



KSDB Health Law INSIGHTS

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Your peer review file

By David R. Dearden, Esquire

Every healthcare organization that utilizes a credentialing process to qualify providers maintains a "peer-review" file for each provider. Typically, this file contains the data maintained by the National Practitioner Data Bank (NPDB). This data reveals adverse licensure actions and settlements and adverse judgments in professional liability cases, among other information.

Federal law

The NPDB provider profiles are the direct result of the Healthcare Quality Improvement Act. This Act was an attempt on the federal level to improve the overall quality of healthcare by making information available to healthcare organizations that will help in the due diligence required during the credentialing process. The data stored by the

NPDB is not available to the general public and the information sent by the NPDB to your peer review file is considered confidential and is privileged from use in litigation by federal law.

State law

However, the federal privilege is limited and protects only material generated by the NPDB. The other documents that

If such frank discussions could be used as evidence of negligence in lawsuits, there is a concern that discussions would be more guarded and organizations would react more slowly to making quality improvements.

may be contained in a credentialing file, such as applications, recommendations and reference letters are entitled to a peer review privilege under the law in most states, like the Pennsylvania Peer Review Protection Act. The legislature recognized that there are benefits to allowing organizations to openly document errors and actions in privacy in order to take corrective action to improve the qual-

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Front row: Leif, Bill Back row: Dave, Mike, Susan, Jeff

Your peer review file

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ity of the services that are provided. If such frank discussions could be used as evidence of negligence in lawsuits, there is a concern that discussions would be more guarded and organizations would react more slowly to making quality improvements.

However, the peer review privilege has been interpreted inconsistently by the courts. For example, the Pennsylvania Supreme Court has ruled that the Peer Review Act does not apply to protect from disclosure information maintained in a health maintenance organization file. A distinction has been made between factual information which is discoverable and deliberative information which is not discoverable. The Act may not protect incident reports that are submitted to and considered by Peer Review Committees if they are not created by the Peer Review Committee itself. The Peer Review privilege will not apply when the underlying suit relates to a physician's own challenge of medical staffing decisions.

Recent case

In a 2005 case entitled *Troeschler v. Grody*, the Pennsylvania Superior Court decided that even correspondence and recommendations prepared by Temple University Hospital's general counsel were covered

The Pennsylvania Medical Care Availability and Reduction of Error Act (MCARE) contains provisions that provide privilege protection for information generated in the "patient safety review process."

by the Peer Review Act and were not available for use in a medical malpractice case. The majority opinion emphasized the policy goal of protecting the hospital's ability to freely regulate and improve the conduct of the staff physicians. The dissenting opinion, however, stated that healthcare providers accused of negligent supervision should not be able to shield themselves from liability by using the Peer Review Act. The dissenting judge would have allowed the plaintiff to access the credentialing file of physicians to support the claim of corporate negligence.

MCARE Act

There is a new statutory source that physicians can attempt to use to broaden the peer review privilege. The Pennsylvania Medical Care Availability and Reduction of Error Act (MCARE) contains provisions that provide privilege protection for information generated in the "patient safety review process." The lan-

guage of the Act has not yet been analyzed by any appellate court considering the peer review privilege issue, but it arguably provides an additional protection for documents, materials and information prepared for patient safety reasons.

Practical advice

Practitioners should maintain all peer review type documents that are created with an appropriate legend to maximize the chance that the court reviewing this information will draw the conclusion that the documents are entitled to the privilege. If the papers can be linked to improving patient safety this theme can help expand the privilege. Counsel representing such providers should use federal and state law references to increase the scope of the peer review privilege. ■



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Making sure you can afford your partner's retirement

By Leif C. Beck, J.D., CHBC, Of Counsel

Medical and dental groups have co-owner buy-out arrangements to deal with the inevitable but often unpredictable event of a member's leaving the practice. These arrangements are typically set out in corporate or partnership documents which may have been written and signed many years ago.

Having advised about and drafted such agreements for many clients, we routinely urge reviewing them at almost every practice annual meeting. Times and circumstances change over the years, and what may have seemed appropriate before may not be so workable now or in the near future. Even though we point that out, "partners" find it difficult or unpleasant to deal with the question.

