Hot Fraud and Abuse Issues for Ambulatory Surgery Centers: An Advanced Interactive Discussion

This webinar is brought to you by the Fraud and Abuse (Fraud) Practice Group.

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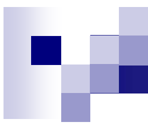
Overview

- How To Redeem Physician Owners, And Under What Terms?
- How To Minimize Legal/Regulatory Risk When All "Safe Harbor" Requirements Are Not Being Followed?
- Structuring Anesthesia Arrangements post-OIG Opinion 12-06
- Billing For Office-based v. ASC Procedures
- Selling "Shares" To New Physician Owners?
- Converting Freestanding ASCs To Hospital-based Facilities



How To Redeem Physician Owners, And Under What Terms?

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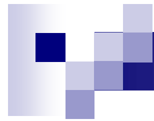
- Breach of the Shareholders/Operating Agreement?
  - failure to comply with safe harbor requirements
  - other terms of agreement,
  - ASC policies/procedures
- Pros & cons of:
  - Redemptions where physicians not fully compliant with safe harbor
  - Other “for cause” buy-outs (based on breaches, etc.)
  - “Without cause” buy-out provisions



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How To Redeem Physician Owners, And Under What Terms? *(cont'd)*

- Uniformity
  - Consistent determinations are key
  - FMV of buyout price
    - adverse or non adverse price
  - Use of formula or other provisions re: buy-out price
  - Reduction in price due to breaches (adverse)
  - Enforcement of non-competes
- Effect of waivers as to non-competes and safe harbors

How To Minimize Legal/Regulatory Risk When All "Safe Harbor" Requirements Are Not Being Followed?

- 1/3 Tests:
  - For all ACSs: at least 1/3 of each physician investor's medical practice income from all sources for the previous 12 month period must be derived from the physician investor's performance of ASC procedures
  - For multi-specialty ASCs: at least 1/3 of the ASC procedures performed by physician investor for the previous 12 month period must be performed at the ASC
- Patients must be informed of physician's ownership
- Terms cannot be conditioned on investor's past or expected volume of referrals

How To Minimize Legal/Regulatory Risk When All "Safe Harbor" Requirements Are Not Being Followed? *(cont'd)*

- If there are exceptions to the 1/3 requirements, explain rationale for any deviation, and be as uniform as possible
- Multi-specialty ASCs vs. single specialty ASCs
  - Can 2nd 1/3 requirement be imposed if not required?
- Inability of physicians in certain specialties to meet certain 1/3 tests (i.e., urology)

How To Minimize Legal/Regulatory Risk When All “Safe Harbor” Requirements Are Not Being Followed? *(cont’d)*

- Apply consistently, provide chances to cure, discuss use ultimately of non-adverse price – effect on price?
- Benefits of attestations/audits and consider indirect referrals
- On termination, make sure it is for non-compliance, not for non-referral of cases
- If not terminating, make sure board has reasoned discussion as to why not terminating

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Structuring Anesthesia Arrangements post-OIG Opinion 12-06

- OIG Opinion 12-06 issued May 25, 2012
- Requestor was a physician-owned anesthesia group providing services on exclusive basis to physician-owned ASCs
- Proposed 2 separate arrangements

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Arrangement A

- Requestor would pay ASCs FMV per-patient fees, excluding Medicare patients, for "Management Services"
- OIG found that carving out Medicare patients may violate AKS by disguising remuneration for Fed healthcare program business through payment of $ purportedly related to non-Fed healthcare program business
  - Payments for management services may induce referrals to anesthesiology group of Fed insured patients
- Also, ASC paid twice for same service since expenses for management services are included in facility fee, and those fees could unduly influence ASC to select anesthesia group as ASC's exclusive provider of anesthesia services

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Arrangement B

- ASC physician-owners would establish subsidiaries to exclusively provide anesthesia services
- Subsidiaries would engage Requestor as independent contractor to provide services on exclusive basis
- OIG found that remuneration to subsidiaries was not protected by ASC safe harbor because the subsidiaries were distinct entities from the ASC
- Further problematic because designed to permit ASC owners "to do indirectly what they cannot do directly"

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How To Structure Anesthesia Arrangements Now?

