You Have Enough Problems. Why Buy Compliance Risk?

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In his 1796 farewell address, president George Washington warned about the danger of foreign entanglements.

In this article, I warn about an analogous issue: The danger of taking on, *or of actually buying*, the entanglements of federal Anti-Kickback Statute compliance risk. In particular, we'll address entanglements inherent in physician-to-physician dealings when either recruiting physicians to your facility, or in investing in facilities, such as in physician-owned hospitals or ASCs.

Background

It's no secret that the hospital business, whether for-profit or nonprofit, is becoming tougher each year.

Hospitals located in large urban areas face competition from their competitors in the market. Hospitals in rural areas face climbing costs that outstrip reimbursement.

And all hospitals, in whatever setting, face the new reality that any case that can be performed on an outpatient basis will, today, or in the very near future, be performed in a freestanding ambulatory surgery center and not on an inpatient basis or even on an outpatient basis in a hospital outpatient department.

As technology advances and as the safety of procedures in the ASC setting increases, more and more procedures are being added to Medicare's list of approved outpatient surgery center procedures. Because many, if not all, private payers follow Medicare's lead on this, private payers, too, are pushing procedures out to ASCs because reimbursement is much lower and because outcomes are much greater: less chance of infection, more efficiency and happier patients paying lower copays and having much better patient care experiences.

Among the strategies that hospitals are engaging in to counter these threats are the aggressive recruitment of "star" physicians/medical groups with significant referral and patient bases [addressing the issue of competition by other hospitals], and the pursuit of investments in either existing, or planned, physician-owned ASCs [an "if you can't beat them, join them" strategy] to at least share in what would otherwise be business lost to the hospital.

Although the universe of compliance issues in connection with either strategy is broad and expanding, this article focuses on the need for hospitals to avoid Anti-Kickback Statute (AKS) liability as a result of physician-to-physician dealings that are essentially self-created when recruiting physicians under the first strategy, or purchased (for real, hard cash) when buying an interest in physician owned or co-owned facility, whether a physician-owned hospital or an ASC.

We'll use two real-life situations as avatars for your avoidance.

Creating Kickback Situations When Recruiting Physicians

Consider the following set of facts. Prior to the 2010 recruiting efforts that led to the creation of the compliance issue, an anesthesia group held the exclusive contract to provide all anesthesia services at a hospital that we'll refer to using the fictitious name "St. Marks."

In late 2010, a psychiatry group with a practice centering on performing ECT procedures relocated to St. Marks. "Dr. X," board-certified in both psychiatry and anesthesiology, was one of the owners of the psychiatry group.

In 2011, the anesthesia group began negotiating with St. Marks for the renewal of its exclusive contract. St. Marks demanded an initial carve out from the scope of the exclusive contract: Dr. X would be allowed to independently provide anesthesia services to ECT patients.

The following year, when negotiating the 2012 renewal, St. Marks demanded amendments to the carve-out provision. Among the expanded carve-outs, Dr. X would be allowed to provide anesthesia services to ECT patients, and the anesthesia group would be required to provide coverage for Dr. X.

And, pursuant to what was called the "Additional Anesthesiologist Provision," the psychiatry group would determine if an additional anesthesiologist was needed for ECT anesthesia. If so, the anesthesia group would negotiate with the psychiatry group to provide those services. If the anesthesia group and the psychiatry group did not agree on terms, the psychiatry group or Dr. X could contract with an additional anesthesiologist.

Subsequently, the psychiatry group informed the anesthesia group that an additional anesthesiologist was needed. The parties began negotiating and arrived at a proposed contractual arrangement under which the anesthesia group would provide the additional ECT anesthesia services. The anesthesia group would reassign to the psychiatry group its right to bill and collect for the services. The psychiatry group would pay the anesthesia group a per diem rate. The psychiatry group would retain the difference between the amount collected and the per diem rate.

Before finalizing the deal, the anesthesia group presented the proposed arrangement to the Office of Inspector General of the U.S. Department of Health and Human Services (OIG) for an advisory opinion, which resulted in the issuance of Advisory Opinion 13-15. [*Author's Note*: I represented the anesthesia group in its request for Advisory Opinion 13-15.]

The OIG's Analysis

The OIG has stated on numerous occasions that the opportunity to generate a fee could constitute illegal remuneration under the AKS *even if no payment is made for a referral*. Under the proposed arrangement, the psychiatry group would have the opportunity to generate a fee equal to the difference between the amount it would bill and collect and the per diem rate paid to the anesthesiologists.

The OIG found that the proposed arrangement would not qualify for protection under the AKS's safe harbor for personal services and management contracts. Those safe harbors protect only payments made by a principal (here, the psychiatry group) *to* an agent (here, the anesthesia group). *No safe harbor would protect the remuneration the anesthesia group would provide to the psychiatry group by way of the discount between the per diem rate their group would receive and the amount that the psychiatry group would collect.*

Because failure to comply with a safe harbor does not necessarily render an arrangement illegal, the OIG analyzed whether, given the facts, the proposed arrangement would pose no more than a minimal risk under the AKS.

The OIG flatly stated that "the proposed arrangement appears to be designed to permit the psychiatry group to do indirectly what it cannot do directly; that is, to receive compensation, in the form of a portion of the anesthesia group's revenues, in return for the psychiatry group's referrals of patients to the anesthesia group for anesthesia services."

The OIG concluded that the proposed arrangement could potentially generate prohibited remuneration under the AKS and that the OIG could impose administrative sanctions in connection with the proposed arrangement. In other words, the OIG declined to approve the arrangement.

