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HEALTH LAW NEWS



What's Hot in the Medical and Dental Practice Merger and Acquisition Fronts

By: *Vasilios J. Kalogredis, Esquire, Health Law Department Chairman*

ON A MACRO LEVEL, many have been able to read about Amazon, Berkshire Hathaway and J.P. Morgan coming together to form a new health-care company. That venture is intending to use technology in order to try to meet the dual major goals of improving

quality and reigning in costs in healthcare. No one knows for sure what this will entail. However, it does show that there are entities with a lot of money looking at the medical market and considering different ways of dealing with it. The CVS Aetna merger is another example of that, where providers and payors have come together in the healthcare realm.

This article is not intended to focus on those mega entities. However, they do provide evidence that many are anticipating a larger shift in the healthcare paradigm.

Based on my own personal experiences in advising physicians and dentists for decades, I will say that the opportunities out there for doctors are increasing in today's world.

The population is aging, there is a greater demand for healthcare generally, and there is increasing pressure on all healthcare

organizations to provide quality healthcare at the lowest cost. This increases the need for substantial resources to invest in the necessary, state-of-the-art, electronic medical record systems, data analytics, and whatever is needed to increase care coordination (among staff, doctors, relative to protocols, and the like). The goal of bigness espoused by some is believed to more readily allow for the provision of the necessary capital and to potentially provide benefits from larger economies of scale. In addition, it is believed by some that this will allow larger entities to have and provide better administrative talent, billing, IT and marketing capabilities. This will be important in recruiting the necessary providers and technical staff to best accomplish these goals.

At Lamb McErlane, we are indeed seeing an increase in transactions whereby smaller medical and dental practices are selling and/or merging with larger organizations.

We have recently been involved with some dental practice sales. One common "pattern" involves a successful single dentist owned primary care practice (in some cases with other employed/independent contractor dentists) selling to either another dental practitioner or to a larger Dental Management Services Organization. In some of

Andrew Stein, Esquire Joins Lamb McErlane's Health Law Department

BILL KALOGREDIS JOINED Lamb McErlane PC two years ago to chair its Health Law Department, with a goal of building that facet of the Firm's practice. Growth is happening, both in the volume of work and depth and breadth of services being provided. Lamb McErlane is pleased to announce that Andrew Stein has joined the Firm as an Associate in the Health Law Department. Andrew will focus his practice on health and business law, representing the Firm's medical and dental practitioners and medical and dental practice clients. He brings substantial experience handling complex business transactions and serving companies as outside general counsel. Andrew earned his undergraduate degree from Boston University and his law degree from Villanova. Andrew offers the Firm and its clients a unique perspective gained in part from his study at the University of Oxford where he earned an MBA. He applies business fundamentals to his legal analyses to ensure clients receive counsel that takes corporate and economic realities into account.

Prior to joining Lamb McErlane, Andrew worked for a New Jersey-based firm where he prepared commercial contracts and litigated corporate disputes for healthcare and other clients. Please visit www.lambmcerlane.com for more information.

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those cases, it involved a situation whereby the selling dentist was planning his “exit strategy.” He was selling while the practice was still strong. He was planning to continue to practice for at least another three-to-five years and it made sense in those circumstances to execute the deal. It also allowed the buyer to add to its base of dental practices. The selling doctor was able to focus on the clinical side of dentistry without worrying about the day-to-day management and about having to go out and expend resources to obtain improved electronic dental records systems, potentially more expensive/sophisticated staff, and the like. Both parties going into those deals viewed it as a win-win situation.

Obviously, some doctors want to retain independence and do not want to have a “boss” telling them when to work, where to work, etc.

We are seeing increased interest in some medical specialties from Private Equity organizations. Some of them are offering large sums of money to a seller. Of course, one must recognize that the dollars and cents need to make sense to both parties for such a transaction to be made from a purely economic standpoint. One needs to look carefully and critically at what his/her goals are, whether you are the buyer or the seller.

Looking at it from the seller's standpoint, some are happy to “cash in” for a big practice sale price (often times with some of the purchase price going into equity in the acquirer), even recognizing that the ongoing remuneration as a worker bee after the sale may be less than when the doctor owned the practice. One needs to look at the tax aspects and compare that to what one believes he/she would be able to earn if he/she continued private practice as opposed to partaking in this sale/merger deal. We assist our clients in putting pencil to paper and explaining the economic pros and cons of such a transaction.

