



# Accountable Care Legal Guide



# Accountable Care Legal Guide

## INTRODUCTION

This analysis of legal issues<sup>1</sup> affecting accountable care organizations (“ACOs”) is an adjunct to The Physician’s Accountable Care Toolkit©. It is another “tool” to further prepare physicians for the approaching accountable care era.

This, and the other resources of this project, could not have been created without the generous support of the members of the Toward Accountable Care Consortium listed on page 1 and 2, in-kind contributions of the North Carolina Medical Society and the Smith Anderson law firm, and a significant grant from the Physician’s Foundation.

### ***County / Regional Medical Societies***

Cleveland County Medical Society  
Craven-Pamlico-Jones County Medical Society  
Durham-Orange County Medical Society  
Mecklenburg County Medical Society  
Forsyth-Stokes-Davie County Medical Society  
New Hanover-Pender County Medical Society  
Pitt County Medical Society  
Rutherford County Medical Society  
Western Carolina Medical Society  
Wake County Medical Society

### ***Specialty Societies***

Carolinas Chapter, American Association of Clinical Endocrinology  
North Carolina Academy of Family Physicians  
North Carolina Chapter of the American College of Physicians  
North Carolina College of Emergency Physicians

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<sup>1</sup> It is not the purpose of this paper to provide legal advice. Any person considering participation in an ACO should seek the advice of legal counsel.

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North Carolina Council on Child and Adolescent Psychiatry  
North Carolina Dermatology Association  
North Carolina Neurological Society  
North Carolina Obstetrical and Gynecological Society  
North Carolina Orthopaedic Association  
North Carolina Pediatric Society  
North Carolina Psychiatric Association  
North Carolina Radiologic Society  
North Carolina Society of Anesthesiologists  
North Carolina Soc. of Asthma, Allergy & Clinical Immunology  
North Carolina Society of Eye Physicians and Surgeons  
North Carolina Society of Otolaryngology – Head and Neck Surgery  
North Carolina Society of Pathologists  
North Carolina Society of Plastic Surgeons  
North Carolina Spine Society

## ***State Societies / Organizations***

Community Care of North Carolina  
Carolinas Center for Hospice and End of Life Care  
North Carolina Academy of Physician Assistants  
North Carolina Medical Group Managers  
North Carolina Medical Society

## I. OVERVIEW: UNCERTAINTY INEVITABLE

Achieving legal compliance for ACOs is like navigating through a minefield. This is because the encouraged collaboration among sometimes competitors and providers often in a position to refer potentially implicates a body of laws enacted in the fee-for-service environment. Conduct encouraged under the value-payment model might be prohibited by laws enacted to avoid abuses under the fee-for-service model. In addition, ACOs are new and clear legal guidance on all issues is not yet available. Besides the highly regulated health care compliance issues, ACOs also raise a number novel business law issues. These factors combine to create confusion and uncertainty.



However, this legal minefield is navigable, and the purpose of this paper is to provide the reader with general guidance to help successfully navigate through this minefield. Recognizing the legal compliance uncertainty, the federal regulators have taken historic unified steps to provide guidance to ACOs.

## II. LEGAL COMPLIANCE ROADMAP

The following is an introduction to the principle bodies of law impacting ACOs:

**A. Antitrust** – Antitrust laws aim to protect consumers by promoting competition. The two agencies enforcing the federal antitrust laws, the U.S. Department of Justice (“DOJ”) and the Federal Trade Commission (“FTC”), look to avoid unfair collusions of supposed competitors and monopolistic behavior. Health care has been regulated by the antitrust laws since 1974, and the agencies have developed expertise and guidance regarding which behaviors are not pro-competitive.

The federal antitrust laws are principally found in three key statutes: The Sherman Act, the Clayton Act, and the Federal Trade Commission Act.

Section 1 of the Sherman Act, 15 U.S.C. § 1, prohibits contracts, combinations and conspiracies which unreasonably restrain competition.

Section 2 of the Sherman Act, 15 U.S.C. § 2, prohibits monopolization, attempted monopolization and conspiracies to monopolize.

Section 7 of the Clayton Act, 15 U.S.C. § 18, prohibits mergers and acquisitions which may lessen competition or tend to create a monopoly.

Section 7A of the Clayton Act, 15 U.S.C. § 18(a), known as the “Hart-Scott-Rodino Antitrust Improvements Act of 1976,” requires parties to certain mergers, acquisitions, joint ventures and corporate and non-corporate formations to notify the FTC and DOJ about the transaction before the transaction closes.

Section 5 of the FTC Act, 15 U.S.C. § 45, prohibits unfair methods of competition. The FTC Act can also be used to challenge mergers which are not technically covered under Section 7 of the Clayton Act. See *FTC v. Brown Shoe Co.*, 384 U.S. 316, 321 (1966). Only the FTC has jurisdiction to sue under the FTC Act.

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While ACOs can provide a pro-competitive integrated method to raise quality and lower costs, impossible for its component parts to delivery individually, it is also a collaboration of erstwhile competitors negotiating, collecting, and distributing significant dollars. The antitrust laws potentially apply to ACOs through fee negotiations, market allocation within an ACO or among ACOs, exclusivity, boycotts, and undue market power. Detailed compliance analysis is beyond the purview of this overview, but the body of guidance provided by the DOJ and FTC will allow the ACO dedicated to providing greater value to be organized and operated successfully. Most noteworthy is the “clinical integration” exception first articulated in *The Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care (1996)*, Statement 8, Physician Network Joint Ventures (“1996 Statements”). The antitrust laws generally apply to private commercial health care, rather than to public payors.

The FTC and DOJ issued a Final Statement in October 2011 regarding how they will evaluate the potentially pro- and anti-competitive impacts of ACOs. The Final Statement focuses primarily on ACOs participating in the Medicare Shared Savings Program (“MSSP”), but discusses their anticipated interaction with commercial payors. The guidelines, they state, are applications of the principles enunciated in the 1996 Statements and related antitrust guidelines and advisory opinions. Providers were seeking clarity on whether ACOs qualifying for the MSSP would be presumed to be “clinically integrated.” The Final Statement provides that in light of the degree of clinical integration that must be achieved in order to be certified for the MSSP by CMS, ACOs in the MSSP “are reasonably likely to be *bona fide* arrangements intended to improve the quality, and reduce the cost, of providing medical and other health care services through their participant’s joint efforts.” The Agencies will therefore apply a “rule of reason” rather than a “*per se*” analysis of such ACOs in the commercial market if it operates in the same manner as under the MSSP. The rule of reason analysis allows for the weighing of likely pro- and anti-competitive effects. A *per se* analysis does not. The Agencies also set forth certain safety zones for ACOs based primarily on market share and non-exclusivity.

An ACO outside the safety zone or not participating in the MSSP may still be in compliance. The 1996 Statements and their progeny still continue to provide guidance, and the Agencies added the following warnings of behavior for ACOs to avoid consistent with those statements:

- Preventing or discouraging private payors from incentivizing patients to choose certain providers, including providers not participating in the ACO.
- Linking the sales of ACO services to the private payor’s purchase of other services from providers outside the ACO. For example, an ACO should not require a payor to contract with all of the hospitals under the same system of the hospital participating in the ACO.
- Contracting exclusively with ACO physicians, hospitals, ambulatory surgery centers, and other providers to prevent those providers from contracting with payors outside the ACO.

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- Restricting a private payor's ability to share enrollees information on its health plan cost, quality, efficiency, and performance to help enrollee choose providers—if that information is similar to the cost, quality, efficiency, and performance measures used in MSSP.

