The PPM Trap

Mark D. Olson, Esq.
Philip E. Lane, M.D., J.D., MBA

At first look, the concept makes uncommonly good sense. Physician Practice Management Companies (PPMs) manage the business of a medical practice giving physicians freedom to practice medicine. The PPM buys the assets of the medical practice in exchange for cash and/or stock and long term employment agreements with the physicians. Qualms about becoming salaried employees and covenants not to compete are assuaged by large checks at closing. Nobody pays much attention to the 15% management fee.

When something sounds too good to be true, it often is. A recent lawsuit filed against PhyCor by 38 physicians who were part of the Holt Krock Clinic in Fort Smith, Arkansas provides insight into what happens when financial results fail to meet expectations.

PhyCor, formed in 1988, is a large, publicly traded PPM with second quarter 1998 net revenues of $376.3 million, a 41% increase from one year ago. PhyCor has projected a revenue growth of 20 to 25% for 1999, but the stock market boom seems to be off the PhyCor rose. Its stock (PHYC – NASDAQ) has plunged from $27 in January, 1998 to $7.25 on November 4, 1998. PHYC traded in the $3 to $4 range in September and October.

Holt Krock, founded in 1921, is a multi-specialty general partnership based in Fort Smith, Arkansas and is known for its radiation oncology and renal dialysis treatment centers. In 1994, when PhyCor purchased Holt Krock’s assets, Holt Krock employed 130 physicians in 21 different locations in Arkansas and Oklahoma. Arrex Chemical and Laboratory Company (owned by Holt Krock) provides in-house laboratory services for clinic patients.

Some of the key terms of the Asset Purchase Agreement (references to Holt Krock are to the Clinic; references to Arrex are to the laboratory) follow:

Purchase price: $47,720,000; payable:

- $27,276,763 in cash,
- $5,920,000 in a subordinated convertible note at the annual interest rate of 7%; with the entire unpaid balance due and payable in 5 years. Note may be converted into shares of common stock of PhyCor at $53.14 per share;
- The assumption of liabilities of $10,023,237;

1 The authors gratefully acknowledge the contributions of Heather McDermott, Chicago Kent College of Law and summer law clerk at Olson & Associates, P.C. to this article.
• One year after closing, PhyCor pays Holt Krock an additional $3 million; two years after closing, another $1.5 million.

Included in the list of assets not purchased in the transaction were:

• Holt Krock & Arrex’s ownership interests in all real property;

• Employment or non-compete agreements between Holt Krock and its physicians;

• Holt Krock’s & Arrex’s pension, retirement or profit sharing plans;

• Goodwill of the physicians;

• Cash, certificates of deposit, money market accounts, bank accounts and other cash equivalents;

• Arrex equipment pledged to secure bond financing.

When the documents were signed, the average cash distribution per Holt Krock physician was approximately $209,800. The $4.5 million in deferred payments adds another $34,600/physician. The distributions to the senior physicians were obviously much higher as some of the junior physician-employees presumably had little or no equity in the business. Other documents in the transaction provided that:

• The term of the Agreement was forty (40) years.

• PhyCor’s Management Fee was 15% of net clinic revenues (less clinic expenses).

• Holt Krock would not establish, operate or provide physician services at any medical office, clinic or other health care facility providing similar services within 30 miles of any facility for the 40-year term of the Service Agreement.

• PhyCor agreed not to purchase the assets of, establish operate or enter into a service agreement with a multi or single specialty group within 30 miles of any facility for the term of the Service Agreement.

• Holt Krock agreed to obtain and enforce restrictive covenants from its current physician partners, physician employees and any future physician partners and physician employees wherein the physician would agree not to establish, operate or provide services at any medical office offering similar services within 30 miles of any Holt Krock facility during and for 18 months after termination of employment.

