Posted on 4/24/98

[date]

[name and address redacted]

Re: [name redacted]
Advisory Opinion No. 98-5

Dear [name redacted]:

We are writing in response to your request for an advisory opinion, which seeks our opinion regarding the "coordination of benefits" ("COB") provisions of a provider agreement between Nursing Home A (the "Nursing Home") and a health care plan. In particular, your request asks whether the health care plan's method of coordinating insurance benefits (the "Arrangement"), which effectively requires Nursing Home A to forgo certain Medicare cost-sharing amounts, involves prohibited remuneration under the anti-kickback statute, § 1128B(b) of the Social Security Act (the "Act") or would be grounds for sanction under § 1128B(b) of the Act, exclusion under § 1128(b)(7) of the Act [fraud, kickbacks, and other prohibited activities], or civil monetary penalties under § 1128A(a)(7) of the Act [to the extent it relates to kickbacks].

You have certified that all of the information you provided in your request, including all supplementary letters, is true and correct, and constitutes a complete description of the facts and agreements among the parties regarding the Arrangement. In issuing this opinion, we have relied solely on the facts and information you presented to us. This opinion is limited to the facts presented. We have not undertaken any independent investigation of such information.

Based on the information you have provided, we conclude that the Arrangement may involve prohibited remuneration under the anti-kickback statute and may subject the parties to sanction under sections 1128B(b), 1128(b)(7), and 1128A(a)(7) of the Act.

I. FACTUAL BACKGROUND

A. The Parties

Nursing Home A is a State X not-for-profit corporation licensed as a residential health care center by the State X Department of Health. The Nursing Home provides long and short term skilled nursing, subacute, and rehabilitative services to approximately xxx residents. The Nursing Home is a Medicare provider and participates in the Medicare RUGs III Demonstration Project.[1]

Health Plan B (the "Plan") is a State X, not-for-profit corporation licensed as a health maintenance organization under [citation redacted] of the State X Public Health Law. Health Plan B and its affiliated companies offer multiple health care products, including a health maintenance organization (the "HMO"), a point of service plan, a Medicare managed care plan, and customized coverage for self-funded benefit programs.

B. The Arrangement

Since 1985, the Nursing Home has provided short term subacute and rehabilitative services to the Plan's HMO members, including members who are eligible for Medicare Part A and are not enrolled in the Plan's Medicare managed care plan, pursuant to various oral and written agreements. In 1997, the Nursing Home entered into a provider agreement with the Plan that contained a fee schedule for services provided by the Nursing Home to Plan members (the "Plan Fee Schedule") and certain coordination of benefits provisions that (i) release the Plan from any obligation to pay benefits where the Nursing Home has already received payment from the patient's primary insurer in an amount equal to or exceeding the Plan Fee Schedule amount and (ii) require the Nursing Home to hold Plan members harmless from any charges, including copayments and deductibles (the "Coordination of Benefits" or "COB" provisions). Specifically, § 6.2 of the provider agreement provides:

> When Health Care Plan C is a secondary or later plan (not primary plan as defined in [statutory citation redacted], it shall only pay when the Health Plan C allowed amount listed on Schedule B has not been paid to Participating Provider by the primary plan. If the Health Plan C allowed

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[1]The RUGs III Demonstration Project tests a case-mix adjusted payment system pursuant to which a SNF's per diem payment is tied to the intensity of care and services required for each patient. The demonstration involves forty-four Resource Utilization Groups (RUGs).

> amount listed in Schedule B has been paid to Participating Provider by the primary plan, then Participating Provider shall hold the Member harmless from an against any and all charges including charges for copayments and deductibles. For purposes of this Agreement, primary plan may include hospital service corporations, indemnity corporations, commercial carriers, self-insured or self-funded plans and Medicare.[2]

The Nursing Home has asked whether the provider agreement's COB provisions violate the anti-kickback statute when applied to reimbursement for Nursing Home services to Plan members who have primary coverage under Medicare Part A and are not members of the Plan's Medicare managed care plan. These members typically receive Plan coverage as retirees through various employer group health plans purchased from the Plan by their former employers. For purposes of coordinating benefits, the Plan has determined that Medicare is primary payer for these beneficiaries.[3]

II. LEGAL ANALYSIS

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by the Federal health care programs. See § 1128B(b) of the Act. Where remuneration is paid purposefully to induce referrals of items or services for which

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[2]A second provision, § 5.2 of the contract, expressly prohibits direct billing of Plan members: "Participating Provider hereby agrees that in no event . . . shall Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Health Care Plan C Members. . . ."