**B. Stark Law** – Stark Law is the federal physician self-referral law. The law reflects Congress' fear that patient referrals are often unduly influenced by a profit motive, thereby undermining utilization, patient choice, and competition among participants in the federal healthcare programs. A government concern in the ACO context occurs when physician referrals are “controlled by those sharing profits or receiving remuneration, the medical marketplace suffers since new competitors can no longer win business with superior quality, service, or price.”<sup>2</sup>

Stark Law has two basic prohibitions: a referral prohibition and a billing prohibition. Under the referral prohibition, a physician may not refer certain services to an entity where payment for that a designated health service (“DHS”) is made under Medicare and where the physician (or a family member) has a financial relationship with the entity.<sup>3</sup> The term “financial relationship” is defined in the Stark Law to include both compensation arrangements and interests in investment and/or ownership. Under the billing prohibition, a healthcare provider may not bill for improperly referred services.

Congress and CMS have created dozens of exceptions to mitigate the breadth and strict liability harshness of the law. ACOs generally will need to navigate the Stark Law and regulations by determining if there is a “physician” making a “referral” to an “entity” for the “furnishing” of a “DHS” covered by Medicare. Next, if so, does the physician (or immediate family member) have a “financial relationship” with the entity? Next, if so, does this arrangement qualify under one of the exceptions? Although there are myriads of ACO referral scenarios, it is highly probable that there will be a Stark Law triggering “referral” and “financial relationship,” especially if a hospital is involved in the ACO. If the source of funds is not a participating hospital or passes through the hospital, chance of applicability is much reduced.

In July 2008, CMS proposed a new exception covering shared savings. In addition, the employment, personal services, fair market value, and indirect compensation arrangement exceptions may apply to typical ACO arrangements.

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<sup>2</sup> Stark II, Phase II Proposed Regulations (Preamble), 63 Federal Register 1659, 1662 (1998).

<sup>3</sup> 42 U.S.C. §1395(n)(n).

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In October 2011, CMS and the OIG issued an interim final rule (“IFR”) with comment period (“IFC”) establishing five waivers for ACOs, but only those ACOs participating in the MSSP. Waivers are applicable to private payor arrangements, but these must show that they are reasonably related to the ACO’s participation in the MSSP. The five waivers address different circumstances:

- An “ACO pre-participation” waiver;
- An “ACO participation” waiver;
- A “shared savings distribution” waiver;
- A “compliance with the Physician Self-Referral Law” waiver; and
- A “patient incentive” waiver of the federal Anti-Kickback Law and the Civil Monetary Penalties Law.

CMS and the OIG stated that “this IFC sets forth waivers of certain provisions of the Physician Self-Referral Law (“Stark law”), the federal anti-kickback statute, the CMP law [Civil Monetary Penalties Law] prohibiting hospital payments to physicians to limit services (the “Gainsharing CMP”), and the CMP law prohibiting inducements to beneficiaries (the “Beneficiary Inducements CMP”) as necessary to carry out the...[MSSP legislation]. We seek to waive application of these fraud and abuse laws to ACOs formed in connection with the Shared Savings Program so that the laws do not unduly impede development of beneficial ACOs, while also ensuring that ACO arrangements are not misused for fraudulent or abusive purposes...” As a threshold requirement, the ACO and those involved must meet all the MSSP laws and regulations. The waivers are self-implementations, meaning that the ACO does not need to apply to CMS or the OIG for approval.

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**C. Anti-Kickback Law** – There are both federal and state anti-kickback laws. The federal Anti-Kickback Law is related to the Stark Law and it prohibits one person from “knowingly and willingly” giving “remuneration” to another if the payment is intended to “induce” the recipient to (1) refer an individual to a person for the furnishing of any item or service for which payment may be made, in whole or in part, under a federal healthcare program; (2) purchase, order or lease any covered item or service; (3) arrange for the purchase, order or lease of any covered item or service; or (4) recommend the purchase, order or lease of any covered item or service. In short, the law prohibits any payment intended for referrals where payment for services is made under a federal healthcare program.<sup>4</sup> Unlike the Stark Law, however, the federal Anti-Kickback Law is an intent-based statute with both criminal and civil liabilities. Also, the Stark Law’s prohibitions apply only to Medicare; the Anti-Kickback Law covers all federal health care programs (with the exception of the Federal Employee Health Benefits Program).

The federal Anti-Kickback Law is so broad that it covers many common and non-abusive arrangements. Recognizing this over-breadth, the U.S. Department of Health and Human Services Office of Inspector General—the agency charged with enforcing the Anti-Kickback Law—has established a large number of statutory exceptions and regulatory safe harbors. Several exceptions/safe harbors may apply to the ACO model, including Personal Service Arrangements, Fair Market Value Compensation, and Indirect Compensation arrangements. The safe harbors, however, are fairly narrow, especially in the face of the breadth of the Anti-Kickback Law.

To augment the protection provided by the safe harbors, the Office of Inspector General has implemented an “advisory opinion” program through which organizations and arrangements apply for a waiver. Pursuant to this program, organizations may submit proposed arrangements to the agency and request, in effect, a “case-specific” safe harbor. The Office of Inspector General has issued over two hundred advisory opinions so far over the lifespan of the federal Anti-Kickback Law.

An ACO would analyze applicability of the Anti-Kickback Law as follows: Was there “remuneration” flowing from a person or entity in a position to benefit from a referral of a federal health care program patient to the potential referral source? If so, was it intended to induce conduct in violation of the Act? If so, is it protected by a safe harbor? If not, is there a material risk of an abuse sought to be prohibited by the Act?

To mitigate risk, ACOs should not be making arrangements with this intent and should have safeguards in place. An MSSP participating ACO may avail itself of the waivers affecting the Anti-Kickback Law mentioned in the above Stark Law analysis.

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<sup>4</sup> 42 U.S.C. §1320a-7b(b).

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**D. Civil Monetary Penalties Law** – The Civil Monetary Penalties (“CMP”) Law provides that if a “hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals” who are (1) entitled to Medicare or Medicaid benefits and (2) “under the direct care of the physician,” then the hospital and physician are subject to a Civil Monetary Penalty of \$2,000 for each individual with respect to whom the payment is made.<sup>5</sup> The CMP Law only applies to payments from hospitals to physicians. The key to the law is that if the hospital is paying or administering ACO-related payments (*i.e.*, incentives to physicians), *the goal cannot be to limit care to necessary services*. The CMP Law recognizes that hospitals have a legitimate need to eliminate “unnecessary care;” however, there is no explicit distinction made in the law between “necessary” and “unnecessary” care.

There is inherent tension between the CMP Law and the ACO model. In reality, the efficacy, efficiency and lowered costs of ACOs depend on the incentives of gainsharing and value-based reimbursements. However, bundled payments, gainsharing and capitated arrangements (in which the hospital keeps the remainder of payments not distributed to the physicians) all may implicate the CMP Law. The Patient Protection and Affordable Care Act includes an amendment to the CMP Law for remuneration that promotes access to care and poses a low risk of harm to participants. On December 31, 2012 the OIG issued OIG Advisory Opinion No. 12-22 which approved a cardiac catheterization hospital/physician co-management agreement with a performance based payment, including for cost reductions attributable to lab procedures.

Note that the CMP Law only applies to Medicare or Medicaid payments from hospitals to physicians. However, if it is, “reduce or limit” services has been interpreted quite broadly. There have been a number of advisory opinions from the OIG. If the narrower CMP Law is applicable, an ACO either refrains from the conduct or undertakes it consistent with the OIG’s guidance and/or the PPACA amendments to mitigate, but not eliminate, the risk. If the ACO is participating in the MSSP, it may avail itself of the self-implementing waivers affecting the CMP Law’s application discussed in the above Stark Law analysis.



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<sup>5</sup> 42 U.S.C. §1320 a-7a(b)(1)

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**E. Tax Exemption and Inurement** – The first tax exemption question is whether the newly-created ACO entity might qualify for tax exemption? Early indications are that a properly structured one can. The next question is whether the shared savings and other payments among tax-exempt members of the ACO are consistent with their tax-exempt status? A related question is whether, for example, payment from a hospital's ACO to a member of its medical staff is an improper "inurement?"