• Physician partners or employees may be released from their restrictive covenants by paying liquidated damages.
• For those physicians that received cash in the transaction, liquidated damages in the event of breach will be:

  • that physician’s income for a the most recent year, or
  • that physician’s pro rata share of Holt Krock’s proceeds from the sale of assets to PhyCor

• For those not participating in the proceeds from the sale to PhyCor and physicians employed after the transaction, liquidated damages will be that physician’s income for the most recent year

An overlooked but important question is, "where does PhyCor’s 15% come from"? The standard answer is cost savings through expense consolidation; more management efficiency leading to a better bottom line; enhanced revenues through better billing; more favorable agreements with managed care organizations (MCOs); expanded revenues through practice growth; and enhanced revenues from ancillary services.

Those “promises” plus the check (sometimes common stock is also an important part of the deal) usually carry the day. It is not, however, quite that simple. “Consolidation of cost” and “management efficiencies” add something to the bottom line, but nothing that will approach $7,000,000 (the 15% PhyCor yearly management fee). Clinic profits will simply not increase by 15% through cost savings and management efficiency. Also, it is unlikely that MCO contracts will be a source of new profits those agreements tend to limit revenue growth. If anything, a number of those agreements will put pressure on margins.

The underlying assumption in all of these deals is that revenues will increase substantially and now. There are only three ways for Holt Krock’s revenue line to grow: (a) Fee increases; (b) Growing the practice, i.e. adding physicians that generate more billings, or (c) increased ancillary service revenues (laboratory, physical medicine, radiology centers, cardiac laboratories) from existing services or those not previously offered.

As it is unlikely that fee increases will generate the needed revenues; the dollars have to come from either (b) or (c). The problem is that, post PPM acquisition, the group practice is now a direct and feared competitor of both the hospitals and other physicians and group practices in the service area. Everyone will be recruiting to fill perceived needs and there are no assurances that Holt Krock can grow at the rate needed to pay an additional $7 million in costs.

Ancillary services growth may also be problematic. Area hospitals will aggressively act to protect their principal profit stream, i.e. outpatient and ancillary services. There are also (in some states) Certificate of Need laws to consider. The PPM may not be able to add ancillary service revenues without jumping through some expensive and lengthy regulatory hoops.

If the PPM cannot generate the necessary revenues to pay the 15% fee plus increases in the physician group members’ compensation, the “more money tomorrow”, which was an integral part of the deal, doesn’t happen. When the money disappears, somehow, magically, lawsuits appear. Physicians at Holt Krock filed the lawsuit in April 1998 due to a significant salary cut in the second half of 1997. The ostensible cause was a new computer system; the effect was a 10% drop in income for primary care physicians and a 17% hit for specialists.6

---

In the lawsuit, the doctors are asking the court to release them from the contracts because:

- The restrictive covenant and liquidated damages provisions in the Agreement and the Management Letter are unenforceable and the entire contract should be cancelled as being illegal;

- The covenants not to compete are void and unenforceable because they:
  - restrict ordinary competition
  - are contrary public policy in precluding physicians from providing medical services to patients of their choice
  - permit PhyCor to engage in the illegal practice of medicine as a corporation
  - permit PhyCor to illegally split profits and physician professional fees
  - are unreasonably long in duration and broad in geographic scope
  - would, if enforced adversely affect and restrict the availability of physician services in the community

- The Asset Purchase Agreement, Service Agreement and Management Letter (the principal transaction documents) all violate the corporate practice of medicine doctrine which prohibits publicly owned and publicly traded for-profit corporations from providing physician medical services for a profit

- The fee under the service agreement is based on a percentage of net profits generated by the physicians & therefore is an illegal division of income and profits between the physicians and PhyCor.
  - The management fee amounts to an average of $7 million per year;
  - As a result, the incomes of the physicians have been significantly diminished.

- The liquidated damages provisions are unenforceable penalty provisions in that they do not bear any reasonable proportion to the damages that the parties contemplated might flow from the failure of the parties to perform.

The pay cut was a serious dose of reality. The lesson – never add a substantial cost unless someone has a clue as to where the revenues will come from to cover that cost. $7 million/year (some $28-30 million since the inception of the PhyCor – Holt Krock contract in 1994) is, by any objective standard, a substantial new cost.

