs that could negatively affect physicians providing diagnostic tests include: an IDTF is prohibited from sharing its practice location with other Medicare-enrolled providers or leasing or subleasing its operation or practice location to other Medicare providers; supervising physicians IDTFs can provide general supervision at no more than three IDTF locations; supervising physicians for IDTFs must evidence proficiency in the performance and interpretation of each diagnostic test that the IDTF performs; and non-physician personnel performing services for IDTF

Health care law arbitration

Vasilios J. Kalogredis, Esquire is on the list of arbitrators of the American Health Lawyers Association Alternative Dispute Resolution Service ("AHLA ADRS") and has served as an Arbitrator in several Arbitrations. More information on AHLA ADRS may be obtained by visiting its website www.healthlawyers.org/adr or e-mailing adr@healthlawyers.org.

must satisfy more stringent requirements.

If the foregoing IDTF proposal is adopted, physician groups that currently share space for the performance of diagnostic tests will no longer be able to do so. This seems contrary to the intent evidenced by CMS in examining the alternatives to the anti-markup rule, one of which may expand the definition of "office of the billing physician" to incorporate locations in the same building. While the proposed rule if enacted in its current form would not go into effect until September 30, 2009 for existing physician entities already enrolled in Medicare, physician and non-physician providers should keep a close eye on this provision.

Finally, the 2009 Fee Schedule proposed a new Stark exception for "gainsharing arrangements." This exception will not be foreign to those who have followed the gainsharing arrangements approved by the Office of Inspector General to the Department of Health and Human Services ("OIG") under various opinions under the Federal Anti-Kickback Statute. Among other things, gainsharing programs (i.e. "incentive payment and shared savings" programs) would permit the payment of remuneration by a hospital to physicians pursuant to a written agreement that satisfies 16 different criteria, including but not limited to the use of defined performance measures, baseline levels and target levels; requirements related to the physicians who participate in the gainsharing program (at least five physicians must participate); the requirement of independent medical review to ensure that quality of care is not diminished; the absence of limitations on the items, supplies or devices available to physicians; and a three-year term limitation. Please remember that compliance with the Stark legislation and regulations does not ensure compliance with other laws such as the Federal Anti-Kickback Statute and, in this instance, the Civil Monetary Penalties Law (which prohibits any hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries under the physician's care), and these laws must be analyzed and satisfied separately as well.

Please remember that proposals made in the Fee Schedule each year are not always finalized in the form in which they are proposed, nor are they always finalized in the final Fee Schedule for such year. As such, these are issues for physicians to be aware of and to consider as physicians and physician groups may need to make changes in their practices if these proposed regulations are implemented in this form or a revised form. ■

Impact of IRC Section 409A on separation pay

By Jeffrey B. Sansweet, Esquire

Most medical and dental professional corporations structure the owner buy-outs upon death, disability, retirement, or any other termination of employment as part stock purchase and part separation pay/deferred compensation. Often the stock price is based just upon the value of the tangible assets – the medical equipment, office furniture, computer hardware and software, supplies and leasehold improvements, while the separation pay is typically based upon some multiple of the owner's compensation and is meant to pay for "goodwill" and accounts receivable. The corporation cannot deduct the stock payments and the recipient gets favorable capital gains treatment. In contrast, the corporation deducts the separation pay and the recipient incurs ordinary income tax treatment.

In October of 2004, Section 409A was added to the Internal Revenue Code, and final regulations were issued in April of 2007 (397 pages worth!) which basically require compliance by December 31, 2008. Section 409A sets forth special tax rules for nonqualified deferred compensation plans. The basic purpose of the rules is to prevent employees from having control over the timing of certain compensation payments in order to straddle more than one tax year. If the various documentation and operational requirements are not met, the employee would be taxed in the year of the deferral, even if the funds are received in a later year, and a 20% excise tax would be assessed along with interest.

From a conceptual standpoint, a typical separation pay provision in a medical/dental employment contract should not be subject to

Section 409A since there is no actual deferral of earned income from one year to the next. However, the regulations do specify that separation pay pursuant to an employment agreement is subject to 409A except in the following very limited circumstance: when an employee is involuntarily terminated, the separation pay is not greater than the lesser of (i) two times the employee's compensation for the year prior to separation, or (ii) $230,000 (for 2008), and is paid no later than December 31 of the second calendar year following the calendar year in which termination occurs.

Therefore, unless and until broader exceptions are enacted, medical and dental corporations will arguably need to comply with Section 409A. Unfortunately, there is only one completely "fail-safe" way to avoid any 409A issues — structure the buy-out completely as a stock payment. Since that will not be a very popular choice, the other ways to try to avoid problems include:

1. Amend the employment agreement before 2009 to say that any provision in such agreement that would cause the applicability of Section 409 shall have no effect.
2. Use the term "termination pay" in your documents as opposed to "separation pay" or deferred compensation to try to avoid IRS scrutiny upon audit.
3. Do not allow separation pay to be paid until after separation of service. Some practices allow a doctor or dentist to sell his or her stock, and begin to receive separation pay while still working part-time. This may violate Section 409A.
4. Do not allow a terminated owner or the corporation to accelerate the schedule of separation payments set forth in the agreement.

Please call Jeff Sansweet for further guidance. ■

PDOH issues draft regulations on confidentiality of drug and alcohol treatment records

By Karilynn Bayus, Esquire

For those of you who treat patients for drug and/or alcohol abuse and dependence issues, the Pennsylvania Department of Health ("PDOH") has proposed changes to the Pennsylvania privacy rule affecting the medical records of those patients (4 Pa. Code § 255.5).