The IRS Issued Notice 2011-20 (2011-16 I.R.B. 652 (April 18, 2011)) (the "Notice") to address whether Section 501(c)(3) hospitals and other tax-exempt health care entities participating in the MSSP through an ACO may be affected by current limitations on such entities under the Internal Revenue Code. On October 20, 2011, the IRS issued Fact Sheet 2011-11, which confirms that Notice 2011-20 continues to reflect the IRS's expectations regarding ACOs participating in the MSSP.

The IRS has provided guidance on what would be acceptable conduct of a tax-exempt entity participating in an MSSP-qualifying ACO:

- The terms of the tax-exempt entity's participation in the MSSP through an ACO are set forth in advance in a written agreement negotiated at arm's length.
- CMS has accepted the ACO into, and has not terminated the ACO from, the MSSP.
- The tax-exempt entity's share of the economic benefits derived from the ACO (including its share of MSSP shared savings payments) is proportional to the benefits or contributions that the entity provides to the ACO.
- The ownership interest received by the tax-exempt entity, if any, is proportional and equal in value to its capital contributions to the ACO, and all ACO returns of capital, allocations, and distributions are made in proportion to such ownership interest.
- The tax-exempt entity's share of ACO losses (including its share of MSSP losses) does not exceed the share of ACO economic benefits to which the entity is entitled.
- All contracts and transactions entered into by the tax-exempt entity with the ACO and the ACO participants, and by the ACO with the ACO participants and other parties, are at fair market value.

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**F. HIPAA and Other Health Information Privacy and Security Laws** – The rules adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) established standards and requirements for healthcare providers and health plans to protect confidential patient information. HIPAA’s privacy standards (impacting covered entities and individuals) can be organized into four major areas: (1) administrative and training requirements; (2) the requirement for policies, procedures, and forms regarding how patient information is used and disclosed; (3) certain requirements regarding patient access to their own information; and (4) the requirement for agreements and policies regarding how business associates keep information confidential.



For health information privacy and security law, the critical sections are the Privacy Rule and the Security Rule of Title II of HIPAA. The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. The Security Rule complements the Privacy rule and specifies a series of administrative, physical, and technical safeguards for covered entities to assure the confidentiality, integrity, and availability of electronic protected health information.

HIPAA sets the federal “floor” of health privacy protections. There are other, more stringent, health information privacy laws, both at the state and federal level. For example, Part 2 of Title 42 of the Code of Federal Regulations regulates the privacy restrictions on information

regarding substance abuse. For example, health information privacy laws related to mental health and communicable diseases are prescribed by the state in North Carolina. HIPAA privacy regulations generally do not preempt state laws that are more stringent than the HIPAA privacy standards regarding patient confidentiality or reporting.

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HIPAA was amended by the Health Information Technology for Economic and Clinical Health Act (the “HITECH” Act), which was enacted as part of the American Recovery and Reinvestment Act of 2009. HITECH enacted expansive changes to HIPAA aimed at encouraging the sharing of electronic health information. It also provides funding assistance and incentives to encourage implementation of electronic health records. It expanded business associate responsibilities and liability (discussed below) and expanded patient rights.

The well-known compliance considerations for HIPAA and related laws are generally the same regarding health information exchange (“HIE”) within and among ACOs.

## **G. Professional Liability**

**1. Common Law** – Malpractice is a cause of action that by its nature differs from other liability theories in ways that make it less susceptible to sudden change. A professional liability, or malpractice, claim must generally demonstrate that harm arose from a departure from the “standard of care.” The standard of care must be established by medical expert testimony and the harm for which the plaintiff seeks damages must proximately arise from a breach of the standard of care.

**2. ACO Digital Health Information Exchange—Professional Liability Issues** – ACOs are deeply involved in the aggregation of digital health information to be available at the point of care and in fostering best practices to influence physician medical decision-making. These activities raise interesting malpractice issues:

- **The Duty to Consult Medical Records** – Because the standard of care in medical malpractice cases is based upon medical expert testimony, it is an evolving, normative measure of physician performance. Failure to consult electronic medical records may not be negligent today, but as the standard of care evolves, failure to consult may constitute negligence in the future. Thus, a claim for malpractice involving failure to review an electronic health record (“EHR”) would have to show that: (1) the standard of care included a duty to consult the medical record; and (2) the electronic technology involved was the medium dictated by the standard of care to access the medical record in question. However, the case law on the basic question of whether physicians have a duty to consult a medical record is inconclusive. Relatedly, how much of a potentially voluminous digital medical records must the physician review?

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- The Duty to Adopt New Technology – New technology is sought by an ACO to give physicians access to more records and tools to promote better health care. Should that new technology (such as a database allowing access to a patient's information) change the standard of care and thereby enhance medical liability exposure for laggard adopters of a given technology? However, by their nature, standards of care change rather slowly. Those involving a duty to use a particular technology will as well.
- Negligence in EHR Use – Malpractice risks may stem from improper data entry, with later reliance on that data resulting in patient harm. Even with good data entered, there could be user error or a system-wide EHR failure. There can be negligent documentation gaps caused by the interface between payor and electronic records. These risks can be mitigated by prudent system design, training, and monitoring.
- Corporate Negligence – ACOs may be subject to claims for corporate negligence, a claim for liability based upon an independent duty of care owed by a provider institution to its patients. Corporate liability involving HIE could be triggered by premature or inadequate deployment of EHRs or HIT that results in errors, possibly resulting from inadequate staff training, erroneous data entry, flawed applications, or inadequate IT infrastructure. As with any technology, errors may occur.
- Bad Protocol as Proximate Cause – Another possible area of exposure would be adherence to an improper protocol that causes the physician to violate the standard of care (i.e., all new mothers discharged within 24 hours of delivery).

### **3. Managing Malpractice Risks In An ACO**

**a. Potential New Risks** – Before discussing management of risks, we need to identify those risks. Some writers have warned of potential new risks in addition to digital data problems noted above, to include:

- These are new and untested waters. Unclear liability responsibilities in a system whereby patients are involved in continuum of care as a whole.
- Will there be heightened, vicarious liability exposure? A new spin in “accountable” care, as it were.
- New duties (i.e., individual care plans) may lead to new claims for breach of those duties.

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- Will “patient-centeredness” create heightened duties of informed consent?
- What happens when that defensive medicine extra test does not compare with the ACO’s best practice guidelines?
- Will it be easier to establish violation of standard of care if physicians did not follow the ACO’s best practice guidelines?

**b. Potential Diminished Risks** – Certain ACO activities may lower professional liability risks:

- Some commentators have confused care coordination for a defined population with hands-on direct individual patient care. Those lines may be crossed, but professional liability claims tend to arise in the latter domain, not in the former, which is the ACO’s sphere of activity.
- Following the evidence-based best practice reduces risks in two ways: First, there will be fewer claims since following best practices will result in fewer mal-occurrences. Second, if you are abiding by an aspirational standard of excellent care, it can serve as a shield for your defense.
- The ACO incentivizes both quality and efficiency. This takes away a plaintiff lawyer’s favorite argument that the physician short-changed care for the sake of “the almighty dollar.”

**c. Managing ACO Professional Liability Risks** – There are several opportunities to reduce professional liability risks unavailable to unaligned physician practices and other strategies to erase or mitigate the above-identified risks:

- Obviously, to obtain the defense “shield” noted above, it is important for the ACO providers to establish, know, and follow evidence-based best practices.
- An ACO can develop system-wide risk management. It should include taking advantage of the fact that there will be care follow-up along the continuum. In the siloed and fragmented system, no one would know the status of that patient. This is the strongest antidote to a defensive medicine action which might be outside the band of best practice care. There can also be real-time adverse event management through the ACO’s data collection.