The Holt Krock physicians now want to unscramble the egg. In Part II we discuss the defenses raised by PhyCor and strategies physicians, who want to repurchase their practices, may want to consider.
The PPM Trap – Part II

Actin v. Holt Krock Clinic
Defenses and Counter Claims

Mark D. Olson, JD
Philip E. Lane, M.D., JD, MBA

At least the Holt Krock physicians were better off than physicians in transactions where the PPM’s stock was given for some or much of the purchase price. Unfortunately, Cinderella’s Cadillac (the market’s view of PPM stocks) is now a pumpkin.

Not only has PhyCor’s stock crashed, the stock of most of the leading PPMs has also gone south. In January 1998, MedPartners (MDM – NYSE) and PhyMatrix (PHMX – NASDAQ) were at $11 and $15 respectively; notwithstanding the major bounce in the Dow in October, these shares opened on November 5 at $3.50 and $3.00 respectively. Judging by the numbers of unhappy physicians consulting lawyers, more than a few unlucky souls are still holding stock of publicly traded PPMs.

The Holt Krock physicians were unhappy because of the pay cuts and the realization that incomes may never achieve the levels that had been indicated during acquisition negotiations or that would have been earned if they had never heard of PhyCor. The logical recourse was a lawsuit. As noted in Part I, the “wrongs” pleaded in the complaint to void the restrictive covenants included allegations that the transaction violated legal prohibitions against fee splitting and the doctrine of “corporate” practice of medicine.

The defendants pleaded the following in response to the physicians’ complaint:

- the non-compete agreements were voluntarily entered into as a material part of the business transaction and are permissible restraints on competition permitted by public policy and Arkansas law;

- the goodwill and non-compete agreements were specifically negotiated as an integral part of the transaction. If the agreements not been intended to be, when executed, binding promises not to compete, PhyCor would not have included them in the transaction documents;

- the liquidated damages provisions were specifically tailored to the Holt Krock transaction and directly related to the damages that would be suffered by PhyCor in the event of a breach.

- the liquidated damages provisions set forth in the Management Letter were the subject of intense negotiation; both sides were represented by counsel; those provisions were clearly bargained for and are enforceable;

---

1 The authors gratefully acknowledge the contribution of Heather McDermott, Chicago Kent College of Law and summer law clerk at Olson & Associates, P.C. to these articles.

the physicians are bound by liquidated damages clauses in the relevant documents, to which they “all – as sophisticated, intelligent, well-educated men and women who have access to legal counsel – agreed to be fair and reasonable;"

- the agreements do not violate the corporate practice of medicine doctrine;
- the agreements do not violate fee splitting laws;
- the restrictive covenants were enforceable under Arkansas law;
- no one ever discussed potential illegality of the Agreements prior to closing the transaction; and
- the physicians were required to join the remaining 88 Holt Krock physicians in the lawsuit as they were necessary and indispensable parties.

PhyCor also pleaded as affirmative defenses that the physicians’ claims have been waived, that the physicians were estopped from raising the claims stated in their complaint and are barred from any recovery by the equitable doctrine of unclean hands.

Finally, PhyCor filed counterclaims against 3 physicians who left Holt Krock and established another medical practice. PhyCor demanded compliance with the non-competition provisions, i.e. either a 15-year management agreement or the cash buyout. The physicians refused to negotiate and are litigating the enforceability of the non-compete covenants.

It is difficult to believe that this case will not settle at some point as both parties have much at stake. From PhyCor’s perspective, a win may be a loss. Although there is much to be said for upholding the integrity of a contract, there are also marketing and public relations considerations. This lawsuit, in the best of circumstances, cannot be helpful in the acquisition of new physician practices.

With the caveat that we are not licensed to practice law in Arkansas, if the case is tried, there are some general principles that may offer some guidance as to whether or not the physicians will be successful.

