On April 10, the OIG released an advisory opinion (Opinion) finding that a proposed management fee calculated on a per patient, per day basis might “simply cloak a success fee,” potentially making the parties subject to administrative sanctions for violating the federal Anti-kickback Statute if the requisite intent existed.¹

Under the proposed arrangement (Proposed Arrangement), a company (Company) would develop and manage distinct-part inpatient rehabilitation units located within acute care hospitals in exchange for a management fee. The OIG found that, despite some safeguards, the risk of overutilization, unnecessarily lengthy stays and other incentives for physicians, nurses and hospitals created by the management fee was not sufficiently low to grant protection to the parties prospectively.

Impact on Health Care Entities

With this Opinion, the OIG reinforces its general disfavor of “per patient-,” “per click-” and “per order-” type arrangements. In the Opinion, the OIG does not specify any safeguards that would limit anti-kickback risk. Rather, the OIG provides a laundry list of ways the Proposed Arrangement poses risk—e.g., the compensation structure encourages overutilization, medical directors and nurses have an incentive to overutilize and increase lengths of stay, and the management company engages in marketing. Entities considering or engaged in management arrangements that involve “per patient-” type fees in hospital or other contexts should consult counsel to determine the nature or the risks posed by the arrangements under this new Opinion.

The Management Fee and Arrangement

Under the Proposed Arrangement, Company, in exchange for a management fee, would enter three-year management agreements with hospitals to develop and operate distinct-part inpatient rehabilitation units. The management fee would be calculated by multiplying a pre-established fixed amount per patient, per day by the aggregate number of patient days for all patients receiving care as inpatients in the given rehabilitation unit during each month. Company certified that the fee would be consistent with fair market value.²

In return for this fee, Company would provide all patient care personnel except for nurses (whom the hospitals would provide) and provide a leadership team consisting of a program director, a community outreach coordinator and a medical director. Company would hire a hospital staff physician to serve as the medical director on an independent contracting basis. Company certified that the written medical directorship

¹ With this Opinion, the OIG reinforces its general disfavor of “per patient-,” “per click-” and “per order-” type arrangements.

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agreement would meet all requirements of the applicable personal services safe harbor/exception under the federal anti-kickback and physician self-referral laws, and that remuneration would be consistent with fair market value in arms'-length transactions.

Under the Proposed Arrangement, the medical director might have a private medical practice and might refer patients to the rehabilitation unit at the given hospital. Likewise, members of the management team would interact (e.g., on a one-on-one basis, in group educational seminars for medical personnel and through distribution of brochures and literature) with persons who might have the ability to make or influence referrals to hospital rehabilitation units. Company would not, however, directly solicit Medicare or Medicaid beneficiaries or other patients in person or by telephone or mail.

Medicare and Medicaid Reimbursement

Medicare and Medicaid reimburse for inpatient rehabilitation services. Medicare instituted a prospective payment system (PPS) for rehabilitation hospitals/units effective for cost reporting periods beginning on or after January 1, 2002 (with transition provisions) if, among other things, the facility serves an inpatient population at least 75 percent of whom require intensive rehabilitation services for one or more of 10 specified conditions, and the facility has in place a pre-admission screening procedure to determine if a patient is likely to benefit significantly from the rehabilitation services. Most state Medicaid programs also pay for rehabilitation services under a prospective payment system or under programs that negotiate payment levels with individual providers. Company estimates that approximately 70 percent of the patients it serves would be Medicare beneficiaries, and less than 5 percent would be Medicaid recipients.

The Law

The Anti-kickback Statute prohibits persons or entities from knowingly and willfully offering, paying, soliciting or receiving any remuneration to induce or reward referrals of items or services payable by a federal health care program. Safe harbors protect activities that are deemed not likely to result in fraud and abuse. Failure to comply fully with a safe harbor is not necessarily an anti-kickback violation; intent must exist and arrangements are scrutinized on a case-by-case basis.

The personal services and management contracts safe harbor protects certain arrangements if, among other things, the aggregate compensation is set in advance, consistent with fair market value in an arms'-length transaction and not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made by a federal health care program.

In addition, “per patient-,” “per click-” and “per order-” type arrangements are generally disfavored under the Anti-kickback Statute because they may promote both overutilization and unnecessarily lengthy stays in violation of the statute.

OIG's Analysis

Here, the OIG found that the arrangement fell outside of the personal services and management contracts safe harbor because the aggregate compensation could not be determined in advance. The OIG therefore scrutinized the Proposed Arrangement and found that the risk of fraud and abuse precluded a prospective determination that administrative sanctions were inappropriate because:

- The per patient, per day fee could “simply cloak a success fee.”
- While Medicare PPS would offset the risk of excessively lengthy stays, it
would not offset the risk of overutilization, as both Company and the hospitals have an incentive to fill beds.

- Medical directors would be in a position to generate patients for the rehabilitation units.
- Nurses performing pre-admission screenings would not be Company employees, but would still have an interest in making the rehabilitation units a success (e.g., through filling beds).
- Under Medicare PPS requirements, 25 percent of the patients could have an array of conditions not specified in the law, and Company and the hospitals would have an undetermined amount of discretion in defining the other 75 percent of the patients who could meet the conditions specified in the law, creating the potential for overutilization.
- Company would be performing community outreach, including marketing.

The OIG concluded that sufficient safeguards did not exist to counteract the incentives created by the per patient, per fee day. The OIG found that the Proposed Arrangement could potentially violate the Anti-kickback Statute, but did not reach a definitive conclusion absent a finding of intent, which is beyond the scope of the advisory opinion process.

**Conclusion**

Because of the risk under the Proposed Arrangement that a per patient, per day fee could potentially “cloak a success fee” and create other incentives antithetical to fraud and abuse law, the OIG did not approve of the proposed management fee and arrangement here.

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**Endnotes**


2. Hospitals and physicians would bill for their respective services performed in the rehabilitation units.

3. See SSA 1886(j); 42 CFR 412.23. The 10 conditions include stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, polyarthritis, and neurological disorders and burns.
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If you have any questions about this Client Alert, please contact any of the following attorneys.

**Boston**
David A. Gordon  
617-663-5700

**Los Angeles**
Daniel K. Settelmayer  
213-485-1234

**Paris**
Jean-Christophe Tristant  
+33 1 40 62 20 00

**Brussels**
John P. Lynch  
+32 (0)2 788 60 00

**San Diego**
Katherine A. Lauer  
619-236-1234

**Chicago**
James A. Cherney  
312-876-7700

**San Francisco**
Jerry Peters  
415-391-0600

**Frankfurt/Hamburg**
Ulrich Börger  
+49-40-41 40 30

**Silicon Valley**
Alan C. Mendelson  
650-328-4600

**Hong Kong**
Mitchell D. Stocks  
+852-2522-7886

**Singapore**
Mark A. Nelson  
+65-6536-1161

**London**
David Miles  
+44-20-7710-1000

**Tokyo**
David L. Shapiro  
+81-3-6212-7800

**Washington, D.C.**
Stuart S. Kurlander  
202-637-2200