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- The ACO may have critical mass to form a captive insurance company, which will allow better use of data, active risk management, and tapping into lower premiums because claims are reduced.
- An ACO could form a Patient Safety Organization, which will allow collection, review, and constant quality improvement (“CQI”) in a secure environment.
- It is relatively easy to create care coordination contractual language to avoid the ACO crossing over the line from guidelines to directing care delivery. The language is called the “Wickline” provision, named after a famous case from the early days of managed care.

**H. Corporate Practice of Medicine** – Many states have “Corporate Practice of Medicine” (“CPOM”) doctrines. They generally prohibit the practice of medicine, or employment of a physician, by business corporations. One must be mindful that the administrative, financial, and practice parameter controls applied by a non-medical practice ACO are not viewed as crossing the line into the “corporate practice of medicine.” Some flatly prohibit percentage billing arrangements. Depending on the state and desired structure, these statutes may have significant impact on the structure of an ACO.

The CPOM doctrine originated to protect the public by requiring that individual physicians bound by professional codes and licensure requirements, not lay-owned corporations, could employ physicians to provide medical care. A corporation’s interest in maximizing profits created a conflict with the paramount duty of unfettered professional focus by the physician on the needs of the patients. Commercialized medicine should not interfere with the physician’s judgment. In a seminal opinion, the Pennsylvania Supreme Court famously held that: “A corporation as such cannot possess the personal qualities required of a practitioner of a profession.”<sup>6</sup>

ACO development may be affected in some states with particular CPOM requirements. CPOM laws and opinions vary, but stem from an essential requirement that only entities owned by licensed physicians may employ licensed health care professionals and splitting fees with non-professionals is prohibited. A state’s CPOM may be found in statute, regulation, case law, attorney general opinions or licensing board enforcement making verification difficult or impossible. In addition, the doctrine is in flux in many states. With this substantial caveat, the CPOM doctrines follow these general patterns:

Many states allow physicians to provide medical treatment through a professional corporation or limited liability company, but each shareholder or member must be a licensed physician. States such as Texas allow physicians to enter into independent contractor relationships with non-physicians, but it cannot be a disguised employment relationship. Many states, like North Carolina, allow hospitals to employ physicians, but some others, like California, Texas, Ohio, Colorado, Iowa, Illinois, New York, and New Jersey, preclude or limit this practice. There are often exceptions for employment by HMOs, public health clinics, charitable nonprofits, and the like.

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<sup>6</sup> *Neill v. Gimbel Brothers, Inc.*, 330 Pa. 213 (1938).

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A 50-state survey of CPOM doctrines is attached at Attachment A.

**1. CPOM and ACO Employment** – The CPOM doctrines prohibiting hospital employment of physicians would prevent a complete integration of hospitals and providers through the employment model. Is this good or bad? The American Medical Association (“AMA”) and other medical professional organizations oppose amending or overriding CPOM doctrines to carve out an exception for hospital employment of physicians to accommodate this type of ACO model. Their concern over interference with professional judgment through employment of physicians by non-physician organizations has been heightened over instances of “economic credentialing.”<sup>7</sup>

On the other hand, the American Hospital Association (“AHA”) submitted a document to the Senate Finance Committee calling on the federal government to, among other things, “Reevaluate the impact governing the corporate practice of medicine on the ability of providers to collaborate.”<sup>8</sup> As of this writing, bills to exempt ACO employment models from CPOM doctrines are being introduced in several states.

As noted in the accompanying *The Physician’s Accountable Care Toolkit*®, neither hospital participation nor employment are necessary prerequisites to ACO success. Even a professional corporation ACO entity, which generally employs its professionals, should include at least initial inclusion of a new desired ACO physician participant by contract. If they “walk the walk” on commitment to adding value, then they may be eligible for employment. We are not aware that any national or state medical association has found that the CPOM doctrine will impair successful ACO development in the patient’s interest.

In addition, for operational separateness, a professional corporation desiring to start essentially its own ACO may want to spin up a simple corporation or limited liability company umbrella organization, regardless of their state’s CPOM doctrine.

**2. CPOM and ACO Governance** – As mentioned, in many CPOM states, only professional corporations owned by physicians may actually employ physicians. Thus, at a minimum, physicians control who is on its board of directors or managers. Some states go further, and the entire board must be comprised of physicians. However, in many states, like North Carolina, only one director must be a “licensee.”<sup>9</sup>

Thus, where the board must be practicing physicians, an apparent conflict arises with the MSSP requirement that, “The ACO governing body must include a Medicare beneficiary representative(s) served by the ACO...”<sup>10</sup> However, in the Preamble to the Final Statement,

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<sup>7</sup> AMA D-215.993 Corporate Practice of Medicine.

<sup>8</sup> American Hospital Association, *Statement of the American Hospital Association to the Senate Finance Committee Roundtable on Health Care Delivery System Reform*, p. 5 (April 21, 2009).

<sup>9</sup> *N.C. Gen. Stat.* § 55B-4(3).

<sup>10</sup> 42 C.F.R. 425.106(c)(2).

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CMS wrote that, “We recognize comments concerning that requiring a beneficiary on the governing body could conflict with state corporate practice of medicine laws. ... Accordingly, an ACO that seeks to compose its governing body in such a way that it does not meet...the requirement regarding beneficiary representation on the governing body would be able to describe in its application how the proposed structure of its government body would involve...a meaningful opportunity for beneficiaries to participate in the governance of the ACO.”<sup>11</sup> CMS is willing to accommodate CPOM doctrines so long as the functional equivalent of meaningful Medicare beneficiary involvement is met.

**3. CPOM and ACO Services** – Some professional corporation and limited liability company laws limit them to providing a single type of “professional service.”<sup>12</sup> It remains to be seen if professional corporation entities with, say, a risk-taking ACO covering multiple counties, would be in compliance with this constraint.

**4. CPOM and ACO MSOs** – In recent years, rather than an employment violation, the focus of CPOM enforcement has been on practice management companies crossing the line to control unduly medical care decisions. An ACO consulting company assisting in ACO development and implementation should not raise concerns. A management services organization (“MSO”) controlling who the ACO physician hires, sees, refers to, etc. is another matter entirely.<sup>13</sup>

**5. Conclusion** – As health care moves to integrated value-based models, persuasive arguments are being made on both sides of the issue that on one hand, the independent medical judgment policy which gave rise to the CPOM doctrine is more important now than ever, or, on the other hand, it is an outmoded anachronism impairing effective ACO development. There may be federal preemption of CPOM laws relative to ACOs, and at the state level, the CPOM is in flux in numerous legislatures. It is important to know the CPOM rules in your state.

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<sup>11</sup> 776 Fed.Reg. 67821 (Nov. 2, 2011); (see, 42 C.F. R. 425.106(c)(5) [request for alternative approach]).

<sup>12</sup> See, *N.C.Gen.Stat.* § 55B-14(a).

<sup>13</sup> See, *Marcus Jimison, The Corporate Practice of Medicine, Prognosis*, Vol. 23, No. 1, p. 8 (November 2006).

# Accountable Care Legal Guide

## I. ACO Contracts

**1. Employment Contracts** – The transformation to integrated value-based reimbursement will require an equally transformative change in a physician's duties, services, and compensation. To be ready for the accountable care era, physician employment agreements, regardless of employer, should have appropriate language, including in the following areas:

- Job responsibilities;
- Compensation rewarding quality and overall savings versus solely production and fee generation;
- Commitment to contributing value;
- Quality and savings metrics—adherence to evidence-based best practices;
- ACO-related leadership and management responsibilities and compensation therefor; and
- Term—for example, the MSSP process requires submission of physician participation agreements for the full three-year term of the MSSP contract.