Covenants Not To Compete

Historically, covenants not to compete were regarded as unreasonable restraints on trade, but today most state courts view them as enforceable if reasonable and consistent with public interest. As a general rule, an enforceable restrictive covenant needs to be ancillary to the principal contract, be supported by consideration and be reasonable. Reasonable usually means that the covenant is no broader than necessary to protect the legitimate business interests of PhyCor, would not be unduly burdensome to the Holt Krock physicians, and is reasonable with respect to duration, geographic scope and scope of the business restrictions.3

Although state courts differ on the definition of “reasonable,” most adhere to similar principles when analyzing non-competition covenants. A few state states (neither Arkansas nor

Oklahoma being among them) specifically invalidate covenants not to compete between physicians or upon the practice of a profession. 4

Illegality/Public Policy Considerations

There is little question that valuable consideration was bargained for and paid and that both parties were represented by counsel. Absent fraud or provisions that violate public policy, the contract will probably be enforced. Courts have routinely assumed that adequate consideration has been met in the context of a sale of a business, 5 although courts will not enforce an agreement deemed to violate public policy in the state.

The major "policy" issue may be applying the corporate practice of medicine doctrine. Generally corporations are prohibited from "practicing medicine", although many hospitals and provider organizations routinely employ physicians. State medical licensure statutes only permit "human persons" to practice medicine and forbid licensed physicians from "aiding and abetting" the unauthorized practice of medicine. 6 Although few states have actually codified the doctrine, courts infer from the licensure statutes that the practice of medicine by unlicensed individuals, including corporations, is strictly prohibited.

Two recent Illinois cases held that the corporate practice of medicine doctrine does not apply to licensed hospitals, whether operated as for-profit or non-profit organizations. 7 Both cases involved physicians seeking to void their employment contracts (with hospitals) containing covenants not to compete. In Berlin the Illinois Supreme Court explained the rationale behind the long-standing prohibitions against corporations "practicing" medicine. 8 In refusing to void the contracts, the Court stated that hospitals are authorized by other Illinois laws to provide medical treatment to patients. 9 As a result, the legislature recognized that hospitals have the authority and, in certain circumstances, may have a duty to employ licensed physicians to assure availability of medical services. 10

The Arkansas legislature has recognized the corporate practice of medicine doctrine, but it has not been codified. 11 PhyCor’s agreements anticipate this issue by maintaining the clinic’s separate legal existence and, by contract, only exerting control over the administrative and managerial functions, while emphasizing the physicians’ control over the medical practice. At the end of the day, the Arkansas Courts will need to deal with a question of fact concerning whether or not a PPM, as a result of the contract structure, is in violation of the recognized doctrine prohibiting corporations from "Practicing" medicine.

Specific Performance/Liquidated Damages

5 See supra note 3 “Coping With Reality...” at 328.
8 Berlin, 688 N.E.2d at 110.
9 Id.
10 Id. at 113.
Can the physicians void the contracts and simply keep the money? Probably not. PhyCor would certainly plead "unjust enrichment".

Can PhyCor demand specific performance? Probably not. The contract contains specific liquidated damage provisions. There are different provisions for physicians who received cash at closing and for those who did not. More than likely, those provisions will control.

It is also unlikely that the terms would be considered an illegal penalty and resulting in a severance of those provisions from the agreements. Courts in many jurisdictions have enforced liquidated damages provisions in physician employment arrangements and acquisitions of practice and partnership agreements. These bear a clear relationship to the consideration exchanged at closing.

Some courts have awarded injunctive relief in addition to liquidated damages when penalizing covenant-breaking physicians. Courts in only a few jurisdictions, however, have recognized that the existence of liquidated damages may prove detrimental to a covenantee winning injunctive or other equitable remedies.

**Fee Splitting**

A final issue for PhyCor will be whether its management fee constitutes illegal fee-splitting. The typical state fee-splitting statute prohibits physicians from dividing or splitting professional fees with anyone other than a licensed physician or within the context of a professional corporation or partnership. Although many state courts, including Arkansas, have not yet addressed the issue and many state regulatory agencies do not strictly enforce the statutes, an increasing number of states have frowned upon arrangements similar to the one at issue here.

The State of Florida Board of Medicine found that a similar arrangement was impermissible under Florida law because it allowed for payment of fees to the management company that were based in part on revenues generated from referrals that the management company had helped to generate.

Prior to becoming a member of a group practice already engaged in a management agreement with a PPM, a Florida physician inquired as to whether he would be subjected to discipline for affiliation with the practice. The Florida Board of Medicine ("Board") answered "yes".

