Accountable Care Organizations Versus Texas’ Corporate Practice of Medicine Doctrine

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Much of the discussion surrounding health care reform prior to and after the enactment of the Patient Protection and Affordable Care Act (PPACA), centered on ways to create higher quality, more efficient care. Included in the PPACA is a provision many health reform experts are hoping will fulfill that goal. Section 3022, the Medicare Shared Savings Program, provides for the establishment of Accountable Care Organizations (ACOs) which are designed to bring together groups of health care providers to manage and coordinate the delivery of care to Medicare beneficiaries. A typically ACO might include a hospital, primary care physicians, specialists, and possibly other healthcare professionals. Those able to create ACOs no later than January 1, 2012, are eligible to receive additional Medicare payments if specified cost savings and other criteria are met, including quality, reporting, and governing structure standards established by the Centers for Medicare and Medicaid Services (CMS). However, many health care providers, health law attorneys, and other experts have their doubts regarding whether ACOs will ever be viable because of the many challenges facing ACOs, including the policies and procedures yet to be developed by the U.S. Department of Health and Human Services (DHHS) Secretary Kathleen Sebelius, the effect of federal and state anti-kickback and self-referral laws, and in a few states including Texas, the corporate practice of medicine prohibition.

PPACA’s Accountable Care Organizations (ACOs)

Though not an innovative concept, Accountable Care Organizations (ACOs) were included in the PPACA as a way to contain skyrocketing health care costs. Dr. Elliott Fisher of Dartmouth Medical School, a primary originator of the theory, defined an ACO as “a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.” The goal of an ACO is to reduce costs and improve quality of care through cooperation

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2. Section 3022 creates a new Section 1899 of the Social Security Act.
and coordination among providers, similar to an integrated health care delivery system.\(^6\) Section 3022 of the PPACA describes the establishment of ACOs as an entity composed of:

(A) groups of providers and suppliers meeting criteria specified by the Secretary [of DHHS] may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization…; and

(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings…\(^7\)

Those health care providers eligible to form an ACO under the shared savings program include: (a) physicians and other practitioners in group practice arrangements; (b) networks of individual physician practices or other clinical practices; (c) partnerships or joint venture arrangements between hospitals and ACO professionals; (d) hospitals employing physicians and other professionals; and (e) other groups of providers of services and suppliers as the Secretary [of DHHS] determines appropriate.\(^8\) ACOs will be required to meet many administrative and quality requirements, including, but not limited to, the following:

1. the ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it;
2. the ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period…;
3. the ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings…to participating providers of services and suppliers;
4. the ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO…At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it … in order to be eligible to participate in the ACO program;
5. the ACO shall have in place a leadership and management structure that includes clinical and administrative systems;
6. the ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.\(^9\)

\(^6\) Id.
\(^7\) PPACA, supra note 1 at § 3022 (§ 1899(a)(1)).
\(^8\) Id. at § 3022 (§ 1899(b)(1)).
\(^9\) Id. at § 3022 (§ 1899(b)(2)).
The DHHS Secretary is provided with substantial discretion\(^\text{10}\) in how to form ACOs as well as implementing applicable policies and procedures, including the authority to waive certain provisions of federal law pertaining to anti-kickback and self-referral laws. However, the Secretary has no authority to modify state laws that may adversely affect the establishment of ACOs, including the corporate practice of medicine doctrine in effect in some states, including Texas.

**Texas’ Corporate Practice of Medicine Doctrine**

The Texas Medical Practice Act\(^\text{11}\) prohibits the corporate practice of medicine (CPOM)—an individual or entity that is not licensed to practice medicine from employing a physician and receiving fees for services rendered. The policy supporting the prohibition is that a physician’s actions and ethics should not be influenced by corporate entities and that he or she should have absolute control over medical decision making. One criticism of the doctrine is that it limits the available options for innovating health care systems by prohibiting employment of physicians. Others argue that the doctrine acts as a barrier to address the growing shortage of physicians in rural areas of the state. Proponents of the doctrine say it is necessary to maintain physicians’ independent medical judgment. Regardless, the CPOM law will likely be a significant barrier to the smooth establishment of an ACO in the state.