Obviously, the devil can be in the details. For example, there are many documents involved with many terms within each of them. An Asset Purchase Agreement (“The Sale of the Practice”) would set forth things such as the purchase price, tax allocation, any non-competition/non-solicitation provisions, and the like. If the seller is going to continue practicing (which is usually the case) then the post-sale Employment Agreement and/or Independent Contractor Agreement needs to be negotiated. This will deal with things such as remuneration, fringe benefits/business expenses, non-competition/non-solicitation provisions, term, places and hours of work, etc.

There are definitely more opportunities available to physicians and dentists today than there have been in the past. But there are many pragmatic, economic, tax, personal and professional ramifications to each alternative to be considered. Looking at things from both sides of the table, I try to determine what legitimate strategic vision justifies the transaction.

The important thing to keep in mind is that if and when you are approached about such a transaction, be sure to get professional advice in order to ask the right questions, critically evaluate the answers, and decide whether such a sale/merger makes sense for you. 🌿

Vasilios “Bill” Kalogredis has been advising physicians, dentists, and other health care professionals and their businesses for over 40 years. He is Chairman of Lamb McErlane PC's Health Law Department. bkalogredis@lambmcerlane.com; phone, 610-701-4402; or fax, 610-692-6210.

Bill served as moderator of a panel on Practice Consolidation at the Dermatological Society of New Jersey's Annual Conference on April 21, 2018. Bill also presented “A Pro-Physician Health Care Attorney's Perspective on Dermatology Practice Transactions” talk at that conference.



Pennsylvania Supreme Court Agrees to Hear Case Involving Admissibility of “Risks and Complications” Evidence

By: Maureen M. McBride, Esquire

THE SUPREME COURT RECENTLY granted review of a case that should be of great interest to all physicians. In *Mitchell v. Shikora*, the Supreme Court agreed to decide the issue of whether, and to what extent, evidence of general “risks and

complications” of surgeries and procedures may be introduced at trial in a medical liability case. Such evidence often is offered to explain that complications can occur even without negligence and that the mere occurrence of a complication during surgery or a procedure does not mean that a breach of the standard of care occurred.

Mitchell involved claims arising from a hysterectomy that Dr. Shikora, an obstetrical and gynecological surgeon, performed on a patient at Magee Women's Hospital. The patient's bowel was severed during the procedure. The patient claimed that Dr. Shikora should have identified her bowel before cutting it, and that, in failing to do so, Dr. Shikora breached his duty of care. Dr. Shikora, by contrast, argued that patient's injury was a complication, not an indication that negligence occurred.

Before trial, Plaintiff filed a motion to prevent Defendants from explaining to the jury how bowel perforation was a risk or complication of a hysterectomy. The trial court denied the motion and permitted the evidence. After the jury returned a defense verdict, the Plaintiff appealed.

On appeal, the Superior Court reversed and granted a new trial. Specifically, the Superior Court held that Defendants' evidence regarding “risks and complications” was irrelevant; moreover, the Court held that its introduction violated an earlier Supreme Court decision (*Brady v. Urbas*, 111 A.3d 1155 (Pa. 2015)), which precluded evidence of informed consent in certain negligence cases. The Superior Court also found that evidence regarding “risks and complications,” if permitted, would prejudice the Plaintiff.

Defendants argued that introduction of “risks and complications” evidence did not violate *Brady* because *Brady* involved the admissibility of informed consent forms. The *Brady* Court ultimately held that such decisions must be made on a case-by-case basis because such forms may be relevant in some cases, but not others, and did not address the issue of “risks and complications.”

The *Mitchell* Defendants, and the various organizations who filed amicus (friend-of-the-court) briefs supporting Defendants'

Pennsylvania Supreme Court Agrees to Hear Case Involving Admissibility of “Risks and Complications” Evidence *(continued)*

position, argued that the occurrence of a complication alone does not establish negligence. They also argued that the jury should be permitted to hear evidence of risks and complications and that, simply because evidence of risk of complications is *relevant* to informed consent does not make it *irrelevant* to the standard of care. For these reasons, Defendants and *amici* argued that the Superior Court’s decision should be reversed by the Supreme Court.

Defendants and *amici* also explained the danger that may result if the Superior Court’s decision is permitted to stand. If the Superior Court’s decision is permitted to stand, they argued, physicians would be subject to a strict liability standard, would become *de facto* guarantors of patient safety and would be potentially liable for any harm – even harm caused by a complication and not by negligence. Defendants and *amici* also pointed out how the Superior Court’s decision will undoubtedly affect the practice of medicine overall by making physicians less likely to perform high-risk procedures. Finally, Defendants argued, if physicians can be held liable for all harm sustained by a patient simply because

the surgery or procedure resulted in complications, malpractice rates will increase – to the detriment of the physicians and the general public.