The price itself

Especially as senior partners approach retirement age — often surprisingly low in medicine and dentistry — they become seriously concerned whether the provisions will work out as long expected. Both the seniors themselves and their younger partners ask, "Is the buy-out price too expensive?" As practice appraisers, we are comfortable evaluating the price figure and advising how to proceed.

Sometimes the answer is double-edged. The price may be "fair" as a matter of proper valuation — in effect, on paper. And yet the ongoing practice may or may not be able to afford it. Let

us explain what appears to be an anomaly.

Three major "asset classes" commonly determine a member's buy-out: cash and physical equipment; accounts receivable; and — the most debated — ongoing earning power (goodwill). A practice co-owner presumably deserves his or her proportionate share of each as when leaving them behind in retirement. Medical and dental practice appraisers generally act properly when they determine that those values exist.

Paying the price

Under normal economic conditions, those values should be readily affordable. Even as to goodwill, the practice can typically earn and pay over a reasonable figure as it continues on its financial path without the departing partner. Perhaps the other partner(s) can carry it, or else they can recruit and hire a new doctor(s) to assume the load at initially lower compensation. Lowering the actual pay-out figure may thus be both incorrect and unfair.

However, the conditions may or may not play out as expected. Especially in medical practice, declining reimbursement rates and increasing price competition may make the projected revenue stream less certain than the ongoing partner(s) feel they can assume. And whether medical or dental, the practice's ongoing provider make-up may not be

conducive to its continued earning capacity. A disparity in the partners' ages, for instance, whether because of poor planning or mere happenstance, sometimes comes into play.

Projecting and spreading the payments

In such circumstances, we may recommend keeping the pay-out figure — based on the practice's fair values — but updating pay-out limits designed to protect the ongoing group. This is part of our long-held overall philosophy: *A group should be generous to a departing longtime partner so long as it protects itself and its ongoing members.* Taking it further, the practice's continued success must be the primary concern.

Some agreements, for example, call for paying out most of the agreed values over a fairly short time period. Sometimes a group must pay for the partner's interest in the

equipment, almost simultaneously pay a substantial malpractice insurance tail premium and also start distributing a portion of monthly accounts receivable over just a few months. The combination can strangle

A group should be generous to a departing longtime partner so long as it protects itself and its ongoing members.

an ongoing practice just hit by a valued member's departure, sometimes planned but some-

Even an apparently hefty goodwill valuation, if appropriate, may be surprisingly affordable when paid for over sixty months.

times due to death or suddenly arising disability. Hence we urge carefully projecting the agreed obligations and planning a pay-out schedule that enables meeting them comfortably.

Such an effort leads to phased pay-out provisions spreading much of the overall figure over as long as five years. Even an apparently hefty goodwill valuation, if appropriate, may be surprisingly affordable when paid for over sixty months.

Gross income limitation

Even so, five years is a long time. Who knows how the practice will function down the road in view of economic and doctor-level uncertainties? The question often leads us to recommend what we call the "gross income limitation." It accepts the basic pay-out duty but attempts to ensure that meeting it will not strap the ongoing practice. In its simplest form it caps the retirement payments so they will not in any year exceed a moderate percentage of practice revenue.

We have seen situations where declining revenue left a group unable to pay out its former partner(s) and have enough re-

maining to fairly compensate its ongoing members for their work. Little can be worse for everyone involved, both those ongoing members and the ex-partner, than to see the group itself splinter and even dissolve. Sometimes only one doctor remains, and s/he decides it better to close the practice and relocate than to continue.

The gross income limitation helps prevent this situation if it is carefully drafted. We ourselves are updating our earlier format to make sure the limit applies currently rather than retroactively. Ample language would limit each monthly payment to a departed partner or partners so it will not exceed a set percentage, sometimes as low as 2% or 3%, of the previous month's gross revenue. This way, the payments will fairly currently track the practice's economic conditions and ability to pay.

Of course, monthly revenues may vary substantially in medical and dental practices. Therefore, we include provisions to carry over any shortfall(s) and pay them in the succeeding months, subject to the same monthly percentage limit. If the shortfalls continue on to the end of the pay-out period (often five years), a carry-over provision can extend the pay-out pattern, but not for more than,

say, two additional years. After all, the obligation must end sometime.