[3]We assume, for purposes of this advisory opinion, that the provider agreement's COB provisions are enforceable. However, we believe the enforceability of these provisions is questionable. Cf. Pennsylvania Medical Society v. Snider, 29 F.3d 886 (3d Cir. 1994); Rehabilitation Association of Virginia, Inc. v. Kozlowski, 42 F.3d 1444 (4th Cir. 1994); New York City Health and Hospitals v. Perales, 954 F.2d 854 (2d Cir. 1992) (holding that for Qualified Medicare Beneficiaries, states could not limit cost-sharing payments to Medicare Part B providers to ensure that total payments to the providers, including Medicare reimbursement, did not exceed the states' Medicaid reimbursement levels for the same items and services).

payment may be made 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, in cash or in-kind, directly or indirectly, covertly or overtly.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration is 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.), cert. denied, 476 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. This Office may also initiate administrative proceedings to exclude persons from the Federal and State health care programs or to impose civil monetary penalties for fraud, kickbacks, and other prohibited activities under §§ 1128(b)(7) and 1128A(a)(7) of the Act.[4]

A number of statutory and regulatory "safe harbors" protect certain arrangements that might otherwise technically violate the anti-kickback statute from prosecution. See § 1128B(b)(3) of the Act; 42 C.F.R. § 1001.952. The safe harbors for the following payment practices are potentially relevant here: (1) certain price reductions to health plans, 42 C.F.R. § 1001.952(m); (2) certain discounts to purchasers of health care items and services, 42 C.F.R. § 1001.952(h); and (3) certain waivers of beneficiary copayments and deductible amounts for inpatient hospital services, 42 C.F.R. § 1001.952(k). Safe harbor protection is afforded only to those arrangements that precisely meet all of the conditions set forth in the safe harbor. Arrangements that do not fit squarely in a safe harbor are not necessarily illegal and must be evaluated on a case-by-case basis.

A. The Arrangement May Involve Prohibited Remuneration.

As a preliminary matter, many Medicare beneficiaries have additional health insurance coverage that supplements their Medicare coverage, such as retiree health benefits. Generally, if supplemental coverage exists for Medicare beneficiaries, claims for Medicare covered health services for such beneficiaries are first submitted to Medicare (the "primary insurer") and the amounts not paid by Medicare are then submitted to the

[4]Because both the criminal and administrative sanctions related to the anti-kickback implications of the Arrangement are based on violations of the anti-kickback statute, the analysis for purposes of this advisory opinion is the same under all three provisions.

supplemental or "secondary" insurer.[5]

In evaluating the provider agreement's COB provisions, we begin with the applicable reimbursement principles for skilled nursing facilities ("SNFs"). Under Medicare Part A, Medicare pays the full amount of the facility's applicable SNF per diem rate, (in this case, the applicable rate under the RUGs III Demonstration Project), for the first 20 days of a beneficiary's stay; however, for days 21 through 100, the facility's payment from Medicare is reduced by an amount equal to one-eighth of the hospital inpatient deductible.[6] See 42 U.S.C. § 1395e; 42 C.F.R. §409.85. Under the Act and implementing regulations, this cost-sharing amount is a beneficiary obligation. See, e.g., 42 C.F.R. § 409.85; 42 C.F.R. §409.61(b).