**2. ACO Contracts** – Physicians may be asked to sign ACO participation agreements with Medicare, Medicaid, private insurance companies, or indirectly with the ACO, whether a hospital employer (see above) or provider network model. Physicians should be particularly mindful of the following areas:

- Investment – Any ACO upfront cost obligations?
- Ongoing Risk – What happens if the ACO takes on medical cost risk and does not meet targets? Are you proportionately responsible?
- Distribution of Savings – It would be distributed in proportion to contribution to savings, after expenses, but will savings go to investors, owners, to cover lost hospital or providers' revenues relative to fee for service?
- Data – Who collects it? Is the severity adjusted? Are the metrics clinically valid for your specialty?
- Corrective Action – Your continued participation is tied to performance. ACO contracts will have “teeth.” Review the fairness and peer review aspects of the contract.

# Accountable Care Legal Guide

- Exclusivity – Are you contractually bound to just one ACO? (Distinguish from extra-contractual restrictions of a payer, including CMS.)
- Support – ACOs are team-based systems that should provide you every reasonable tool and human support to help you optimize your performance and patient care. These should be spelled out. *The Physician's Accountable Care Toolkit*© is specific about what types of support you should seek from your ACO.

**J. Insurance Laws** – If an ACO assumes financial risk for the provision of care, particularly if the arrangement is prepaid and the nature of the care needed is uncertain, it might be viewed as “insurance risk” subjecting the ACO to regulation by the state department of insurance as an insurance company. There is a significant body of law surrounding what is insurance risk. Generally, a no-downside-risk shared savings model does not involve financial risk and is not considered the business of insurance. “Insurance risk” is a term of art and is not necessarily any financial risk. Different states’ departments of insurance may take more or less aggressive interpretive positions on this question. Other financial risk models for ACOs may be.

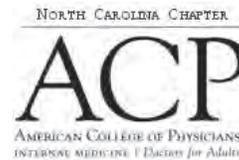
**K. Intellectual Property** – ACOs create novel care pathways. Especially when “hardwired” into technology, this often results in valuable and protectable intellectual property. It is important to protect this “IP” at the beginning through the use of nondisclosure agreements and the like.

**L. State Self-Referral, Anti-Kickback, and Fraud and Abuse Laws** – Many states have self-referral, anti-kickback, and fraud and abuse statutes, which an ACO should consider when organizing.

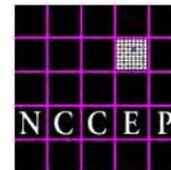
**M. Business Laws** – Corporate, LLC, contract, state taxation, securities, conflicts of interest, unfair trade, and other laws also commonly will come into play during the organization of an ACO.

## III. CONCLUSION

This overview is meant to provide a listing of the typical laws applicable to the formation and operation of ACOs. Space limitation does not permit a more considered analysis. Moreover, there is no “one-size-fits-all” application of the laws to the myriad of ACO possibilities. Experienced health law counsel will be able to navigate you through this legal minefield.



continued next page



**ATTACHMENT A of Accountable Care Legal Guide**  
**Fifty State Survey of Corporate Practice of Medicine Doctrine**  
*Prepared by Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.*

STATE	ORIGINS OF DOCTRINE	SUMMARY
AL	<u>Attorney General Opinion</u> From 2001 Ala. Op. Attorney General 089	Alabama has no prohibition against corporate employment of physicians provided that medical judgment of employed physician is not impaired.
AK	State statutes and regulations do not address CPOM.	Alaska has typical medical licensing and professional corporation acts, but no court has held there to be a prohibition against the corporate practice of medicine.
AZ	<u>Case Law</u> Appears to prohibit corporations from employing physicians to provide medical services. State statutes and regulations do not address CPOM.  Appellate Court ruled upon only the narrow issue presented to us: that the statutory and regulatory scheme pertaining to "outpatient treatment centers" expressly permits the Director to issue a license to a general corporation whether or not that corporation is owned by individuals with a separate license to practice in the health care field at issue.  MIDTOWN MEDICAL GROUP, INC. v. STATE FARM MUTUAL AUTOMOBILE INSURANCE CO. 220 Ariz. 341; 206 P.3d 790; 2008 Ariz. App. LEXIS 208,2008	2008 case indicates that the Director of the Department of Health Services (Director) did not deem it necessary to require that those owning an outpatient treatment center be licensed to practice in a health care related field.  Arizona has no statutory or regulatory prohibition against corporate employment of physicians, but case law makes clear that corporations may not employ a licensed medical provider.
AR	<u>Attorney General Opinion</u> 1994 Op. Ark. Att’y Gen.No. 94-204 and the Arkansas Medical Corporation Act.  <u>Case Law</u> Holding that “statute declaring optometry a learned profession and prohibiting optometrists, physicians and surgeons from accepting employment from an unlicensed corporation is constitutional.” Melton v. Carter (1942) 204 Ark. 595, 164 S.W.2d 453.	The Arkansas Medical Corporation Act requires that only licensed physicians may be officers, directors or shareholders of a medical corporation. Medical corporations, hospitals/ medical service corporations and HMOs are the only entities that may practice medicine.

STATE	ORIGINS OF DOCTRINE	SUMMARY
CA	State law and case law prohibit corporations from employing physicians.	Corporations shall have no professional rights, privileges or powers. However, non-profit medical research corporations, narcotic treatment programs and a hospital owned and operated by a health care district may charge for professional services rendered by employed licensees.
CO	State law prohibits corporations from employing physicians to provide medical care.	Corporations shall not practice medicine, but a hospital may employ physicians so long as the hospital does not exert control over the physician's independent judgment.
CT	<p><u>Case Law</u> Prohibits non-licensed individuals from employing <i>dentists</i> to provide dental care. No case law on physician employment by corporations. State statutes and regulations do not address CPOM</p> <p><u>Attorney General Opinion</u> <i>See 28 Op. Atty. Gen. 248 (1954)</i> (stating that practice of medicine and surgery is restricted to individuals and does not include corporations; nonprofit charitable hospitals are excepted)</p>	Only non-profit charitable hospitals are excepted from the CPOM prohibitions.
DE	Statutes limit practice of medicine to "individuals" and allow corporate practice of medicine by professional service corporations if all shareholders are licensed in the same profession. 8 Del. C. Ch. 6	Practice of medicine is limited to "individuals, but allowing corporate practice of medicine by professional service corporations if all shareholders are licensed in the same profession.
DC	<p><u>Case Law</u> A corporation that operates a clinic or hospital, employs physicians and receives the fees is unlawfully practicing medicine, although a nonprofit corporation offering care by its salaried medical staff to dues paying member was not engaged in the corporate practice of medicine. <u>Lansburgh &amp; Bro., (D.C. Cir. 1940)</u></p>	Appears that CPOM has been adopted but excepts a corporation employment in a limited circumstance.
FL	<p><u>Case Law</u> In <u>Rush v. City of St. Petersburg</u> (Fla. Dist. Ct. App. 1967) 205 So. 2d 11 the court held that the hospital was not engaged in the illegal practice of medicine because the doctor-patient relationship was maintained.</p>	Case law indicates that a corporation may employ a physician if doctor-patient relationship is maintained.

