Over the past 20 years, discount arrangements between health care providers and suppliers have become an increasing focus of False Claims Act (FCA) cases brought based on violations of the Anti-Kickback Statute (AKS). Beginning with the issuance of a Special Fraud Alert in 1994 (Alert), the Department of Health and Human Services Office of Inspector General (OIG) has warned against certain arrangements, where providers exchange discounts for referrals, as potential violations of the AKS. Subsequent opinions and guidance continue to indicate that these types of arrangements are highly suspect. These discount arrangements, which have come to be called “swapping” arrangements, have resulted in numerous investigations and settlements.

Swapping and the AKS
“Swapping” typically refers to arrangements in which providers and/or suppliers give discounts on Medicare Part A services or items in exchange for referrals of Medicare Part B or Part D business. This type of arrangement could arguably be tempting to providers such as skilled nursing facilities (SNFs) and hospitals because of the different ways that Medicare reimburses for services provided to patients covered by Part A compared with patients covered by Part B and Part D.

Generally, Medicare Part A covers hospitalizations and post-acute care. With respect to SNFs, Part A covers care provided to nursing home residents for the first 100 days of their stay. Medicare provides a fixed per diem rate to the SNF for Part A residents, regardless of the actual cost of caring for the resident. The SNF is then responsible for paying for all services received by the patient, including therapy, tests, medical equipment, room and board, and many other items. SNFs are required to submit annual cost reports, which catalog and total all the costs associated with providing services to Part A patients. The government obtains the benefit of any reduced prices offered to the SNF when the cost reports are used to calculate future Part A reimbursements.

With respect to hospitals, Part A generally provides reimbursement for hospital inpatient services, while Part B provides payment for outpatient services (and Part D covers prescription drugs not covered by Part A). Part A hospital payments are based on prospective payments per patient discharged based on that patient’s diagnosis, the hospital’s characteristics, and various other factors, and are designed to cover the hospital’s costs for treating that patient. The hospital must submit periodic cost reports to reconcile outlier costs and ensure that Medicare is using the proper cost-to-charge ratio to determine reimbursement amounts. If the hospital’s actual costs vary from the prospective payment, the hospital will be credited or debited accordingly. The government obtains the benefit of any reduced prices offered to the hospital when the cost reports are used to determine whether the correct cost-to-charge ratio has been used.

This reimbursement construct is designed at least in part to incentivize the hospital or SNF to negotiate the lowest possible rates for the services provided to Part A patients; indeed, Medicare instructs providers to seek to obtain discounts from their suppliers.

Medicare Parts B and D, in contrast, provide a payment directly to the provider or supplier at the Medicare fee schedule rate. Thus, the concern is that a supplier might offer—or a provider might demand—discounts with respect to Part A business in exchange for a commitment by the provider to use the supplier for items or services reimbursed at fee schedule rates under Part B or Part D.

The OIG has published numerous opinions indicating that such arrangements may run afoul of the AKS. Armed with these opinions, qui tam relators are increasingly filing FCA cases claiming that kickbacks resulted from allegedly illegal swapping schemes. Under the AKS, it is illegal to solicit or receive any remuneration in return for a referral for any item or service that may be paid for under a federal health-care program. The FCA provides liability for any person who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval” to the federal government. If a claim submitted to the government is based on or “tainted” by a violation of the AKS, it may be a false claim under the FCA.

The Part A payment system that motivated swapping arrangements was initiated more than 30 years ago, when Medicare Part A began paying hospitals using global rates for each Part A patient. After a number of years, the OIG responded to the increase in discount/swapping arrangements...
Under this payment system by releasing the 1994 Special Fraud Alert. The Alert declared that such swapping arrangements would be illegal remuneration and would not fall under the statutory discount exception or regulatory safe harbor. In 1997, the “Prospective Payment System” (PPS) was enacted, which provided a fixed per diem rate for all services to skilled nursing patients covered under Medicare Part A. The PPS for skilled nursing facilities and the global per diem rates paid to hospitals set the stage for discount arrangements to become more prevalent, and therefore a more tempting target for qui tam relators and government enforcement. Only a few years later, the OIG issued Advisory Opinion No. 99-2 (99-2 Opinion) regarding swapping arrangements, specifically discussing a prospective arrangement between an ambulance company and an SNF. The ambulance company planned to charge the SNF a discounted rate for all ambulance services covered by Medicare Part A, but would charge Medicare the “usual and customary amount” for services billed directly under Part B (up to 50% more than rates charged for Medicare Part A covered services). The ambulance company represented to the OIG that the discount would be attributable to its cost savings, because the process for billing and collecting for services was much cheaper when billing the SNF as opposed to Medicare. However, the OIG concluded that the “competitive market” would not fully justify the discount, and that the discount exception or safe harbor would not protect the arrangement. The OIG advised that the arrangement “might” violate the AKS if the requisite intent to induce referrals of federally funded business were present.

