



[We redact certain identifying information and certain potentially privileged, confidential, or proprietary information associated with the individual or entity, unless otherwise approved by the requestor.]

Issued: December 20, 2010

Posted: December 28, 2010

[Name and address redacted]

Re: OIG Advisory Opinion No. 10-26

Dear [Name redacted]:

We are writing in response to your request for an advisory opinion regarding your proposed payment plans for emergency and non-emergency transportation services provided for Medicaid-covered residents of skilled nursing facilities (the "Proposed Arrangement"). Specifically, you have inquired whether the Proposed Arrangement would constitute grounds for the imposition of sanctions under the exclusion authority at section 1128(b)(7) of the Social Security Act (the "Act"), or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, the Federal anti-kickback statute.

You have certified that all of the information provided in your request, including all supplemental submissions, is true and correct and constitutes a complete description of the relevant facts and agreements among the parties.

In issuing this opinion, we have relied solely on the facts and information presented to us. We have not undertaken an independent investigation of such information. This opinion is limited to the facts presented. If material facts have not been disclosed or have been misrepresented, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute and that the Office of Inspector

General (“OIG”) could potentially impose administrative sanctions on [name redacted] under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement. Any definitive conclusion regarding the existence of an anti-kickback violation requires a determination of the parties’ intent, which determination is beyond the scope of the advisory opinion process.

This opinion may not be relied on by any persons other than [name redacted], the requestor of this opinion, and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

[Name redacted] (the “Requestor”) is a nonprofit, Medicare and [State redacted] Medicaid certified ambulance supplier headquartered in [location redacted]. The Requestor provides emergency and non-emergency transportation services, which include services for Medicaid-covered residents of skilled nursing facilities (“SNFs”) (“Medicaid Transport Services”).

According to the Requestor, the [State redacted] Medicaid program pays nursing facilities a per resident per day rate for ancillary and support costs, as defined by [citation redacted]. Recent state legislation modified the definition of ancillary and support costs to include, among other things, Medicaid Transport Services. See [citation redacted]. In the past, the [State agency redacted] made separate payments for Medicaid Transport Services directly to ambulance suppliers based on a set fee schedule. By operation of the new state law, payment for Medicaid Transport Services to ambulance suppliers must now be paid by the SNFs, as those services are included in the per resident per day rate paid by the [State redacted] Medicaid program for ancillary and support costs. Payments for Medicaid Transport Services are subject to negotiation between the suppliers and the SNFs. In addition, for residents of SNFs who are covered by both Medicare and Medicaid (“Dually Covered Residents”), the SNF is now responsible for paying the Medicare allowable amount that is not covered by Medicare and would otherwise be covered by Medicaid as the secondary payer (e.g., copayment, deductible).

The Requestor seeks to offer SNFs two types of payment plans for its Medicaid Transport Services.

Payment Plan 1: The Requestor would offer the SNFs a capitated rate per resident day for Medicaid Transport Services. This per resident rate would be based on Medicaid resident days, regardless of whether the Medicaid Transport Services are needed for the resident. The capitation amount would pay for the SNF’s liability for

all Medicaid Transport Services, regardless of whether Medicaid is exclusively responsible for payment. In the case of a Dually Covered Resident, the Requestor would continue to bill Medicare as the primary payer, and the capitated rate payment would discharge the SNF's responsibility for the Medicaid-covered copayment and deductible. If all the patients covered by this arrangement were Medicaid-only, then the capitation amount would be less than the Requestor's total costs of the providing the services. However, because some of the residents would be Dually Covered Residents, the capitation amount plus revenues from the Medicare payment for Dually Covered Residents would be greater than the total costs of providing the services.

- **Payment Plan 2:** The Requestor would offer the SNFs a contract under which the SNFs would pay on a fee-for-service basis for any Medicaid Transport Services ordered for their Medicaid-only residents. Fee-for-service amounts would be set at below-cost rates for providing the services. These rates would not apply to transports for Dually Covered Residents. For those transports, the Requestor would bill Medicare as the primary payor, and the SNF would be responsible for the copayment and deductible based on the Medicare allowable amount.