STATE	ORIGINS OF DOCTRINE	SUMMARY
GA	<u>Case Law</u> <u>Sherrer v. Hale</u> (1982) 248 Ga. 793, 285 S.E.2d 714 (a business corporation cannot lawfully practice one of the learned professions, and it is against public policy for a business corporation to perform acts which constitute the practice of medicine.	A corporation is prohibited from employing a professional to perform his/her profession on behalf of the corporation.
HI	NONE	CPOM doctrine has not been adopted
ID	<u>Attorney General Opinion</u> A hospital may not practice medicine or surgery, even though it may own or provide facilities for such activities. There must be a direct relationship between the patient and the medical professional. See Idaho Op. Att'y Gen. (May 26,1954).	
IL	<u>State Statutes</u>  <u>Case Law</u>	The hospital exception to the prohibition of the COPM doctrine is very narrow as reflected in the case where a non-profit health care institute was held to have violated the doctrine by employing a physician. Carter-Shields, MD v. Alton Health Inst. 777 N.E.2d 948 (Ill 2002)
IN	<u>State Statutes</u> §25-22.5-8-1 (practice without a license unlawful) §25-22.5-1-2(20), (21) (exception for licensed hospitals, private mental health institutions, health care organizations whose members are licensed professionals.) §25-22.5-1-2(c) (above entities may employ physicians provided they do not "direct or control independent acts...or judgment of licensed physicians.") <u>Case Law</u> <u>State v. Williams</u> (1937) 211 Ind. 186, 5 N.E.2d 961 (corporation may not practice medicine); <u>Sloan v. Metropolitan Health Council of Indianapolis, Inc.</u> , (Ind. App. Dist. 1987) 516 N.E.2d 1104 (professional corporations may practice medicine).	Statutes and case law prohibit a corporation from practicing medicine, but allows the following to employ or contract with physicians (1) a hospital; (2) a physician; (3) a psychiatric hospital; (4) a health maintenance organization; (5) a health facility; (6) a dentist; (7) a registered or licensed practical nurse; (8) a midwife; (9) an optometrist; (10) a podiatrist; (11) a chiropractor; (12) a physical therapist; or (13) a psychologist.
IA	<u>State Statutes</u> Iowa Code §§147, 147.2 (prohibiting unlicensed practice of medicine) Iowa Code §135B-26 (allowing pathology and radiology services in hospitals) Iowa Code Chapter 514B (HMO's authorized)	Whether the employment of a physician by a corporation violates the CPOM turns on the degree of dominion or control exercised over the physician and is decided on a case by case basis.

STATE	ORIGINS OF DOCTRINE	SUMMARY
	<p>Iowa Code Chapter 496C (professional corporations authorized)</p> <p><u>Case Law</u>  <u>Christensen v. Des Moines Still College of Osteopathy &amp; Surgery</u>, (1957) 248 Iowa 810, 82 N.W.2d 741 (a corporation cannot qualify for a medical license, and an unlicensed person cannot have direct or indirect authoritative control of licensees in performing professional tasks); <u>State v. Plymouth Optical Co.</u>, (1973) 211 N.W.2d 278 (contractual arrangement under which corporation rented space to optometrists (who were obligated not to let their business decline) violated the optometry licensing statute and enjoined the corporation from practicing optometry).</p> <p><u>Attorney General Opinion</u>  Any finding of a violation of the corporate practice/employment prohibition would be based on a detailed factual review of the corporate-physician relationship at issue [with an analysis of the amount of dominion and control exercised by the corporation over the physicians. 91-7-1 (July 12, 1991)]</p>	
KS	<p><u>Case Law</u>  <u>Winslow v. Kansas State Bd. of Dental Examiners</u>, (1924) 115 Kan. 450, 223 P. 308 (corporation may not practice dentistry through employees); <u>State ex rel. Beck v. Goldman Jewelry Co.</u>, (1935) 142 Kan. 881, 51 P.2d 995(ousting corporation for employing optometrists); <u>State ex rel. Fatzer v. Zale Jewelry Co.</u>, (1956) 179 Kan. 628, 298 P. 2d 283 (ousting corporation from practicing optometry through its employee in violation of state statute); <u>Marks v. Frantz</u>, (1958) 183 Kan. 47, 325 P.2d 368 (upholding the revocation of optometrist's license for practicing optometry as a corporate employee); <u>See Copeland v. Kansas State Bd. of Examiners in Optometry</u>, (1974) 213 Kan. 741, 518 P.2d 377 (upholding the revocation of an optometrist's license for violating the statute by practicing optometry as an agent of an unlicensed firm); The Kansas Supreme Court upheld the ban on corporate practice in 1991 in the case of <u>Early Detections Center v. Wilson</u> (Kan. 1991) 248 Kan. 869, 811 P.2d 860. Last year, however, a state district court ruled in <u>Weiss v. St. Francis Regional</u></p>	A not-for profit hospital may employ a physician to practice medicine.

STATE	ORIGINS OF DOCTRINE	SUMMARY
	<p><u>Medical Center</u> that the ban on corporate practice did not apply to not-for-profit hospital corporations.</p>	
<p><b>KY</b></p>	<p><u>Case Law</u>  See <u>Kendall v. Beiling</u>, (1943) 295 Ky. 782, 175 S.W.2d 489 (a corporation cannot lawfully engage in the practice of medicine, and the great weight of authority is that neither a corporation nor any other unlicensed entity may engage in the healing arts through licensed employees)</p> <p>Kentucky Board of Medical Licensure, Private Opinion Letter  It is acceptable for physicians to be full-time employees of hospitals. Kentucky Board of Medical Licensure, Private Opinion Letter Sept. 1993</p> <p>A for-profit corporation may hire a physician. Kentucky Board of Medical Licensure, Private Opinion Letter Sept. 1995</p>	<p>CPOM doctrine has been adopted by the courts, but the Board of Medical Licensure appears to have exempted hospitals and certain for-profit corporations.</p>
<p><b>LA</b></p>	<p><u>Agency Opinions</u>  A Statement of Position by the Louisiana Board of Medical Examiners dated August 20, 1992, concluded that a physician's employment by a corporation other than a professional medical corporation is not per se unlawful under the Louisiana Medical Practice Act. According to the board, the focus of such inquiries should be on the amount of control the corporation is allowed to exercise over the physician.</p>	<p>State statutes and regulations do not address CPOM, however the Louisiana Board of Medical Examiners permit a physician's employment by a corporation other than a professional medical corporation so long as the judgment of the physician nor the physician- patient relationship is not impaired the focus of such inquiries should be on the amount of control the corporation is allowed to exercise over the physician</p>
<p><b>ME</b></p>	<p><u>Agency Opinion</u>  In an opinion of the Maine Board of Licensure in Medicine, the Board stated that each medical license holder is individually responsible for his or her own conduct regardless of any employment relationship. See Opinion of the Board of Licensure in Medicine (Nov. 2, 1992).</p>	<p>State statutes and regulations do not address CPOM, however the Maine Board of Licensure in Medicine indicates that each licensee is responsible to ensure that professional judgment is not compromised by an employment relationship.</p>
<p><b>MD</b></p>	<p>State statutes and regulations do not address CPOM.</p> <p><u>Agency Opinion</u>  A Maryland Board of Physician Quality Assurance prohibits corporations from employing physicians</p>	<p>The Maryland Board of Physician Quality has adopted the CPOM doctrine prohibiting corporate employment of physicians.</p>

STATE	ORIGINS OF DOCTRINE	SUMMARY
	<p>to provide medical services, with limited exceptions.</p> <p><u>Case Law</u>  <u>Backus v. County Bd. of Appeals</u>, (1960 224 Md. 28, 166 A.2d 241 (interpreting statutory provision prohibiting issuance of dental license to any corporation or entity and noting that state laws generally forbid the practice of medicine or dentistry by a corporation through licensed employees).</p>	
<p><b>MA</b></p>	<p>State statutes and regulations do not address CPOM.</p> <p><u>Case Law</u>  <u>McMurdo v. Getter</u>, (1937) 298 Mass. 363, 10 N.E.2d 139 (enjoining corporation from practicing optometry by employing licensed practitioners);  <u>Kay Jewelry Co. v. Board of Registration in Optometry</u>, (1940) 305 Mass. 581, 27 N.E.2d 1 (finding constitutional an amendment to statute which prohibited the sharing of fees by one not authorized to practice optometry); See <u>Silverman v. Board of Registration in Optometry</u>, (1962) 344 Mass. 129, 181 N.E.2d 540 (holding that a board regulation prohibiting optometrists from practicing on the premises of a commercial establishment was valid, as the board could conclude that the optometrist's presence in a commercial establishment could result in mercantile practices and lowering of professional standards).</p>	<p>The Massachusetts Supreme Court has adopted the CPOM doctrine prohibiting corporate employment of physicians. See <u>McMurdo v. Getter</u>, 10 N.E.2d 139, 142 (Mass. 1937).</p>
<p><b>MI</b></p>	<p>State Statute  A general business corporation may not practice a learned profession, because the Professional Service Corporation and Limited Liability Company Act specifically govern the formation of an entity to practice a learned profession. See Mich. Comp. Laws § 450.1251 (2006).</p> <p>Attorney General Opinion  Non-profit corporations (including hospitals) may employ physicians to provide medical services. See MI Op. Att'y Gen. No. 6770 (Sept. 17, 1993).</p>	<p>CPOM doctrine has been adopted with exceptions for non-profit hospitals and medical corporations.</p>