In response to a request for clarification of the 99-2 Opinion, the OIG expanded upon the 99-2 Opinion in a letter that same year. The letter reiterated that the arrangements proposed in the 99-2 Opinion “fell squarely within the anti-kickback statute” and that the possible incentives were “the very evils that the anti-kickback statute is designed to prevent.” The OIG further explained that it looks for whether the discount makes business sense “standing alone,” confirming its stance that “any direct or indirect link” between the discount and referrals would implicate the AKS. Several more OIG Advisory Opinions followed, echoing the same or similar language. Through these statements, the OIG has established the following four maxims regarding swapping arrangements:

- “Any link or connection, whether explicit or implicit, between the price offered for business paid out of the purchaser’s pocket and referrals of Federal program business billable by the…supplier will implicate the anti-kickback statute.”
- “The size of the discount is not determinative…the appropriate question to ask is whether the discount is tied or linked, directly or indirectly, to referrals of other Federal healthcare program business.”
- Although “any link” may implicate the AKS, in order to determine if there should be an inference of an “improper nexus” between discounts and referrals, the government will “look for indicia that the discounted rate is not commercially reasonable in absence of other, non-discounted business.”

While the AKS contains a specific statutory exception for discounts and a regulatory safe harbor was established, these so-called swapping arrangements are illegal remuneration that do not fall within either because those protections were meant solely for arrangements that benefit Medicare or Medicaid.

In addition to its Advisory Opinions, the OIG has released numerous “voluntary compliance program guidance documents” directed at a variety of sectors of the health care industry. Similar to the Advisory Opinions, these compliance program documents have paid increasing attention to discount/swapping arrangements over the past 15 years. Each of these compliance guides has reinforced the four maxims present in the OIG’s previously published opinions.

Over the past 20 years, discount arrangements between health care providers and suppliers have become an increasing focus of FCA cases brought based on violations of the AKS.

Perils for Practitioners

Although the OIG has released numerous opinions and guidance documents, several important questions remain unanswered. These questions typically result in the most hotly contested issues in any investigation or case.

When is a discount “remuneration” within the meaning of the AKS? "In the context of the Anti-Kickback Statute, courts use ‘fair market value’ as the gauge of value when assessing the remuneration element of the offense.” Because the basis of every swapping case is the “discount” offered by one health care entity to another, the determination as to whether a price reduction constitutes something of value qualifying as "remuneration" under the AKS is a constant point of contention. A discount, however, is simply a comparison between an original price and a new price. Without a benchmark, it is impossible to determine the amount of the discount or
whether that price is providing "something of value" to a provider (and therefore, whether that discount is commercially reasonable and/or whether it deviates from fair market value). The OIG has unsatisfactorily attempted to address this in a number of Advisory Opinions, alternately arguing that cost, fair market value, or the competitive market should provide the starting point for analysis. If cost is the appropriate basis, should fully allocated costs or incremental costs be used? If fair market value is the appropriate measure, how should that be determined, and would this require all health care entities to determine, in advance, the fair market value of each service they provide? If an industry is rife with discounts, how would one determine the appropriate competitive market rate? To add further complications to the analysis, qui tam relators often claim that the Medicare Fee Schedule provides an approximation of fair market value, but this argument is unsupported by any published cases or Advisory Opinions. Given the lack of guidance, it is likely this argument will continue to dominate these cases for years to come.

**How low can you go?**
While the OIG has consistently stated that "any link or connection, whether explicit or implicit, between the price offered for business paid out of the purchaser's pocket and referrals of federal program business billable by the...supplier will implicate the anti-kickback statute," a discount will not raise an inference of improper nexus if it still makes sense standing alone. But there has been no guidance indicating how large a discount could be while still making sense standing alone. And, in any event, if the size of the discount is not determinative, is there any reason why the size should matter? A recent complaint, *United States ex rel. Ruscher v. Omnicare*, alleges discounts of nearly 100% resulting from write-offs and collection failures. Could a discount this large ever make sense "standing alone," as the OIG requires? The issue has not yet been fully litigated.

