OIG REAFFIRMS ITS DISAPPROVAL OF MEDICARE “CARVE-OUTS” AND CONTRACTUAL JOINT VENTURES

On May 25, 2012, the Department of Health and Human Services Office of the Inspector General (“OIG”) issued OIG Advisory Opinion 12-06 (the “AO”) finding that two proposed anesthesia services arrangements between a physician-owned anesthesia services provider and physician-owned ambulatory surgical centers (“ASC”) would violate the Federal Anti-Kickback Statute (“AKS”) if the parties had the requisite intent to violate the AKS.

BACKGROUND
A physician-owned anesthesia services provider (“Requestor”) provides anesthesia services on an exclusive basis at several physician entity-owned Medicare-certified ASCs. Currently, the Requestor independently bills Medicare and other third party payors for the professional services provided by its anesthesiologists. For Medicare patients, the ASCs receive payment under Medicare Part B for ASC services, including the ASC facility services (e.g., nursing and technician services, use of the facility, administrative, recordkeeping and housekeeping items and services, anesthesia equipment and supplies) associated with each surgical procedure. The Requestor indicated that it was “under pressure” to enter into certain proposed arrangements, described below, in order to compete with other anesthesiology groups and to prevent the loss of its business.

PROPOSED ARRANGEMENT A
Under proposed arrangement “A,” the Requestor would continue providing the ASCs the same anesthesia services on an exclusive basis and would bill for those professional services. However, it would begin to pay the ASCs a “management services” fee covering the cost of certain ASC expenses (e.g., preoperative nursing assessments, space for the Requestor’s physicians and records) already included in the facility fees paid to the ASCs by private payors and by Medicare. Effectively, this means the ASCs would be paid twice for the same facility costs, once by a payor and a second time by the Requestor. The fee would be structured as a “per-patient” fee set at “fair market value” and would not be charged for any federal health care program patients.

THE OIG’S ANALYSIS OF PROPOSED ARRANGEMENT A
Notwithstanding the federal health care program patient “carve out” from the management services fee, the OIG concluded that proposed arrangement “A” would implicate the AKS. Since the Requestor would continue to be the exclusive provider of anesthesia services to the ASCs, the OIG asserted there would still be risk that the management services fee paid by the Requestor to each ASC would constitute an inducement for each such ASC’s referral of all of its patients, including federally insured patients.

PROPOSED ARRANGEMENT B
Under proposed arrangement “B,” the ASCs' physician owners would set up separate companies for the sole purpose of providing anesthesia services to the ASCs (“Subsidiaries”). The Subsidiaries would either be owned directly by the ASCs or by the physician-owned LLCs or PCs that own the ASCs. In turn, the Subsidiaries would engage the Requestor as an independent contractor to provide the anesthesia services to the ASCs. The Subsidiaries would either employ anesthesia personnel, including employees or owners of the Requestor, or engage the Requestor's anesthesia personnel as independent contractors. The services provided by the Requestor to the ASCs would include recruiting, credentialing and scheduling anesthesia personnel; ordering and maintaining supplies and equipment; monitoring and overseeing regulatory compliance; and implementing quality assurance programs. The Requestor would be paid a negotiated rate for its services out of the Subsidiaries’ collections from Medicare/Medicaid and private payors for anesthesia-related services. Most important of all, the Subsidiaries would retain the profits from their anesthesia services business. In other words, the anesthesia-related remuneration realized by the physician owners of the ASCs would equal the difference between the anesthesia services collections of the Subsidiaries and the amounts the Subsidiaries would pay the Requestor, plus any amounts paid to employed or engaged anesthesia personnel.

THE OIG’S ANALYSIS OF PROPOSED ARRANGEMENT B
Here the OIG concluded that Proposed Arrangement “B” would pose more than a minimal risk of fraud and abuse under the AKS. It believed...
this arrangement was devised to "do indirectly what [the parties] cannot do directly" - to permit the ASCs' physician owners "to receive compensation in the form of a portion of the Requestor's anesthesia services revenues, in return for their referrals to the Requestor." The OIG noted that there is no safe harbor that would protect the remuneration the Subsidiaries would distribute to the ASCs' physician owners. For example, since the Subsidiaries would not provide surgical services, the profits paid to the ASC physician owners could not be protected under the ASC safe harbor.

The OIG also believed the arrangement subject of the AO was substantially similar to the suspect "contractual joint ventures" described in a Special Advisory Bulletin issued on April 30, 2003 ("Bulletin"). In that Bulletin, the OIG provided the following:

(A) health care provider in one line of business (hereinafter referred to as the "Owner") expands into a related health care business by contracting with an existing provider of a related item or service (hereinafter referred to as the "Manager/Supplier") to provide the new item or service to the Owner's existing patient population, including [F]ederal health care program patients. The Manager/Supplier not only manages the new line of business, but may also supply it with inventory, employees, space, billing, and other services. In other words, the Owner contracts out substantially the entire operation of the related line of business to the Manager/Supplier - otherwise a potential competitor - receiving in return the profits of the business as remuneration for its [F]ederal program referrals.

The OIG opined that the ASCs' physician owners and the Requestor would be in the same position, respectively, as the "Owner" and "Manager/Supplier" of the Bulletin. Like the Owner of the Bulletin, the ASCs' physician owners would seek to branch out into a related line of business (anesthesia services) with a minimum of risk and investment to the extent the ASCs' physicians would provide all of the referrals to the Subsidiaries but little of the blood, sweat and tears to operate the Subsidiaries' business. The Requestor, an otherwise competitor to the Subsidiaries and able to provide and bill for anesthesia services in its own right, would effectively operate and manage the anesthesia services business of the Subsidiaries. In this way, the Requestor would enable the ASCs' physician owners to share in the profits of the anesthesia business, which would otherwise inure solely to the benefit of the Requestor as is the case under the present arrangement.

In summary, because the OIG believed proposed arrangement "B" could potentially generate prohibited remuneration under the AKS, it would not endorse this arrangement.

CONCLUSION
This AO is entirely consistent with previous advisory opinions and essentially restates certain established OIG principles:

1. An arrangement involving a federal health care program "carve-out" does not necessarily immunize such an arrangement from scrutiny; remuneration paid to a referral source - even remuneration not directly implicating federal health care program business - still may be viewed as indirectly rewarding federal health care program referrals.

2. Arrangements resembling the contractual joint venture model described above may be viewed as suspect under the AKS.

If you have any questions or would like additional information about this topic, please contact:

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