In addition to Medicaid-only residents and Dually Covered Residents, the SNFs to which the Requestor seeks to offer the aforementioned payment plans would also typically have patients who require ambulance services that are reimbursed to the ambulance supplier under Medicare Part B or by other payers. The Requestor has indicated that under Payment Plan 1, in particular, the SNFs would be likely to refer such business to the Requestor.

II. LEGAL ANALYSIS

A. Law

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Greber, 760 F.2d 68

(3d Cir. 1985), cert. denied, 474 U.S. 988 (1985). Violation of the statute constitutes a felony punishable by a maximum fine of \$25,000, imprisonment up to five years, or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. Where a party commits an act described in section 1128B(b) of the Act, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party under section 1128A(a)(7) of the Act. The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.

B. Analysis

As we stated in the 2003 Compliance Program Guidance (“CPG”) for Ambulance Suppliers, “[a]ny 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 ambulance supplier will implicate the anti-kickback statute.” 68 Fed. Reg. 14245, 14252 (March 24, 2003). This position was reiterated in 2008 in the OIG’s Supplemental CPG for Nursing Homes, in which we stated, “if any direct or indirect link exists between a price offered by a supplier or provider to a nursing facility for items or services that the nursing facility pays for out-of-pocket and referrals of Federal business for which the supplier or provider can bill a Federal health care program, the anti-kickback statute is implicated.” 73 Fed. Reg. 56832, 56844 (Sept. 30, 2008).

Under Payment Plan 1 in the Proposed Arrangement, the Requestor would charge the SNFs a capitation amount that would be below the Requestor’s total costs of providing Medicaid Transport Services if all residents were Medicaid-only residents. Under Payment Plan 2 in the Proposed Arrangement, the Requestor would charge SNFs flat, below-cost rates for Medicaid Transport Services for Medicaid-only residents. Thus, the circumstances surrounding both plans in the Proposed Arrangement suggest that a nexus may exist between the below-cost payment rates offered to the SNFs for Medicaid Transport Services for Medicaid-only residents and referrals of other Federal health care program business. First, the SNFs are in a position to direct business to the Requestor that is not covered by the Payment Plans under the Proposed Arrangement, i.e., services covered by Medicare Part B or other payers. Second, both parties have obvious motives for agreeing to trade below-cost payment rates for Medicaid Transport Services for Medicaid-only residents for referrals of other Federal health care program business: the SNFs to minimize risk of losses and/or maximize gains under the Medicaid per resident per day rate for ancillary and support costs, and the Requestor to secure business in a highly competitive market.

In evaluating whether an improper nexus exists between the rates offered for services and referrals of Federal business in a particular arrangement, we look for indicia that the rate is not commercially reasonable in the absence of other, non-discounted business. Prices

offered to the SNF that are below the supplier's total costs of providing the services—as in the facts presented here—give rise to an inference that the supplier and the SNF may be "swapping" the below-cost rates on business for which the SNF bears the business risk in exchange for other profitable non-discounted Federal business, from which the supplier can recoup losses incurred on the below-cost business, potentially through overutilization or abusive billing practices.

Based on the facts presented here, we are unable to exclude the possibility that the Requestor may be offering improper discounts to the SNFs for their Medicaid Transport Services business with the intent to induce referrals of more lucrative Federal business. Nor are we able to exclude the possibility that the SNFs may be soliciting improper discounts on business for which they bear risk in exchange for referrals of business for which they bear no risk. Indeed, the Proposed Arrangement poses a substantial risk of such improper "swapping" of business that may run afoul of the anti-kickback statute.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute and that the OIG could potentially impose administrative sanctions on [name redacted] under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement. Any definitive conclusion regarding the existence of an anti-kickback violation requires a determination of the parties' intent, which determination is beyond the scope of the advisory opinion process.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only [name redacted] the requestor of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.
- This advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a requestor of this opinion.
- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is expressed or implied herein with respect to the application of any other Federal, state, or local statute, rule, regulation, ordinance, or other law that may be applicable to the Proposed

Arrangement, including, without limitation, the physician self-referral law, section 1877 of the Act.

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.
- This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those which appear similar in nature or scope.
- No opinion is expressed herein regarding the liability of any party under the False Claims Act or other legal authorities for any improper billing, claims submission, cost reporting, or related conduct.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, to rescind, modify, or terminate this opinion.

Sincerely,

/Lewis Morris/

Lewis Morris
Chief Counsel to the Inspector General