**How should the discount safe harbor and statutory exception be applied?**
Although the OIG has consistently disagreed with many commenters on this point, at least some discounts on Part A business must be exempted from the AKS or protected by the discount safe harbor. The AKS contains a specific exception for discounts, which provides that the AKS does not apply to "a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program." In addition, a regulatory discount safe harbor was also established, which also protects discounts under a variety of circumstances. The safe harbor, however, has some additional components. Among other things, under the safe harbor, a discount is not protected when the price reduction is "applicable to one payor but not to Medicare, Medicaid or other Federal health care programs." While both the discount exception and safe harbor could potentially apply to swapping arrangements, the OIG has concluded that neither should apply when the discounted rate is not charged directly to Medicare Part B or D or Medicaid. The OIG has repeatedly conflated the statutory discount exception and regulatory safe harbor, interpreting the safe harbor as merely implementing the exception and not providing its own distinct method by which an arrangement may be protected under the AKS.

Courts have demonstrated the difficulty of analyzing the different elements of the AKS discount exception and safe harbor given the OIG's confusing interpretation. For instance, in *United States v. Shaw*, the court addressed a motion to dismiss a criminal charge of conspiracy to violate the AKS. The defendant argued the special pricing he offered fell within the discount exception (but not the safe harbor). As a result, the court was forced to determine whether the discount exception and safe harbor should be interpreted separately or together. The court echoed the published OIG guidance, finding that the exception was created to encourage providers to seek discounts to the benefit of Medicare and Medicaid programs, and that therefore "one essential component of this exception is that the federal or state health program share in and benefit from the reduced cost of the services or goods." However, the court specifically analyzed the discount exception separately from the discount safe harbor, stating that the discount exception should be analyzed "in light of those discounting arrangements that the safe-harbor provisions have explicitly deemed protected from criminal liability" but should "not be limited by the definitions imposed by the safe-harbor provisions."

Conversely, in *United States ex rel. Jamison v. McKesson*, the court analyzed the transactions under the discount safe harbor,
but conflated the safe harbor with the discount exception. In *McKesson*, the government alleged an illegal swapping arrangement providing remuneration in two separate transactions. In *Shaw*, the court in *McKesson* analyzed the discount exception and safe harbor as if they were part of the same rule. It then dismissed the statutory discount exception with little reasoning, and found that the discount safe harbor would not apply because the discount at hand was not applicable to Medicare, Medicaid, or other federal health care programs.

Just last year, the OIG did give guidance as to when the discount safe harbor may apply, but still did not differentiate between the safe harbor and statutory exception. In Advisory Opinion 13-07 (13-07 Opinion), the OIG stated that where rebates were given based on total annual purchases regardless of whether the items were covered by federal health programs, the discount safe harbor may apply. Unlike a bundle discount where a discount on one product may be contingent on the purchase of another, a tiered rebate providing a discount to a set number of purchases of any product would not make a distinction between products, and the discounted percentage would be accurately attributable to each individual product. This difference was significant to the OIG, and it determined that the proposed rebate would meet the definition of “discount” and “rebate” under the safe harbor. However, the OIG continued to ignore any separation between the discount safe harbor and statutory exception. The question still remains as to whether the broader statutory discount exception could actually protect arrangements even where the safe harbor may not.

**Case Law**

There are very few unsealed cases dealing with these issues, and an even smaller number of published opinions. Although pending cases and settlements typically do not contribute anything to the legal precedent on a particular issue, they provide a window into the types of cases that are being filed and/or intervened in. While the OIG’s guidance advocates a distaste for swapping arrangements, the federal government has declined to intervene in many of these cases, suggesting that while the stated government guidance supports enforcement of the AKS against swapping arrangements, relators are leading the movement.

For instance, in the non-intervened qui tam action *United States ex rel. McDonough v. Symphony Diagnostics* filed in 2008, the Relator alleged Medicare fraud through swapping arrangements. The Relator alleged that the defendant offered discounts to SNFs for x-ray services covered by Medicare Part A, in exchange for patient referrals for the SNFs’ other Medicare and/or Medicaid business. The court denied the defendant’s motion to dismiss and found that it was plausible that the alleged swapping arrangement may violate the AKS. As of the date of publication of this article, *McDonough* is still pending.