The PDOH has indicated that since the current regulations affecting drug and alcohol treatment records were first introduced, there have been numerous advances in understanding drug and alcohol abuse. The PDOH had attempted over the years to issue interpretive guidance regarding the in-place regulations, but over time its interpretations have become confusing and even conflicting.

One problem that has arisen is that under the current regulations, providers cannot always release enough medical information to insurers to enable them to provide coverage benefits for those patients desiring to utilize them for drug and alcohol treatment. Or, alternatively, when such information has been released by providers, they have received citations from the PDOH. The proposed regulations hope to circumvent this issue by allowing providers to release sufficient, limited information to third party payors (with authorization by the patient) to allow the patient's treatment to be covered. Patients may still opt not to utilize insurance benefits for this treatment.

Under the current set of Pennsylvania regulations, drug and alcohol treatment providers may release five pieces of information. This information includes: 1) whether or not the patient is in treatment; 2) the patient's prognosis; 3) the nature of the project/program; 4) a brief description of the patient's progress and 5) a short statement concerning any relapse suffered by the patients.

Under the proposed regulations, the following information may be released by a provider, with the patient's written consent: 1) statement of whether or not the patient is in treatment for drug or alcohol abuse/dependence; 2) the patient's level of intoxication, which includes "quantity, fre-

quency and duration of use" and any withdrawal symptoms experienced by the patient presently or previously; 3) the patient's vital signs, specific medical conditions (which includes pregnancy) and laboratory results; 4) the "specific diagnosis, prognosis, level of functioning, treatment history, and emotional or behavioral problems requiring treatment or negatively impacting responses to emotion or environmental stressors"; 5) brief statement of the patient's progress regarding life issues, participation in program activities and "motivation to change"; 6) the risk level for resuming past behaviors based on use patterns, history of relapse and existing relapse triggers and coping skills; 7) the patient's "social support system, environmental supports and stressors that may impact ongoing recovery." The provided records must be limited to that necessary to obtain coverage for the patient. With the patient's written consent, the same information may be provided to the patient's attorney, probation or parole office (if certain conditions are present) and certain judges.

The proposed regulations further describe exactly what information is necessary for a valid, written consent for disclosure from the patient.

There are certain conditions under the proposed regulations by which information may be released without a patient's written consent. Such conditions include, among others: medical emergency, court order after an application showing good cause for the disclosure, certain limited information to a law enforcement officer directly related to a patient's commitment of a crime on the premises of the drug/alcohol treatment program, and for purposes of a records audit at the premises. Any such disclosures without a patient's consent must be documented in the patient's records, be informed to the patient as soon as possible (that information was disclosed, to whom and for what purpose) and the patient must be informed of their right to review and obtain of copy of the information released.

The proposed regulations will not affect any patients whose plans are covered by what is referred to as "Act 106," which is a Pennsylvania insurance law mandating coverage of substance abuse treatment in group health insurance policies. The new regulations will only affect those patients covered by policies outside the scope of Act 106 (which the PDOH estimates as two thirds of people in Pennsylvania with health insurance coverage). Act 106 itself is not affected by the draft regulations.

Patient confidentiality will be further protected, once records are in third parties' hands, by the Health Insurance Portability and Accountability Act ("HIPAA"), which is not affected by the proposed new Pennsylvania regulations.

The PDOH solicited and accepted comments on the proposed regulations through July 23, 2008. The proposed regulations will have to be watched to see what, if anything, becomes codified. As of the time of publication of this article, it is unclear if the proposed regulations will be further amended. Until a final rule would be codified, providers must continue to follow the current regulations regarding privacy of drug and alcohol treatment records. ■

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Speaking and Writing Information and Website

We have extensive experience in speaking and writing on topics of interest to healthcare practitioners. Whether it be your local, state or national society; a group of residents/fellows; or a study group, we would be interested in talking to you about speaking and/or writing opportunities. For more information on our areas of expertise please visit our new and improved Website at www.KSDBHealthlaw.com.

Bill Kalogredis will speak to the American Academy of Cardiology – Pennsylvania Chapter at its annual meeting on November 1, 2008 on Contracts. Bill will speak in Santa Clara, California on November 4, 2008 to pediatric neurology fellows on Employment Agreements. Bill will present in Seattle at the American Epilepsy Society Meeting on December 5, 2008 on Employment Contracts and Running the Medical Practice as a Successful Business. On December 13, 2008, Bill will speak at the Cosmetic Bootcamp in Las Vegas on Employment Agreements and Hot Topics in Personnel Management. He will also talk in San Francisco at the American Academy of Dermatology Practice Management Symposium in February 2009 on Employment Agreements, Negotiation Tips, and Five Practical Tips.

Jeff Sansweet will speak at the American Academy of Ophthalmology annual meeting on November 10 and 11, 2008 on Employment Contracts and Partnership Deals.

Bill has also been authoring a monthly article on healthcare law for the *Legal Intelligencer.* Bill authored an article for *Physician's News Digest* on "Would a Practice Merger Be Right for You?"

Jeff authored an article on "Practice Buyouts" which is scheduled for publication in *Physician's News Digest* in November.

Mike Burke wrote an article for the September 2008 issue of *MD News* on "Compliance Basics for Physician Practices" and another for the September 2008 issue of *Physician's News Digest* on "Refresher on Medicare's Reassignment of Payment Rules."