As the health care arena continues to evolve, psychologists are coming together to work in new ways, such as independent practice associations (IPAs) and management services organizations (MSOs) (see sidebar). However, with new opportunities come new challenges, cautions Alan Nessman, JD, senior special counsel in the Office of Legal and Regulatory Affairs in the Practice Organization.

“Any time that psychologists are jumping into something new, they need to be aware of how it changes the legal context and risk management issues they need to think about,” says Nessman. These definitely are not do-it-yourself kinds of issues, he emphasizes. “Do not try this at home,” he says. “You should be aware of the kinds of issues that become relevant to you, but you should consult with competent counsel and risk managers about them.”

Whether you’re interested in simply setting up a referral network or exploring a more complex practice model, you must consider how to limit your risks, comply with laws and avoid antitrust violations. Wherever you hope to land on the spectrum, Nessman and other experts have tips for venturing safely beyond traditional models.

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**Risk management considerations**

To protect yourself when transitioning to an alternative practice model, ask these questions, suggests Jana N. Martin, PhD, Chief Executive Officer of The Trust.

- **What’s your role?** Are you an employee or an independent contractor? From a risk standpoint, says Martin, you’re better off as an employee because a lawsuit will typically be filed against the large, deep-pocketed organization. That said, organizations focus on protecting themselves, so it is also advisable for you to have a policy that covers you as an individual. On covered claims, such a policy would provide you with a defense attorney who is looking out for your interests.

- **Have you and a lawyer reviewed your contract thoroughly?** “We just assume the people we’re about
to join and work with have our best interest at heart,” says Martin. They usually do, but people can interpret agreements differently – something that’s usually not discovered until a problem arises. Make sure your contract covers what services you’re agreeing to provide, how you’ll be paid and the terms of your employment. Review and copy documents incorporated into the agreement, such as policies and procedures you agree to abide by. Moreover, try to avoid signing “hold harmless” agreements, which could make you responsible for damages awarded against another party in a lawsuit.

• **What records must you keep?** Be sure you understand what your organization requires. Your contract may require you to submit periodic summaries, for example. Also, adds Martin, “you’re not exempt from knowing what your state law requires just because you work for a group.”

• **Are your informed consent practices adequate?** Find out which members of a group need to see patient records to function effectively as a team, then make sure patients understand that. Many alternative practice models also collect data on providers’ performance, so consent forms need to reflect that, too.

**Legal issues**

There are also key legal issues to explore before you make changes, says Kevin Ryan, JD, a partner at Epstein Becker & Green in Chicago. “It costs lots more to clean up than it does to put in the right structure to begin with,” says Ryan, adding that consequences of getting things wrong include losing your license and facing civil or criminal sanctions.

Some laws you need to consider include:

• **Fee splitting or referral fees.** Almost every state – and the APA Ethics Code – says it’s inappropriate to give or accept fees or other compensation for referring patients to specific providers.

• **Anti-kickback statute.** This statute prohibits offering, paying, soliciting or receiving kickbacks or other compensation to obtain health care work reimbursed by a federal health care program; inducing purchases, leases or orders; or arranging goods or services paid by a federal health care program. In addition to bribes and rebates, potential violations include routinely waiving copays or deductibles for Medicaid and Medicare.

**LEVELS OF PRACTICE MODELS**

Not all alternative practice models are created equal when it comes to how much risk they entail, says Kevin Ryan, JD, a partner with Epstein Becker & Green’s Chicago office. “As you move up on the integration, you also move up on the risk,” he says. Beginning with the least risky and least complex, alternative practice models include:

• **Referral network.** The most basic step toward integration, a referral network means contracting with referral sources. There’s limited risk as long as you abide by the anti-kickback rules, self-referral laws and other regulations that apply in referral relationships, says Ryan.

• **Co-location.** In this model, a psychologist rents or shares office space with possible referral sources. Like referral networks, the risk is minor except for anti-kickback and self-referral laws. You should pay fair market value for the office space and get everything in writing, with all terms spelled out.

• **Independent practice association (IPA).** This model consists of a group of independent practices that have affiliated around a common goal, typically focused on contracting with a specific hospital or in a specific geographic region. This model and the management services organization implicate the antitrust concerns discussed in the main article.

• **Management services organization (MSO).** A comprehensive practice business model, a management service organization takes that basic idea but markets itself to multiple entities rather than a single hospital or payer. An MSO typically brings the practices involved together under a single brand name. While an IPA primarily creates a network of providers, an MSO often offers a variety of management services to those who join it, for example, billing and electronic health records services.

• **Merger.** “A merger isn’t really an alternative practice model but is probably the ultimate step in changing your practice,” says Ryan. While the other practice models are designed to keep you independent, allowing you to participate in much broader networks, a merger means you’re bringing together your assets and liabilities. Because this is much more than just a contractual relationship, says Ryan, it’s “much harder to unwind if things don’t work out.”

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patients or even giving away too many pens to referral sources inscribed with your practice name.

• **Physician’s self-referral law.** Also known as the Stark law, this prohibits physicians from referring patients to certain health services covered by Medicare or Medicaid if they or family members have financial relationships with the service providers. While the law doesn’t apply directly to psychologists, psychologists could find themselves in situations where physicians they collaborate with are barred from referring patients to them.

• **Corporate practice of medicine laws.** In some states, only licensed professionals can own practices. When professional corporations have agreements with management companies, it’s crucial that professional decision-making, rate setting and advertising are handled by licensed professionals.

Other possible pitfalls include fraud and abuse violations and state laws, which differ widely from state to state.

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**Antitrust considerations**

One of the reasons that members are interested in IPAs and MSOs is the ability for independent practices to negotiate fees jointly, says Nessman. However, you have to do this very carefully, he cautions. “To do a joint fee negotiation, the parties have to agree on a price, and price fixing is one of the basic no-nos in antitrust,” he says.

**Most psychologists are interested in clinical integration, which is designed to lower costs, improve quality of care and enhance efficiency.**

There are two strategies psychologists can use to achieve joint negotiations without violating antitrust laws. In the messenger model, the IPA or MSO doesn’t negotiate but instead acts as a passive conduit of fee information between psychologists and companies. The network could ask members to privately send it what fees they would accept for certain services, then tell the insurance company it has 200 providers who would accept $100 for providing a service, for example. If the company responds with a $90 offer, the IPA or MSO can check how many people said they would accept that rate. “The problem is that it’s difficult for people to avoid the temptation to slide into actually negotiating, which this model does not allow,” says Nessman.

The other strategy is financial or clinical integration. Most psychologists are interested in clinical integration, which is designed to lower costs, improve quality of care and enhance efficiency. If the IPA or MSO meets these goals, then antitrust regulators are willing to allow joint negotiation. Collaborations should include measurable goals, educational programs for providers, credentialing procedures, disciplinary processes, clinical protocols, disease management programs and integrated computer systems.

For more information on clinical integration, visit www.apapracticecentral.org.