One of the earliest published cases dealing with a swapping arrangement, *Klaczak v. Consolidated Medical Transport*, was a qui tam action alleging violations of the AKS by several nonprofit hospitals, among others. The Relators claimed that the hospitals knowingly received illegal remuneration in the form of discounts on ambulance transports covered by Medicare Part A in exchange for referrals for transports covered by Medicare Part B. The government declined to intervene in the Relators’ case against the nonprofit hospitals. Finding the AKS was violated but did not actually law.

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Although it was never unsealed, a 2009 case was recently settled by Rural/Metro, a company that acquired the defendant entity in 2011. Rural/Metro’s motion in a bankruptcy action to approve the settlement specifically stated that the Relator alleged improper swapping arrangements with SNFs. The next year, at least two other swapping cases were filed, *United States ex rel. Gale v. Omnicare and United States ex rel. Pasqua v. Kan-Di-Ki, LLC*. In *Gale*, the government declined to intervene; in *Pasqua*, the federal government declined to intervene, but the state of California did intervene. The unsealed complaints in both these settled cases allege swapping arrangements as violating the AKS. In 2011, another case alleging an illegal swapping scheme was filed against Omnicare. The federal government declined to intervene and the case is still pending.

A third case currently pending against Omnicare, discussed briefly above, is *United States ex rel. Ruscher v. Omnicare*, which addresses an arrangement in which Omnicare allegedly forgave debt for its biggest customers on products covered by Part A in exchange for those customers’ Part D business. Thus, the defendants did not allegedly provide “discounts” on Part A services, but they allegedly provided free Part A services in order to induce referrals of Part D business. The federal government declined to intervene in this action, but the relator continues to pursue it. Motions to dismiss are currently pending, and the court’s rulings may provide much-needed legal precedent for future cases involving analogous swapping arrangements.

These cases are likely just the tip of the iceberg. Relators have shown increasing interest in swapping cases, often...
Analysis

Courts have demonstrated the difficulty of analyzing the different elements of the AKS discount exception and safe harbor given the OIG’s confusing interpretation.

continuing to litigate even when the government declines to intervene. In a further indicator of the prevalence of these actions, the OIG has noted that the “absence of publicized litigation should not be construed as an absence of enforcement activity” in this area. Because of the whistleblower protections and the extra time given to the government to investigate qui tam cases prior to unsealing, many cases remain sealed for years, or are settled without ever being unsealed. In addition, two senators recently sent letters to five healthcare companies inquiring about possible “pull-through” discount arrangements, which are generally similar to swapping arrangements. These letters indicate that the federal investigation of these types of arrangements is likely increasing. Whether by eager relators or the federal government, there are no signs that this increase in enforcement activities related to discount arrangements is slowing or will do so in the future.

Tension between Encouraging Discounts and Targeting Swapping Arrangements

As reflected in the Klauczak court’s analysis, there is a clear tension between the increasing prevalence of swapping cases and the government’s purported encouragement of discounts. And it is clear that the government intended to encourage health care providers to seek discounts. First, the legislative history of the AKS indicates that discounting was intended to be exempted from the AKS entirely. Second, Medicare has specifically instructed providers to be “prudent buyers” by seeking to economize by minimizing costs and refusing to pay more than the going price for a product or service. Medicare providers are “expected” to seek “advantages” such as discounts. Third, the enactment of the statutory discount exception and regulatory safe harbor reflect the importance the federal government has placed on health care providers seeking discounts. The OIG indicated that the safe harbor was “designed to permit individuals and entities to freely engage in business practices and arrangements that encourage competition, innovation and economy.”

Recognizing that its guidance condemning swapping arrangements and its stated encouragement of discounts are in apparent conflict, the OIG has attempted to distinguish one from the other by claiming that the discount protections are only “intended to encourage price competition that benefits Medicare and Medicaid programs.” Courts have reflected this sentiment as well. For example, in United States v. Shaw, the court stated that the discount exception “reflects a predictive understanding that competitive pricing schemes within the healthcare field will lower the cost of healthcare services and goods” while acknowledging that an “essential component” of the exception was that government programs “share in and benefit from the reduced cost of services or goods.” This claim, however, ignores the fact that the government clearly benefits from the Part A discounts that form the basis for nearly every allegedly improper swapping arrangement. In fact, the government arguably stands to benefit from all discounts obtained by Part A providers.