- Opinion led to review of many arrangements, slowdown in development of aggressive models, & restructuring of existing models
- Most conservative route? Center and owners don't profit from anesthesia
- Other routes depend on facts and circumstances
  - Employment by ASC/affiliate, JV with anesthesia group, & per diem contract with anesthesia group

How To Structure Anesthesia Arrangements Now? *(cont'd)*

- Anesthesia not generally Stark service, so not outright prohibited
  - Question is whether an agreement from anesthesia provider to pay something or give up profits is in exchange for ability to serve ASC patients
- Risk tolerance?
- Look at State law too!

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Billing For Office-based v. ASC Procedures

Problem: Some specialties prefer doing procedures in office to make more money (higher professional fees)

- Still satisfy safe harbor 1/3 test?
- Payors restricting certain procedures to offices & not paying if performed in ASCs
- Potential AKS issue with prohibiting physicians from doing office-based procedures
- Procedures included in safe harbor tests and potentially in noncompetes
- Impact on best practices, quality, etc.?

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Selling “Shares” To New Physician Owners?

- Cannot offer shares based on volume/value of past or expected referrals
- Discourage financing from Center or other physicians
- Is price FMV terms at time of the sale?
  - Use 3rd party valuation or clear path of judgment with backup by board
  - Avoid statements such as “We want the smallest defensible price”

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Selling "Shares" To New Physician Owners? *(cont'd)*

- Be Consistent – best to use same methodology utilized to value shares previously
- Caution re: inconsistent sales prices
- Discourage installment payments (as per safe harbor) - unless ownership increments are issued as incremental payments are received
- Methodology for selecting new shareholders?
- Classes of Ownership with different rights?

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Converting Freestanding ASCs To Hospital-based Facilities

- Co-Management Model
  - Hospital buys physicians' interest in ASC
  - Site is de-certified as an ASC and becomes part of hospital outpatient department
  - Hospital then enters into a "co-management" agreement with previous physician-owners to maintain their involvement (review recent OIG opinion 12-22)
- Hospital could also buy ASC without a co-management agreement in effect thereafter

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Converting Freestanding ASCs To Hospital-based Facilities *(cont'd)*

- Regulatory Concerns: Provider-Based Rule
  - Medicare requirements for provider-based entities
    - 42 CFR 413.65
  - Operate under same license as main provider
    - 42 CFR 413.65(d)
  - Clearly evidenced clinical integration
  - Report costs appropriately as per the financial integration requirement
    - 42 CFR 413.65(d)(4)

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Converting Freestanding ASCs To Hospital-based Facilities *(cont'd)*

- ID the facility as a hospital entity
  - Hold out to the public as part of the main provider
- Follow location rules (35 miles)
  - 42 CFR 413.65(e)
- Follow general obligations of hospital outpatient departments
  - e.g., comply with all terms of hospital's provider agreement
  - 42 CFR 413.65(g)

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Converting Freestanding ASCs To Hospital-based Facilities *(cont'd)*

- Operational Concerns
  - Involve physicians in the decision-making process
  - Function like a freestanding facility
- Benefits
  - Reimbursement
  - Economies of scale
  - Contracted services with hospital
  - Managed care credentialing/negotiation

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Converting Freestanding ASCs To Hospital-based Facilities *(cont'd)*

- Fraud & Abuse Concerns
  - Is it continued co-management for referrals?
    - Is co-management fee FMV?
  - How long is term?
  - How is $ distributed?
  - Are performance indicators clear & objective and not focused on reduction in care or increase in referrals?

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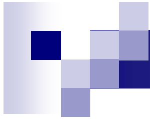
Converting Freestanding ASCs To Hospital-based Facilities *(cont'd)*

- OIG Work Plan for 2013
  - "We will determine the extent to which hospitals acquire ASCs and convert them to hospital outpatient departments. We will also determine the effect of such acquisitions on Medicare payments and beneficiary cost sharing. Medicare reimburses outpatient surgical services performed in hospital outpatient departments at a higher rate than similar services performed in ASCs. Hospitals may be acquiring ASCs and providing outpatient surgical services in that setting."



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Questions

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