Thus, Defendants and *amici* urged the Supreme Court to reject Plaintiff’s approach and refuse to allow a *per se* rule (*i.e.*, precluding evidence of risks and complications) to dramatically change the way in which medical malpractice cases are tried.

The Pennsylvania Medical Society retained Lamb McErlane PC attorneys Maureen McBride and James C. Sargent to represent it in filing an Amicus Curiae brief in the case.

The *Mitchell* case has been briefed and likely will be argued this summer. A decision from the Supreme Court is expected by the end of 2018 or early 2019.

Maureen Murphy McBride is co-chair of Lamb McErlane’s Appellate Department and is a member of Litigation Department and the Firm’s Executive Committee. She concentrates her practice on appellate law and litigation in state and federal courts. mmcbride@lambmcerlane.com, 610-701-4410.



Owning Your Office – Does it Make Sense? *By: Roger N. Huggins, Esquire*

IN THESE DAYS when the stock market is volatile and the threat of rising interest rates challenges the value of bonds and other fixed income investments, does it make sense for a physician or dentist to own his or her office? In many cases, it does, but always go in with your eyes open. While there can be

many benefits, real estate is not a liquid investment and can take time to convert to cash should the need arise. On the other hand, a good property in a favored location can not only enhance your practice, it can provide value and cash flow for years to come and can even be an important item in your estate plan.

In the simplest model, a solo or small group practitioner locates a suitable property, either a stand-alone building or a unit in an office park, usually a condominium. An agreement of sale is negotiated, the property inspected and financing acquired. Closing takes place and now you own your office and are free to set up shop configuring and outfitting the space as you see fit. Typically, you would form an entity (owned by you) whose sole purpose is to hold title to the property. That entity would then, in turn, lease the office to your practice entity. Rent would be paid by the practice as in the past, but instead of it going to an unrelated third party, it now comes to your new entity to pay the mortgage and over time, create equity in the property. The practice expenses the rent and the owning entity (or you as the owner of that entity) has income. As an added bonus, however, the tax laws allow you to take non-cash deductions for depreciation that effectively allow you to offset a portion of that income for tax purposes.


Things become more complicated if you bring in additional partners or purchase a property that includes more space than you plan to

occupy and which will be leased to others. These complications include addressing economic and management issues among the partners as well as restrictions on the transfer of ownership interests in the entity owning the building. Many of these are not unlike the succession issues many of you who are in group practices currently deal with at the practice level. Another complication arises with respect to management of the property and leasing risk. Real estate requires care and maintenance. Not only can these things be beyond the expertise of medical professionals, they can be time consuming and either take you away from your practice or infringe on your time for other activities. Fortunately, there are a number of excellent property management companies that can help. Because vacant space costs money but generates no income, finding and keeping tenants is a must. Again, there are many qualified brokers to assist, but market forces can sometimes overtake even the best of efforts. Of course, these services, as well as repair and maintenance expenses, cost money and must be taken into consideration in evaluating the investment.

In almost every case, the acquisition of an office property will require financing. Typically, this will come in the form of a mortgage loan from a commercial bank. The borrower will be the entity owning the property and the principal will often be required to provide a personal guaranty. Fortunately, we are presently in a favorable interest rate environment; however, there continues to be upward pressure on rates. Medical and dental professionals are usually considered to be attractive borrowers by most banks. Medical and dental office space are also uses that banks generally view favorably. A bank will generally require a down payment in the 20 – 25% range. But there are alternatives. One is the SBA 504 loan which requires only 10% down with the bank funding 50% and the SBA funding the other 40%. These loans can be especially attractive as the SBA can offer rates that are fixed for as long as 20 years.

Owning Your Office – Does it Make Sense? *(continued)*

The bottom line is that owning the office (or even an office building) in which your practice is housed can be a very attractive and lucrative investment providing income and increased value over a number of years. It can provide welcome diversification to any portfolio. Returns, however, do not come without risk. Fortunately, most of the risks can be quantified and in many cases, managed. Nothing is more important than proper planning and documentation at the outset. This will require an investment of time and money and the recognition that you are making a long-term commitment. Engaging a team experienced in

such transactions is crucial. This will include accounting, financial and legal professionals. At Lamb McErlane, we have assisted in many such transactions over the years and are standing by ready, willing and able to consult with you and assist in all aspects of your office acquisition. 