With respect to hospitals, the hospital’s annual costs of providing items and services covered under Part A are reflected in the hospital’s cost reports. To the extent the hospital’s costs are lower, the amount that the hospital is paid through the cost report will be less. Thus, there is a direct relationship between the amount that Medicare pays to the hospital and the amount that the hospital claims as costs, and as costs go down, so do Medicare Part A payments.

With respect to SNFs, although Medicare Part A payments come in the form of per diem rates, those rates are not drawn from thin air. The per diem rates for skilled nursing stays are calculated based on a number of factors, including the “market basket index.” The market basket index is “a measure of the national average price level for the goods and services,” and is directly based on annual cost reports submitted by Part A service providers such as SNFs. SNFs also are required to submit an annual cost report, which ensures that future per diem rates are proper for the actual costs for services provided to Part A patients. Although the PPS rates are expected to cover all Part A related services, the provider reports the costs for Part A patients to provide Medicare with the data necessary to calculate future increases or decreases in the per diem rates, not to increase or decrease their reimbursement for any individual patient. Thus, when an SNF receives a discount on services covered by Part A, those reduced costs are considered in calculating future Part A payments. Over time, the per diem rate will be adjusted to reflect discounts that SNFs receive on Part A care. In fact, Part A per diem rates would decrease over time as more discounts were provided to SNFs, and the overall per-patient costs for the Part A program would go down. This government benefit is exactly what the statutory discount exception and regulatory safe harbor were meant to encourage.

But the system is not working the way that it should, due to the increasing frequency with which swapping arrangements are coming under fire. Instead of motivating providers to seek out discounts on services provided to Part A patients, the OIG’s guidance in this area tells providers that they would be safer not to accept any discounts on services for Part A patients, lest the government or an enthusiastic relator second-guess the arrange-
ment and find it to be an illegal swap. Increased attention to this matter from the relators’ bar has a similar effect. As a result, Part A services are less frequently discounted, and the government does not obtain the benefit of the lower rates in determining future reimbursements. Faced with these facts, even those former OIG employees who were instrumental in drafting the OIG opinions that first drew attention to the “swapping” trend in the 1990s have identified ways in which the government and relators have applied the rule to situations to which it was not originally intended to apply. The increase in qui tam cases involving swapping arrangements, and the OIG’s refusal to update and clarify important questions relating to swapping under the AKS, is likely only to lead to increased Medicare costs, and is discouraging the very thing that legislators intended to encourage when excluding discounts from the original list of prohibited kickbacks.

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Endnotes


5. Provider Reimbursement Manual Part I, Centers for Medicare and Medicaid Services, ch. 21, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html?DLPage=1&DLSort=0&DLSortDir=ascending (last visited Jan. 15, 2014) (“A prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost.”).

6. See Id.


14. Id.

15. Id.

16. Id.

17. Id.


19. Id.

20. Id.

Analysis

25 42 U.S.C. § 1320a-7(b)(3)(A) (stating that “a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program.”); 42 C.F.R. § 1001.952(h)(5)(iii); OIG Advisory Opinion No. 99-2 (Mar. 04, 1999), available at https://oig.hhs.gov/fraud/docs/advisoryopinions/1999/a099_2.htm.
28 OIG Advisory Opinion No. 12-09 (July 30, 2012), available at https://oig.hhs.gov/fraud/docs/advisoryopinions/2012/AdvOpn12-09.pdf (discussing that the proposed transactions could implicate the AKS, but did not give rise to an inference of an “improper nexus” between the discounted business and referrals for federally reimbursable business because the prices were FMV and above the provider’s costs); OIG Advisory Opinion No. 99-2 (Mar. 04, 1999), available at https://oig.hhs.gov/fraud/docs/advisoryopinions/1999/a099_2.htm (analyzing whether the “competitive market” justified the discount).
31 42 C.F.R. § 1001.952(h).
32 42 C.F.R. § 1001.952(h)(5)(iii).
36 Id.
37 Id. at 115.
38 Id. at 113.
40 Id. at 411.
42 Id. at 625, 633.
43 Id. at 627.
44 Id. at 633.