STATE	ORIGINS OF DOCTRINE	SUMMARY
MN	<p>State statutes and regulations do not address CPOM.</p> <p><u>Attorney General Opinion</u>  In an opinion written October 5, 1955 (92-B-11), the Attorney General found that a nonprofit corporation organized to contract on behalf of its members with doctors for rendering medical services, and specifically prohibited from intervening in the professional relationship between the physician and patient would be for "a lawful purpose" and permissible under the Minnesota Nonprofit Corporation Act.</p>	<p>A for-profit corporation may not employ a physician in Minnesota but a not-for profit can</p>
MS	<p>State statutes and regulations do not address CPOM.</p> <p><u>Agency Opinion</u>  Allows physician employment by a corporation so long as there is no interference with independent medical judgment. See, Mississippi State Board of Medical Licensure, "Internal Policy Regarding Corporate Practice of Medicine," revised May 16, 1996, and September 20, 2001.</p>	<p>Mississippi abandoned the CPOM doctrine and now adheres to the position that as long as there is no interference with the physician-patient relationship, then various forms of business relationships with physicians are permissible.</p>
MO	<p><u>Attorney General Opinion</u>  allows a corporation to contract with a licensed physician to furnish medical services. See Mo. Op. Att'y Gen. No. 8 (Mar. 15, 1962).</p>	<p>A licensed physician may contract with a corporation to furnish medical services.</p>
MT	<p><u>State Statutes</u>  Mont. Code Ann. §37-3-322(23)(providing that practicing medicine as a partner, agent, or employee of or in joint venture with a person who does not hold license constitutes unprofessional conduct.</p> <p>Mont. Code Ann. §37-3-322(23) does not prohibit:  (a) the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4; (b) a single consultation with or a single treatment by a person or persons licensed to practice medicine and surgery in another state or territory of the United States or foreign country; or (c) practicing medicine as the partner, agent, or employee of or in joint venture with a hospital, medical assistance facility, or other licensed health care provider. However, (i)</p>	<p>A physician may contract with a corporation so long as it is evidenced by a written agreement containing language to the effect that the relationship created by the agreement may not affect the exercise of the physician's independent judgment in the practice of medicine; (ii) the physician's independent judgment in the practice of medicine must in fact be unaffected by the relationship; and (iii) the physician may not be required to refer any patient to a particular provider or supplier or take any other action the physician determines not to be in the patient's best interest.</p>

STATE	ORIGINS OF DOCTRINE	SUMMARY
	the partnership, agency, employment, or joint venture.	
NE	<p>State statutes and regulations do not address CPOM.</p> <p><u>Case Law</u> A corporation contracting with a physician did not constitute the practice of medicine or violate the law or public policy of Nebraska. See State Electro-Med. Inst. v. Platner, 103 N.W. 1079, 1082 (Neb. 1905).</p>	Corporations may contract with physicians to render medical services.
NV	<p><u>Attorney General Opinion</u> Only a professional corporation or association may practice medicine. No general, for-profit corporation may practice medicine. Nev. Op. Att'y Gen. No. 77-219 (Oct. 3, 1977).</p>	Only non-profit corporations may employ physicians to render medical services.
NH	State statutes and regulations do not address CPOM	No CPOM Doctrine
NJ	<p><u>State Statutes</u> A physician may offer health care services as an employee of a general business corporation only in one of the following situations: (1) the corporation is licensed by the New Jersey Department of Health as an HMO, hospital, long or short-term care facility, ambulatory care facility or other type of health care facility or health care provider; (2) the corporation is not in the business of offering treatment services but maintains a medical clinic for the purpose of providing first aid; (3) the corporation is a non-profit corporation sponsored by a union, social or religious or fraternal organization providing health care services to members only; (4) the corporation is an accredited educational institution that maintains a medical clinic for services for students and faculty; or (5) the corporation is licensed by the State Department of Insurance as an insurance carrier. See N.J. Admin. Code 13, § 35-6.16(f) (2006).</p>	CPOM Doctrine in effect with enumerated exceptions.

STATE	ORIGINS OF DOCTRINE	SUMMARY
<p style="text-align: center;"><b>NM</b></p>	<p>State statutes and regulations do not address CPOM.</p> <p><u>Attorney General Opinion</u> Corporations organized and controlled by non-physicians may provide medical services to the public through employed physicians, unless laypeople control medical decisions. New Mexico Att'y Gen. Op. No. 97-39 (July 30, 1987).</p>	<p>A corporation may employ a physician to provide medical services if the corporation does not interfere with the physician's independent medical judgment</p>
<p style="text-align: center;"><b>NY</b></p>	<p><u>State Statutes</u> Only a person licensed or otherwise authorized under article shall practice medicine. See N.Y. Educ. Law 2006). A non-profit medical or dental expense indemnity corporation or a hospital service corporation may licensed physicians. See N.Y. Educ. Law § 6527 The use of the word "person" in the physician licensing statute means that a corporation may not practice Corporations may not employ licensed professionals practice medicine. See People v. John H. Woodbury Dermatological Inst., 85 N.E. 697 (N.Y. 1908).</p>	<p>State laws appear to prohibit corporations from employing physicians to provide medical services, with limited exceptions.</p>
<p style="text-align: center;"><b>NC</b></p>	<p><u>Attorney General Opinion</u> Allows employment of physicians by “non-profit and public hospitals’ but prohibits private corporations from employing physicians to provide medical services. See 33 N.C. Att'y Gen. Rep. 43 (1955).</p> <p>The enactment in 1970 of the Professional Corporation Act allowed physician owners to employ a corporate structure to practice medicine. N. C. Gen. Stat. § 55B-1 to 15. A health maintenance organization may employ providers. N. C. Gen. Stat. § 58-67-35(a)(3); 58-67-170(c).</p>	<p>Physicians may be employed by professional corporations, professional LLCs, hospitals, and HMOs.</p>
<p style="text-align: center;"><b>ND</b></p>	<p><u>State Statutes</u> §43-17-42 (added in 1991) Authorizing hospital employment of physicians provided that the employment contract contains specific language that the hospital's employment with the physician may not affect the exercise of the physician's independent judgment in the practice of medicine and that the physician's independent judgment in the practice of medicine</p>	<p>Hospitals may employ physicians to the extent that professional judgment is not encumbered.</p>