The following provisions of the Texas Occupations Code create the basis for the prohibition against the corporate practice of medicine in Texas:

- Section 155.001 provides that a person may not practice medicine in the State of Texas unless that person holds a license;
- Section 155.003 describes the requirements for a license to practice medicine which only an individual can meet; a corporation or other entity is unable to meet such requirements;\(^\text{12}\)
- Section 157.001 allows a physician to delegate to a qualified and properly trained person acting under the physician’s supervision any reasonable medical act if it may be safely performed by the person and is not in violation of any other law; also, the person to whom the act is delegated may not represent to the public that he or she is authorized to practice medicine;

\(^{10}\) *Id.* at § 3022 (§ 1899(c)) “[t]he Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title...”

\(^{11}\) *TEX. OCC. CODE ANN.* § 151.001 *et seq.* (Vernon 2007).

\(^{12}\) Some have argued that it is unwise to jump from the fact that a corporation cannot be licensed to a finding of unlawful practice by the corporation when it employs someone that is licensed. *See Sloan v. Metropolitan Health Council*, 516 N.E.2d 1104, 1007 (Ind. Cto. App. 1987) (“[I]t is, however, a non sequitur to conclude that because a hospital cannot practice medicine or psychiatry, it cannot be liable for the actions of its employed agents and servants who may be so licensed. Similar logic would dictate that a city cannot be liable for the negligence of its employees in driving automobiles since the city cannot hold a driver's license or that a corporation cannot be liable for the misactions of its house counsel since it could not [sic] hold a license to practice law.”). Key cases governing Texas appear to have rejected this criticism, however. *See Garcia v. Texas State Board of Medical Examiners*, 384 F.Supp. 434 (W.D. Tex. 1974).
• Section 164.052(8) prohibits a physician from selling the physician’s medical degree or license to practice medicine; subsection (13) prohibits a physician from permitting another to use his/her license or certificate to practice medicine; and subsection (17) prohibits a physician from directly or indirectly aiding or abetting the practice of medicine by a person, partnership, association or corporation that is not licensed to practice medicine;

• Section 165.156 specifically provides that a person, partnership, trust, association or corporation commits an offense if it in any manner indicates entitlement to practice medicine when it is not licensed to do so.13

Additionally, Texas law prohibits the direct division on a percentage basis of a physician’s professional income with lay persons or to lay shareholders in a corporation or other business enterprise, as interpreted by the Office of the Attorney General.14

In any arrangement between physicians and non-physicians, the CPOM doctrine in Texas applies and the physician must function as an independent contractor or fit another exception. However, even independent contractor agreements have come under fire in recent years. In Flynn Brothers, Inc. v. First Medical Associates,15 a Texas appellate court found that the practical effect of an employment contract between a lay entity and medical professionals was that of employer-employee, not independent contractor. Of course, the parties also admitted that they drafted the contract with the intent to avoid CPOM violations.

Exceptions to the Texas CPOM involve the formation of specific entities authorized to provide medical services. Such entities include those formed under the Texas Non-Profit Corporation Act,16 if such entity is organized an operated as a “migrant, community, or homeless health center” under federal law;17 or is a federally qualified health center under federal law.18

Additionally, specific exceptions to the CPOM doctrine have been carved out by legislative action in recent years allowing certain types of entities such as private, nonprofit medical schools, federally qualified health care centers, and certain hospital districts to employ physicians. Certainly, legislation amending the Texas CPOM to allow for direct formation of ACOs would be the easiest solution—other than outright removal of the prohibition.

Conclusion

13 Jennifer B. Claymon, Corporate Practice of Medicine and Non-Profit Health Organizations, presented at the 21st Annual Health Law Conference in Houston, Texas (April 2009).
15 715 S.W.2d 782 (Tex.App.—Dallas 1986).
16 TEX. OCC. CODE ANN. § 162.001(c)(1) (Vernon 2007).
17 TEX. OCC. CODE ANN. § 162.001(c)(2)(A) (Vernon 2007).
18 TEX. OCC. CODE ANN. § 162.001(c)(2)(B) (Vernon 2007).
In addition to the many logistical hurdles facing the establishment of ACOs nationwide is the view among some physicians regarding the difficulty of getting providers to work together. Physicians used to controlling their work-flow and own fee-for-service businesses may hesitate to sign up for a “share of savings” that is dependent on reduced billings by ACO providers, especially if there were other costs necessary to maintain the ACO.\(^\text{19}\)

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\(^{19}\) See Collier, *supra* note 5.