The COB provisions contained in the Nursing Home's provider agreement with the Plan, in conjunction with the Plan Fee Schedule, result in a full or partial waiver of this Medicare cost-sharing amount when Medicare is the primary payer and the applicable Medicare reimbursement is higher than the Plan Fee Schedule amount. The following hypothetical example provided by the Nursing Home is illustrative:

> For purposes of this example, the Nursing Home's Medicare RUGs rate is $300/day. The Medicare copayment is $95/day for days 21-100. The Plan Fee Schedule rate is $225/day.
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> A patient is admitted to the Nursing Home for a 31 day stay. A Medicare copayment of $950 ($95 x 10 days) applies to the last 10 days. For those days, the Nursing Home is entitled to Medicare reimbursement of $3,000 ($300 x 10 days). Medicare pays the Nursing Home $2,050 ($3,000 - $950 copayment). The Nursing Home bills the Plan for the $950 copayment.
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> The Plan, applying its COB provisions, limits the Nursing Home's reimbursement to $2,250 ($225 x 10 days). The Plan pays the Nursing Home $200 ($2,250 - $2,050 Medicare payment). The Nursing Home still has a balance owing of $750 for the Medicare copayment. Under its

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[5]In some situations not relevant here, employer plans are primary to Medicare under section 1862(b)(2) of the Act.

[6]In some circumstances, the applicable copayment may be a lesser amount if a facility's actual charge is less than one-eighth of the hospital inpatient deductible. In such cases, the daily coinsurance is the amount of the actual charge per day. See 42 C.F.R. § 409.85.

agreement with the Plan, the Nursing Home is prohibited from billing the patient for the balance of the copayment.

In this example, the balance of the Medicare copayment owed to the Nursing Home is effectively waived. This waiver potentially implicates the anti-kickback statute, because it represents a financial benefit from the Nursing Home to the Plan (i.e. forgiveness of the obligation to pay the remaining coinsurance amount) that may be for the purpose of inducing the Plan's referral of Plan members, including Medicare beneficiaries, to the Nursing Home.[7]

B. The Arrangement Does Not Fit Any Safe Harbor

The Arrangement does not fit within any available safe harbor to the anti-kickback statute. First, the Arrangement does not fit within the safe harbor for price reductions offered by contracted providers to health care plans. That safe harbor has six elements, one of which prohibits a provider that submits claims or requests for payment to Medicare for items or services furnished in accordance with a contract between the provider and a plan from claiming or requesting payment for amounts in excess of the contract's fee schedule. See 42 C.F.R. § 1001.952(m). The Arrangement fails to satisfy this requirement because the Nursing Home submits its claims to Medicare for services to Medicare beneficiaries using the full Medicare reimbursement under the RUGs III Demonstration Project.[8]

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[7]The parties' agreement that the Nursing Home will not collect cost-sharing amounts from beneficiaries in effect shifts the Medicare copayment obligation from the Plan's members to the Plan.

[8]Although we do not decide the issue here, we note that the Arrangement might fit in the price reduction safe harbor if the Nursing Home were able to bill Medicare in a manner that satisfies the following requirements: (i) Medicare is billed an amount less than or equal to the Plan Fee Schedule amount; (ii) the billing methodology results in the Plan paying the full amount of the applicable Medicare copayment; and (iii) the billing methodology is acceptable to the Nursing Home's fiscal intermediary. It is not clear that a satisfactory reimbursement methodology could be developed for Part A reimbursement. We note that for similarly situated plans and providers contracting for Part B services, agreements that require providers to bill Medicare no more than the contracted fee schedule amount may qualify for safe harbor protection, provided they meet all other applicable conditions.

Second, the Arrangement does not qualify under the waiver of coinsurance safe harbor, because that safe harbor is limited to certain waivers of coinsurance by hospitals for inpatient hospital services. The safe harbor specifically provides that protected waivers do not include waivers that are part of cost reduction agreements between hospitals and plans, other than Medicare SELECT plans. See 42 C.F.R. § 1001.952(k).

Third, the discount safe harbor is not applicable. The discount safe harbor applies only to discounts obtained by the party submitting claims to the Medicare program. See 42 C.F.R. § 1001.952(h). In the Arrangement, the Nursing Home, which submits claims to Medicare, is the party that provides the discount, rather than the party that receives it. Accordingly, the Arrangement does not satisfy the safe harbor conditions. See 61 Fed. Reg. 2122, 2124 (January 25, 1996). Moreover, the safe harbor requires that the discount be offered to Medicare and Medicaid. This is not the case here.