The Florida statute prohibiting fee splitting states that any licensed physician may be subjected to disciplinary action for “paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement ... with a physician, organization, agency, or person ... for patients referred to providers of healthcare goods or services ...” Although recent Florida case law regarding the statute does not prohibit “traditional fee-splitting” in the

---

13 Id. note 6 “Copier With Reality...” at 337.
15 Id. Final Order at 4.
sense that physicians contract with a PPM for payment of a flat fee, the Board concluded that this arrangement had a different, distinguishable twist.\textsuperscript{17}

The agreement required the PPM to create a physician provider network and develop relationships and affiliations to acquire a greater number of patient referrals for the Practice.\textsuperscript{18} The contract also stipulated the fees paid to the PPM were as follows: an operations fee amounting to the actual expenses incurred by the PPM; a general management fee of $450,000 annually; and an annual performance fee equaling 30% of the group practice’s net income each year, which encompasses all of the revenues generated by or on behalf of the group practice.\textsuperscript{19}

With the caveat that their statement is not a ruling on the legal validity or enforceability of the agreement, the Board held that arrangement is prohibited by the fee-splitting statute.\textsuperscript{20} Through the enactment of the Patient Brokering Act in 1996 (which the Board declined to interpret for purposes of in this case), the Board found that the Florida legislature intended to prohibit the payment of fees directly or indirectly related to the referral of patients to health care providers.\textsuperscript{21} Therefore, the Board concluded that the payments of fees to the PPM were based on revenue generated, at least in part, due to the referrals that the PPM had helped to generate for the physician practice. Furthermore, the performance fees were calculated without regard to the cost of providing services supplied by the PPM and without regard to whether the billings are for services performed by or under the supervision of the physician.\textsuperscript{22} This performance fee, as viewed by the Board, was clearly a prohibited arrangement to split professional fees.

PhyCor obviously anticipated this issue and made it clear in its management services agreement “that the benefits to Holt Krock . . . do not require, are not payment for, and are not in any way contingent upon the admission, referral or any other arrangement for the provision of any item or service offered by PhyCor...” However, PhyCor agreed in the management services contract to design and implement an public relations program for Holt Krock emphasizing the availability of services at the Clinic, presumably to increase patient referrals. The most problematic element of the agreement for PhyCor will be getting around the annual fee equaling 15% of the Clinic’s Distribution Funds. How the Arkansas courts treat the PhyCor/Holt Krock agreement in light of the Florida Board of Medicine’s Final Order will be interesting considering the amount of controversy the Florida ruling has incited.\textsuperscript{23}

**Strategies**

Assuming that a physician or physician group has sold to a PPM and wants to leave, the preferred exit strategy is fairly simple. If negotiations are ongoing, you may want to carefully review the liquidated damages provisions. The important question in either case will be how much money it will cost to "repurchase" the practice if the deal goes sour.

Litigation is an expensive (and usually unproductive) alternative. Absent clear guidance from the legislature, policy arguments are both difficult and carry a high risk of failure. Success is likely only in the appellate courts. No matter who wins at trial, the loser will appeal, which

\textsuperscript{17} See supra note 14 Final Order at 5.
\textsuperscript{18} Id.
\textsuperscript{19} Id. at 3.
\textsuperscript{20} Id. at 8.
\textsuperscript{22} Id. at 6.
\textsuperscript{23} See supra note 6 “The Art of Herding Cats...” at 396.
will both prolong uncertainty and increase costs. Appeals, particularly following trials of complex issues as are present in Aclin only add incrementally to an already costly process.

The corporate practice of medicine doctrine may be a relatively simple hurdle for PPMs to overcome, with careful contract drafting and maintaining the physician practice as a separate, distinct entity from the Manager. Fee splitting, on the other hand, can be problematic. The optimal way for PPMs to reap the benefits of their investment is to charge management fees based on a percentage of the physicians' revenues. A contingency (or percentage of gross) fee for acquiring patients is simply a concept that rubs public policy the wrong way. Conversely, a flat management fee arrangement, no matter how the practice performs financially, may make these contracts virtually impossible to void.