Potential Impact on Your Hospital

Although it might appear that the fact situation and the OIG's analysis

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presented previously implicate only the psychiatry group and the anesthesia group, had they entered into the proposed transaction, a hospital in the position of St. Marks could easily be seen to have *conspired* with the psychiatry group to permit it to obtain remuneration in violation of the AKS.

But there are other dangers as well for a hospital in this seemingly physician-to-physician situation: Although not officially within the scope of the opinion, the OIG also stated in Advisory Opinion 13-15 that it could not exclude the possibility that (i) the hospital pushed for the carve out to reward the psychiatry group for its referrals of patients to the hospital and that, (ii) the hospital leveraged its control over anesthesia referrals to induce the anesthesia group to agree to the carve out.

In other words, the OIG points out that there are significant stand-alone AKS compliance issues for a hospital in the position of St. Marks.

Note well that there's nothing in Advisory Opinion 13-15 that limits its warnings to dealings in connection with the recruitment of ECT performing psychiatry groups and the impact on anesthesia groups.

The warning applies to any situation in which a hospital enters into an arrangement under which it can be seen as rewarding a physician or medical group with contract rights (or freedom from existing contract rights in favor of a third party) in return for referrals.

Buying Kickback Situations When Acquiring Interests in Physician-Owned Facilities

Tenet Healthcare Corporation's quarterly report for the period ended September 30, 2019, indicates that it's in the process of settling a whistleblower suit involving, among other serious allegations, that it participated in a so-called "company model of anesthesia services" scheme. That's an arrangement in which, roughly speaking, the surgeons working at a facility, usually owners of the facility, and perhaps the facility itself, own the entity providing anesthesia services.

The cost of the potential settlement? Tenet's 10-Q filing states that it's $66 million with another $2 million reserved for the relator's attorneys' fees and other costs. A review of court's docket in the case, discussed below, indicates that no settlement has been finalized. As of this writing, the court has granted a lengthy stay, presumably for the parties to come to terms.

The lawsuit, entitled *U.S. ex rel. Wayne Allison, etc., et al. v. Southwest Orthopaedic Specialists, PLLC, et al.*, centers around numerous Oklahoma orthopedic surgeons, their practice, Southwest Orthopaedic Specialists (SOS), and the surgical hospital they created, Oklahoma Center for Orthopaedic and Multispecialty Surgery (OCOM) with United Surgical Partners, Inc. (USPI).

Among other things, the lawsuit alleges that SOS and other defendants, including USPI, entered into an anesthesia company scheme under which they formed and operated an entity called Anesthesia Partners of Oklahoma, LLC, to which OCOM granted the exclusive anesthesia contract. The complaint alleges that, as a result, anesthesia company profits were distributed to those owners in a manner directly related to the volume and value of referrals by the SOS surgeons. Subsequent to the commencement of the alleged illegalities, Tenet Healthcare acquired majority ownership of USPI and was thus drawn into the fray. Stated differently, it appears as if Tenet essentially *bought* the problem when it acquired USPI, the co-owner of OCOM.

Although it must be stressed that Tenet is in the process of settling the case, certainly without any admission of liability, $66 million is no small chunk of change.

A similar amount could destroy many facilities, including many already fragile community hospitals.

Takeaways for You

1. Hospital executives often wonder, after the fact, of course, why their attorneys didn't sound the alarm prior to the hospital entering into a non-compliant deal. Or, even worse, after someone points out the compliance issues inherent in the situation, why counsel didn't tell them to unwind the deal.

Unfortunately, it's often the case, even in today's supercharged compliance sensitive world, that regular hospital counsel are disposed to say "yes" rather than risk souring the client relationship. And, once they bless the structure, they suffer not only from conformity bias when presented with valid arguments challenging the deal as illegal (e.g., "we told them the structure was OK, *so it is OK*"), they also suffer from fear of losing the client or, even worse, of malpractice liability (e.g., "we told them the structure was OK, *so it has to be OK and we're never going to agree that it's not*").

Just as the first thing to do when you find yourself in a hole is to stop digging, the first thing to do when considering a fact situation that presents significant compliance concern is to bring in special counsel not dependent on saying "yes" to retain your business. In like manner, if a third party points out a potential problem with an already existing arrangement, it only makes sense to bring in different counsel to advise you on the situation, not

the firm that structured the arrangement in the first place.

2. Even if your hospital or health system doesn't profit from a questionable deal between physicians, permitting it to occur within your facility (e.g., giving a carveout from an exclusive contract, or even granting an exclusive contract) can pull you into the mess.

For example, granting a gastroenterology group the right to bring its captive anesthesia providers into your facility can be seen as conspiring with the gastroenterologists to violate the AKS as to the inherent discount in the relationship between the anesthesia providers and the gastroenterologist owners. Separately, the arrangement itself can be interpreted as a kickback from the hospital to the gastroenterologists. In addition, if the "favor" for the gastroenterologists is a carve out from an exclusive contract with a third-party anesthesia group, then the contract rights themselves can constitute illegal remuneration in violation of the AKS.

3. Investigate, then investigate some more, before your hospital invests in another facility, especially one that's physician-owned. Due diligence in connection with any proposed transaction must include a deep dive into the relationships *between* providers, which might not be readily apparent, and which might "live" outside the four walls of the facility, in addition to the usual review of relationships between the target facility and the providers.

4. And, last, on a personal level, *personal for you, that is*, note that OCOM's CEO, Michael Kinsey, a USPI employee, and its former CEO, Steve Hendley, also a USPI employee, were personally named as additional defendants in the Oklahoma whistleblower lawsuit. Only time will tell if those USPI "suits" are hung out to dry.

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