Non-competition

Other provisions may also help ensure that the ongoing group can afford to buy out its longstanding partners. For one, a former partner should not receive continuing payments if he or she leaves and practices even slightly competitively. That doctor hardly deserves payment for what remains behind if s/he takes any advantage of it. We do not consider such a provision equivalent to the much-questioned and maligned restrictive covenant, for it merely reduces or eliminates a

contracted payment for "competing."

For these and other reasons, look again at your arrangements for a member's departure. Consider, too, that one never knows which partner may be the departing person. While the senior member will presumably retire first, a younger partner may instead die, become disabled

or just plain decide to leave for reasonable personal or professional reasons. If so, the pay-out burdens may be vastly more difficult to meet even if they were not the main subject of earlier planning. ■

Other provisions may also help ensure that the ongoing group can afford to buy out its longstanding partners. For one, a former partner should not receive continuing payments if he or she leaves and practices even slightly competitively.

Draft regulations proposed in Pennsylvania related to outpatient health care facilities

By Michael R. Burke, Esquire

The Pennsylvania Department of Health (“PADOH”) recently posted to its website (www.dsf.health.state.pa.us/health/site) draft proposed regulations that would revise existing regulations related to the licensing of hospitals and health care facilities in Pennsylvania (“Draft”). When we went to press, the Draft was still available for review on the PADOH website. PADOH posted it while still subjecting it to internal review, and it seeks responses and comments before proposing and ultimately publishing them based on constructive input.

Our clients will be most concerned with the Draft’s proposed new requirement to license “outpatient health care facilities.” While specifically excluding typical physicians’ offices, it defines “outpatient health care facility” as one that provides diagnostic, therapeutic, treatment or rehabilitation services either to outpatients or to individual patients for less than a twenty-four (24) hour consecutive period, by or under the supervision of a physician(s) or other licensed practitioner(s) within their scope of practice. An illustrative list of outpatient health care services includes but is not limited to emergency, cardiac catheterization, cancer treatment involving radiation therapy, imaging, pain management, burn center, ambulatory surgery and any other clinical service that PADOH might later

specifically add.

There is currently no “grandfathering” provision in the Draft that would allow unlicensed “outpatient health care facilities” in existence prior to the date on which the Draft is finalized to continue in existence without obtaining a license. This means that if the Draft is finalized, physician practices that already have such a facility in place may have to comply with a new set of regulations and obtain a license (depending upon how the facility is classified under the Draft’s definitions) even though it is already up and running.

Goals and definitions

In drafting these suggested regulations, PADOH proposes to establish minimum licensing requirements for health care providers to construct, operate and maintain health care facilities in Pennsylvania. The Draft focuses on achieving the following goals:

- patient-centered care;
- zero tolerance of serious events and medical errors;
- elimination of health care disparities;
- priority to patient safety and quality improvements; and
- innovation and experimentation in health care and health facilities.

Unfortunately, the Draft is not satisfactorily clear as to whether a group practice operates an office or an outpatient health care facility, as discussed further below. While an office used primarily for a practitioner’s private practice is

not considered an “outpatient health care facility,” the Draft does include in the definition of “outpatient health care facility” clinics and group practice facilities that provide diagnostic and treatment services (other than primary care) in a specific specialized area of medicine. It does this by defining “office” as a place where professional activities are conducted, but not extending to specialty clinical areas for diagnosis or treatment.

We consider this lack of specificity a significant concern for many medical specialty and subspecialty practices and hope it will be dealt with further before the final Draft regulations are adopted.

The Draft also excludes from the definition of “outpatient health care facilities” hospital-licensed services provided on-site. However, outpatient services that are not provided under the hospital license, even if on-site, are not excluded from the definition. This may pose a problem for some of our clients, as well.

Problem areas

We see a number of shortcomings, and we hope to see them corrected during the comment process. The Draft on its face lacks enough detail for physi-

Physician practices that already have such a facility in place may have to comply with a new set of regulations and obtain a license.

icians to determine whether the services that they provide rise to the level of requiring licensure. By excluding an “office” used primarily for the private practice of a health care practitioner, but including clinics and group practice facilities providing specialty services, as noted, the Draft leaves a large gray area.

Query, for instance, whether a group practice using a “centralized location” to provide certain in-office ancillary services (radiology services, physical therapy services, etc.), as contemplated under the Stark II legislation, would require PADOH licensure? Taking the question further, query if the answer would be different if the group also used the location to provide non-ancillary services like physician office visits? More detail is needed for physicians and their advisors to determine whether or not they will need to follow the

By excluding an “office” used primarily for the private practice of a health care practitioner, but including clinics and group practice facilities providing specialty services, as noted, the Draft leaves a large gray area.

licensure process in order to provide certain ancillary services that are increasingly important to their practices.