C. The Arrangement Poses a Potential Risk of Program Fraud and Abuse

The potential for fraud and abuse from the routine waiver of Medicare cost-sharing amounts by providers has been a longstanding concern of this Office. See Preamble to Final Rule, 61 Fed. Reg. 2122 (January 25, 1996); cf. Special Fraud Alert, 59 Fed. Reg. 242 (1994). Most recently, in OIG Advisory Opinion 97-4, we addressed a provider's proposal to forgo collecting copayments from Medicare beneficiaries where a health plan providing secondary coverage was refusing to pay the Medicare copayments. In that case, the provider did not have an agreement with the health care plan and was not contractually prohibited from billing Medicare beneficiaries for copayment amounts. In those circumstances, we concluded that the provider's failure to undertake reasonable collection efforts, including seeking collection from beneficiaries, could constitute a violation of the anti-kickback statute.

We have also previously articulated our concern that agreements between providers and health plans to forgo deductible or coinsurance amounts may result in kickbacks from providers to health care plans in exchange for Federal program business. For example, we stated in our preamble to the 1996 Final Rule establishing certain managed care safe harbors that:

> The [anti-kickback] statute prohibits any remuneration which is in return for, or which is designed to induce, the flow of Medicare and Medicaid program-related business. Therefore, it could cover a hospital's agreement to forego or reduce coinsurance or deductibles in exchange for increased

> program-related business. It does not matter that the payment is made to a third party rather than the beneficiary.

61 Fed. Reg. 2122, 2124 (January 25, 1996).

Arrangements that release both the beneficiaries and the secondary insurer from the obligation to pay Medicare cost-sharing amounts pose a risk of overutilization and increased program costs. Thus, under the Arrangement, the Nursing Home may have an incentive to prolong Medicare patient stays in order to recoup forgone copayments, while the Plan has no incentive to control costs associated with Medicare fee-for-service beneficiaries for whom it pays little or nothing.[9] Moreover, to the extent that the Nursing Home receives less than the applicable RUGs III reimbursement rate (including copayments and deductibles), the Nursing Home may have an increased incentive to shortchange Medicare beneficiaries by stinting on services. Finally, the Arrangement may lead to unfair competition for competing health plans that meet their insureds' Medicare copayment obligations and refuse to participate in comparable schemes.[10] Given these risks, we cannot conclude that the Arrangement poses little or no risk of Federal program fraud or abuse.[11]

D. Conclusion

For the above-stated reasons, we conclude that the Arrangement may involve prohibited remuneration under the anti-kickback statute and thus potentially be subject to sanction under section 1128B(b) of the Act, to exclusion under section 1128(b)(7) of the Act, and

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[9]In addition, arrangements such as the one at issue here may, in some circumstances, provide an incentive for providers to offer lower rates to health care plans for non-Medicare "managed care" patients in exchange for access to Medicare beneficiaries for whom the providers can bill Medicare on a fee-for-service basis.

[10]We note further that the Arrangement may violate other fraud laws in connection with representations that the Plan may have made to Plan members and the Plan's collection of premiums, if any, from beneficiaries. In addition, the Arrangement may violate other state insurance or consumer protection statutes.

[11]Our conclusion regarding the risk of abuse in relation to the anti-kickback statute should not be construed to mean that a finding of abuse is an implied element necessary to establish a violation of the statute.

civil monetary penalties under 1128A(a)(7).[12] This conclusion is consistent with our prior guidance on waivers of copayments generally and on waivers negotiated between providers and health plans specifically. It is also consistent with the legal principle that a private contractual arrangement cannot override a requirement of Federal law (cf. note 2 above).

III. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is applicable only to the statutory provisions specifically noted in the first paragraph of this advisory opinion. No opinion is herein expressed or implied 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 Arrangement.

- This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.

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, modify or terminate this opinion.

Sincerely,

/s/

D. McCarty Thornton
Chief Counsel to the Inspector General

[12] 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.