Roger N. Huggins is a partner at Lamb McErlane PC. He practices in the areas of Commercial and Real Estate Transactions, Real Estate and Equipment Leasing, Business Law, Finance, Banking and Contracts. His clients include individuals and businesses, ranging from small local businesses, dental and medical professionals to publicly traded corporations, lending institutions and public and private non-profit institutions. rhuggins@lambmcerlane.com. 610-701-3276.



Estate Planning After the New Tax Law *By: Stephanie P. Kalogredis, Esq.*

THE TAX CUTS AND JOBS ACT OF 2017 (“TCJA”) made significant changes to the federal estate and gift tax laws impacting existing estate planning. Most notable is the increase in the amount an individual can shelter from federal estate tax (“FET”) from \$5.6M to \$11.18M per person. With

minimal planning a couple can now transfer up to \$22.4M to their heirs free from FET.

Sound too good to be true? Well, it might be. As with all “good things,” the increased exemption will come to an end. The new law has a sunset provision and the shelter amount will revert back to the \$5.6M exemption level of 2017 (maybe adjusted for inflation) in just 8 years. And since the FET is a political hot potato, it is conceivable that a subsequent Congress could change or repeal the current law.


So, what are you to do? As with any change, you will need to look at your current estate plan (or lack of one) to make sure it still accomplishes your goals and make changes as needed. Here are some things to consider.

- 1. Limited or No Estate Planning.** Estate planning is much more than just taxes and what happens to your money when you die. A good estate plan addresses the issue of financial management, aging, incapacity, and death. Failing to plan sufficiently, exposes you and your family to court supervised guardianships, and sometimes surprising outcomes on distributions when you die.
- 2. Existing Estate Plan.** This may be the perfect time to update wills that have not been revised in several years to eliminate trusts based solely on FET. You may want to include or modify trusts for beneficiaries. Trusts can be used to address problems. They can provide protection from creditors and divorcing spouses, make provisions for children of a previous marriage or control how beneficiaries inherit wealth. Trusts can be particularly important for families with spendthrift, mental illness and addiction concerns.

Income tax planning is becoming a more important element in estate planning than before. Consideration should be given to planning for a periodic stepped up basis for trust assets, reducing tax on subsequent sales.

Finally, previously established trusts or family entities primarily for the purpose of minimizing estate taxes may have served their purpose and consideration should be given to modifying them or dismantling the arrangement.

- 3. Rethinking Gifting Strategies.** Many clients are in the habit of making annual gifts that are exempt from gift tax, currently \$15,000 per person per recipient per year (\$30,000 for married donors). Individuals will want to consider whether making gifts during their lifetime is still the right estate planning strategy. If estate tax is no longer a concern, limiting gifts to the annual exclusion amount may no longer be necessary. In either case, special consideration has to be given to the income tax effect of lifetime gifts (loss of stepped up basis).
- 4. Flexibility.** While only a small fraction of U.S. estates will be subject to FET under the most recent tax reform, it is important to keep in mind that there have been three legislative changes to the FET exemption in the past twenty years. Make sure your estate plan provides a degree of flexibility to address the ever changing tax climate.
- 5. Wealth.** For our wealthiest of clients, the need for complex federal estate tax planning is still an important part of planning. You may want to review your FET exposure under the new rules. Most of the traditional wealth transfer strategies are still useful. You may want to utilize the current \$11.18M lifetime gift tax and generation skipping tax exemption while available and take advantage of the increased exemption over the 2026 sunset exemption.

On the surface, the increase in the FET exemption may make it seem like the need for estate planning is less relevant than before. However, significant changes in the law are always a good reason to review your estate plan and make sure it provides some flexibility to respond to the ever changing estate tax law. 

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The Membership Model for Medical Practices

By: Andrew Stein, Esquire

FROM AMAZON PRIME TO the local gym, everyone is familiar with the membership business model. Customers pay a regular fee and receive membership benefits in exchange. As with a service like Netflix, the benefits may include access to all products that the company offers. At the other end of

the spectrum are many big box stores, such as Sam's Club, at which the membership fee buys little more than access to the store. The customers must then pay the (albeit discounted) retail price for desired goods. On the continuum between those two examples are services like Amazon Prime that offer a substantial suite of services for the standard membership fee, but also offer additional benefits for additional fees. This article addresses the application of the membership model to the practice of medicine—often called concierge or retainer medicine—and discusses some advantages and disadvantages of the trend.

Frustrated with billing complexities, weekday schedules filled with too-many-too-short appointments, patient lists approaching 3,000, and the misaligned incentives that often ignore patient outcomes, doctors are increasingly turning to the alternative of membership models for their practices. Many doctors see little room in the traditional model for appointments of a length necessary to truly address the patients' concerns, much less time adequate to provide the patient with comprehensive, preventative care. These doctors often turn to the membership model as a remedy.