We see another problem in that the Draft lumps outpatient health care facilities together with hospitals in many of its proposed requirements. This requires a high level of detail and compliance relating to such matters as staffing, governance, business dealings and finance. The requirements probably go beyond what most physicians expect when they consider whether to pursue an ancillary service undertaking. Covered facilities would also have to develop and comply with a “patient bill of rights” as set out in the Draft.

Charity Care

The Draft also contains charity care requirements that would apply to hospitals and licensed outpatient health care facilities. Under the Draft, legal action may be taken by a health care provider to collect outstanding amounts only where there is evidence that the patient or responsible party has income and/or assets to meet his or her obligation. Health care providers will not be permitted

to force a sale or foreclosure of a patient’s primary residence to pay an outstanding medical bill. This would impose another layer of complexity and regulation on physicians who already struggle to determine when they should pursue the collection of outstanding bills from a patient.

Conclusion

Please keep in mind that the Draft has only been promulgated and posted in draft on the PADOH website. It has not been formally published in the *Pennsylvania Bulletin* (or subject to the formal review and comment period associated with proposed regulations) and is currently subject to change; the PADOH is seeking comments on how to make the Draft better. However, we hope this discussion shows you what may be in store for Pennsylvania physicians that provide (or may decide to provide in the future) ancillary services within their practice.

Visit the PADOH website (listed above) and click on the link for “Draft Regulations” and consider sending your comments and suggestions, especially if you care about being further burdened by physician practice regulation. Especially of concern, in our view, are proposals that would in many instances lump the requirements for outpatient health care facilities together with hospitals. If the link is not yet available when you read this article, you may contact the PADOH directly to request a copy. And, of course, look for the Draft’s final publication in the *Pennsylvania Bulletin*. ■

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Some practical advice

By Vasilios J. Kalogredis,
Esquire

We are amazed how often we are brought into situations that were much messier than they needed to be for one very simple reason — no signed Agreements were in place!

In the past several weeks, I have been engaged to assist a couple of groups in which one

of their doctor-owners was departing. If well thought out and executed agreements were in existence, the clearly defined terms would set forth the road map as to what should take place. Unfortunately, in the aforementioned two matters, there were no such documents. The end result will be a lot of angst for all involved, lengthy negotiations which may or may

not end up with a satisfactory result, dedication of a lot of time and money, and possibly, litigation.

I cannot emphasize enough the importance of entering into definitive Agreements that reflect the arrangements before a crisis arises. Spending the time and money to appropriately deal with things “up front,” will save a lot more in the future. ■

Retirement plan update

By Jeffrey B. Sansweet, *Esquire*

Good news continues for physicians in the retirement plan area. The maximum allowable combined pension and profit sharing plan annual contribution has increased from \$42,000 to \$44,000 for plan years beginning in 2006. The annual compensation limit has also risen from \$210,000 to \$220,000. For practices with a profit sharing plan with “permitted disparity,” that will mean a staff contribution of 16.74% for 2006.

For those of you with 401(k) plans, the 2006 annual elective deferral limit is \$15,000. Also, if you are at least age 50 by the end of that year, an additional “catch-up” 401(k) contribution is allowed of up to \$5,000. Still further, if your 401(k) allows for them, a participant may be able to make after-tax “Roth 401(k)” contributions beginning this year, offering the potentially valuable advantage of not being taxable when later withdrawn. ■

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. You are encouraged to visit our Website at www.KSDBHealthlaw.com for more information on our areas of expertise and articles we have written and talks we have given.

- Vasilios J. Kalogredis spoke at the American Academy of Dermatology Annual Meeting in San Francisco on March

2, 2006 on “Employment Agreements” and “Personnel Management.”

- Vasilios J. Kalogredis has written an article on “Developing a Solo Practice Exit Strategy” which is scheduled to be published in the April issue of Family Practice Management.
- Vasilios J. Kalogredis has also been writing a monthly article on healthcare law for the Legal Intelligencer in Philadelphia.

Please contact us if you would like to explore the possibilities.



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