STATE	ORIGINS OF DOCTRINE	SUMMARY
	is in fact unaffected by the physician's employment relationship with the hospital.	
OH	<u>State Statutes</u> A corporation can practice a profession, but cannot control the professional clinical judgment exercised by a physician. See Ohio Rev. Code Ann. § 1701 (2005)	Corporations may practice a profession if the corporation does not interfere with the professional's independent judgment.
OK	<u>State Statutes</u> Title 59 §510 (allowing firms, associations, or corporations to engage in the practice of medicine as long as each and every member of such firms, associations, or corporations is duly licensed to practice medicine and surgery in the state of Oklahoma.)	State statutes appear to allow hospitals to employ physicians to practice medicine without being regarded as itself practicing medicine.
OR	<u>Attorney General Opinion</u> It is settled law in Oregon that a corporation cannot practice a profession, except to the extent that "professional corporations" or hospital corporations are authorized to do so. See Op. Or. Att'y. Gen. No. 5689 (1984).	Hospitals may employ physicians
s		
PA	<u>State Statutes</u> A health care practitioner may practice the healing arts as an employee or independent contractor of a health care facility or health care provider or an affiliate of a health care facility or health care provider established to provide health care. See 35 P.S. § 448.817a (2006)	A recently passed state statute appears to allow health care facilities, which includes hospices, to employ physicians to provide medical services
RI	State statutes and regulations do not address CPOM.	No additional guidance is available.
SC	<u>Case Law</u> South Carolina has a common law prohibition against the CPOM. See Baird v. Charleston County, 511 S.E.2d 69, 78 (S.C. 1999).	CPOM is prohibited. No exceptions identified.
SD	<u>State Statutes</u> §36-4-8.1-specifically prohibits a corporation from the practice of medicine or osteopathy, but allowing employment agreements with the physician provided that the agreement or relationship does not: (1) in any manner directly or indirectly supplant, diminish or regulate the physician's independent judgment concerning the	State law appears to prohibit a corporation from practicing medicine through employed physicians if the corporation gains profit from the physician's practice of medicine.

STATE	ORIGINS OF DOCTRINE	SUMMARY
	<p>practice of medicine or the diagnosis and treatment of any patient; (2) result in profit to corporation from the practice of medicine itself, such as by a corporation charging a greater fee for the physician's services than the physician would otherwise recently charge as an independent practitioner; and (3) remain effective for a period of more than three years, after which it may be renewed by both parties annually.</p> <p>§47-11 et seq. (medical corporations authorized).</p>	
<p><b>TN</b></p>	<p><u>State Statutes</u>  The practice of medicine by non-professional corporations is allowed if the employment relationship between the physician and the corporation is evidenced by a written contract with a job description and with language that does not restrict the physician from exercising independent medical judgment in diagnosing and treating patients. If so, then the corporation shall not be deemed to be engaged in the practice of medicine. See Tenn. Code Ann. § 63-6-204(c) (2006).</p>	<p>CPOM is permissible but with defined conditions</p>
<p><b>TX</b></p>	<p><u>Attorney General Opinion</u>  The Attorney General of the state of Texas affirmed in 1989 that "arrangements by which a corporation formed by non-physicians employs physicians to render medical services to the corporation's clients consistently have been held to constitute both the unlawful practice of medicine by the corporation and the violation by the employee -- physician of the prohibitions in §3.08(12) of the Medical Practice Act, V.G.C.S. Article 4495(b)."  See Attorney General letter, April 24, 1989</p> <p>It is a violation of the doctrine for a corporation comprised lay persons to hire licensed physicians to treat patients and receive fees for these services. See Gupta v. E. Idaho Tumor Institute, Inc., 140 S.W.3d 747, 752 (Tex. App. 2004).</p> <p>In 2011, Texas passed legislation allowing rural hospitals to employ physicians.</p>	<p>CPOM is prohibited</p>
<p><b>UT</b></p>	<p><u>State Statutes</u>  An individual licensed physician may be employed by another person. See Utah Code Ann. § 58-67-</p>	<p>A corporation may employ a physician to provide medical services if the corporation does not interfere with the</p>

STATE	ORIGINS OF DOCTRINE	SUMMARY
	<p>802(1)(b) (2006). Any person who manages and has a financial interest in a licensed physician's professional practice may not substantially interfere with a licensee's practice of medicine. See Utah Code Ann.§ 58-67-501(1)(c) (2006).</p>	<p>physician's independent medical judgment.</p>
<p><b>VT</b></p>	<p><u>State Statutes</u> §1354(21) Medical license may be revoked for permitting physician's name or license to be used by a corporation when the physician is not in charge of treatment.</p>	<p>No clear guidance on CPOM doctrine, but appears that a corporation may employ a physician to provide medical services if the corporation does not interfere with the physician's independent medical judgment.</p>
<p><b>VA</b></p>	<p><u>Attorney General Opinion</u> The corporate practice of medicine doctrine has not been adopted in Virginia statute or court decisions. The opinion points out that statutes prohibiting physicians practice in connection with commercial or mercantile establishments were repealed in 1986. See 1992 Va. Op. Att'y. Gen. 147</p>	<p>A hospital may retain a physician as an employee as long as the physician exercises control over the diagnosis and treatment.</p>
<p><b>WA</b></p>	<p><u>Case Law</u> The Washington Supreme Court affirmed the viability of the corporate practice of medicine doctrine in RCW ch. 19.68. Columbia Physical Therapy, Inc., P.S. v. Benton Franklin Orthopedic Assocs., PLLC, No. 81734-1 (March 18, 2010)</p>	<p>A hospital organized under RCW ch. 70.41 is permitted to employ a licensed physician to provide medical services.</p>
<p><b>WV</b></p>	<p><u>Case Law</u> Neither a corporation nor any unlicensed person or entity may engage, through licensed employees, in the practice of the learned professions. See Morelli v. Ehsan, 756 P.2d 129, 131 (1988).  <u>Attorney General Opinion</u> A corporation cannot, under any circumstances, employ a licensed physician to practice medicine on its behalf without violating the law. See 46 Op. W. Va. Att'y Gen. 202 (1955).</p>	<p>CPOM adopted with no exceptions</p>
<p><b>WI</b></p>	<p><u>Attorney General Opinion</u> For-profit general business corporations are prohibited from practicing medicine through employed licensed professionals because: (1) state statutes only permit individuals, not corporations, to obtain licenses to practice</p>	<p>Appears that the CPOM is adopted as to for-profit corporate entities. No available guidance on Not-profits employing licensed physicians.</p>

STATE	ORIGINS OF DOCTRINE	SUMMARY
	<p>medicine; (2) medical professionals cannot split fees with a corporation in exchange for referrals; and (3) CPOM raises public policy concerns. See 75 Op. Wis. Att'y Gen 200 (1986).</p>	
<b>WY</b>	<p>State statutes and regulations do not address CPOM.</p>	<p>No additional guidance is available.</p>

**County / Regional Medical Societies**

Cleveland County Medical Society  
Craven-Pamlico-Jones County Medical Society  
Durham-Orange County Medical Society  
Mecklenburg County Medical Society  
Forsyth-Stokes-Davie County Medical Society  
New Hanover-Pender County Medical Society  
Pitt County Medical Society  
Rutherford County Medical Society  
Western Carolina Medical Society  
Wake County Medical Society

**Specialty Societies**

Carolinas Chapter, American Association of Clinical Endocrinology  
North Carolina Academy of Family Physicians  
North Carolina Chapter of the American College of Physicians  
North Carolina College of Emergency Physicians  
North Carolina Council on Child and Adolescent Psychiatry  
North Carolina Dermatology Association  
North Carolina Neurological Society  
North Carolina Obstetrical and Gynecological Society  
North Carolina Orthopaedic Association  
North Carolina Pediatric Society  
North Carolina Psychiatric Association  
North Carolina Radiologic Society  
North Carolina Society of Anesthesiologists  
North Carolina Soc. of Asthma, Allergy & Clinical Immunology  
North Carolina Society of Eye Physicians and Surgeons  
North Carolina Society of Otolaryngology – Head and Neck Surgery  
North Carolina Society of Pathologists  
North Carolina Society of Plastic Surgeons  
North Carolina Spine Society

**State Society / Organizations**

Community Care of North Carolina  
Carolinas Center for Hospice and End of Life Care  
North Carolina Academy of Physician Assistants  
North Carolina Medical Group Managers  
North Carolina Medical Society