To avoid the double-dipping concerns associated with third-party payers (e.g., Medicare and insurers), the access-only model linked above with big box stores is largely unavailable to medical practices. Instead, the model as applied to medical practices typically falls somewhere on a narrower continuum between the Netflix-like "all-inclusive" structure (a.k.a., fee for all services) and the more Prime-like tiered structure (a.k.a., fee for extra services).

In a fee for all services practice (as described above), the member-patient pays a set fee in exchange for all primary care services one would expect from a medical practice. The suite of services can include regular checkups, screenings, and diagnostic tests—all included in the membership fee. The practices only form of revenue is the membership fee, which makes this structure the cleanest and most legally simple. This is because it avoids concerns of "double-dipping," i.e., overlapping those membership fees from patients with reimbursements from Medicare or insurers for the same service. Note, however, that a practice adopting this model must submit an affidavit to Medicare advising explicitly that the practice is foregoing Medicare payments. The practice must thereafter follow through on its pure structure and actually forego submitting any claims to either Medicare or an insurance carrier. This requires the practice to enter into separate remuneration agreements with Medicare patients for direct payment of the membership fee.

If that structure is too extreme a transition from the traditional model, the fee for extra services model offers something more akin to a hybrid approach. The patient pays the membership fee in exchange for a suite of services. In addition to those, the practice can submit a claim to Medicare or to the patient's insurer for any services not included in the membership suite of services. A practice adopting this hybrid structure can apply the membership fee to a more personal suite of services (e.g., longer appointments, immediate call-backs, direct cellphone access, weekend and evening availability, and house calls) and submit more standard services to Medicare and private insurers. Alternatively, the structure may grant members a suite of standard services and only submit claims to Medicare and private insurers for more complex procedures or tests not included in the membership suite.

In either instance, the practice must carefully segregate the services for which it receives Medicare and private insurance reimbursements from the services it includes in the membership fee. Failing to do so may subject the practice to allegations, as discussed above, of accepting the same fee from two sources for the same service—i.e., "double dipping." There is divided opinion regarding how a practice can successfully accomplish this segregation. Some say it is proper to apply the membership fee to wellness programs, certain excess administrative costs, newsletters, and longer appointment times, but others have concerns regarding the ethical implications of particular distinctions. A practice is therefore best served by seeking legal counsel before transitioning to any form of membership-based medical care. While searching for counsel, note that the rules vary from state to state.

There are many advantages to the membership model of medical practice, in either pure or hybrid form. The regular and consistent revenue from membership fees makes the practice's finances more predictable. Also, cutting overall patient numbers down to approximately 500-800 allows physicians to listen more carefully, respond more fully, and focus more on preventative advice. In fact, the membership model turns incentives on their head. Specifically, where a traditional practice benefits from maximizing the number of paying patients coming through the door, the membership structure benefits when paying members have no need for an appointment. By way of analogy, think of the financial benefits realized by an empty gym with 500 paying members. In the membership model, doctors have a financial incentive to do what most doctors want to do anyway—that is, actively assist their patients with comprehensive preventative care until visits become rarer and rarer.

The lower patient count also limits paperwork. In the fee for all services (as defined above) model, many billing and reimbursement headaches also go away. Even if their structure makes them available for weekend and evening calls, many doctors find that the membership structure allows them to have a better work-life balance. Overall, doctors are given the opportunity to develop a deeper and more productive relationship with their patients.

The membership model is not without its disadvantages, however. Apart from the "double dipping" concerns addressed above, the transition itself requires a potentially disruptive restructuring and often substantial retraining of administrative and support staff. Further, as revenue (or at least some revenue) is coming directly from patients—and a smaller group of patients, at that—rather than from Medicare and insurance carriers, the practice must institute aggressive and effective collections procedures to maintain cash flow. It must also have a reputation adequate to attract patients with wherewithal willing and able to pay out-of-pocket for this.

Depending on the market, doctors wishing to adopt the membership model may face one of two problems. In some markets there is a glut of prospective and current patients at which point the challenge is deciding which patients to turn away. In other markets, doctors may face a dearth of prospective and current patients unable to support the membership model in the first place.

A traditional practice considering the transition to a membership model must carefully consider the foregoing advantages and disadvantages because not every practice will benefit from such a structure. If the transition seems like the right move, then the next step is to contact experienced legal counsel to evaluate the economic, practical and legal ramifications.

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