

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

Issued: October 31, 2001

Posted: November 7, 2001

[Names and addresses redacted]

Re: OIG Advisory Opinion No. 01-18

Gentlemen:

We are writing in response to your request for an advisory opinion regarding an exclusive contract for emergency ambulance services between County A, State B and Medical Center C (the "Requestors") under which County A has assumed the obligation to pay otherwise uncollected coinsurance amounts on behalf of County A residents (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, or under the civil monetary penalties provision for illegal remuneration to beneficiaries at section 1128A(a)(5) of the Act.

You have certified that all of the information provided in your request, including all supplementary letters, 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, if the requisite intent to induce or reward referrals of Federal health care program business were present, but that the Office of Inspector General (“OIG”) would not impose administrative sanctions on

County A, State B or Medical Center C 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. In addition, the OIG would not impose administrative sanctions on the Requestors under section 1128A(a)(5) of the Act in connection with the Proposed Arrangement.

This opinion may not be relied on by any persons other than County A, State B and Medical Center C, the Requestors 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

County A, State B (the “County”),¹ is a rural county with a large indigent population and few ambulance services. The County provides emergency medical services (“EMS”) under the auspices of its Emergency Medical Services Board. Pursuant to a County ordinance, the County imposes an annual fee of \$ [x] per household for EMS. In September 2000, the County requested bids for the provision of EMS for the period from January 1, 2001, through December 31, 2002.² The County employed an open competitive bidding process consistent with the relevant government contracting laws. The request for proposals specified the type and scope of ambulance services desired, but did not include any specifications related to compensation or billing for ambulance services.

Medical Center C, a non-profit institution (the “Ambulance Provider”), was the sole bidder for, and was awarded, the contract. The Ambulance Provider is located outside the County’s EMS District. Most County EMS patients are delivered to facilities unrelated to the Ambulance Provider. Under the contract, the Ambulance Provider will respond to all emergency calls for the County, serving County residents and non-residents, whether insured or not.³

¹For purposes of this opinion, County A refers to the [name of entity redacted], the legal entity comprising the County government.

²The bid included all of County A, with the exception of the City of D.

³The Requestors have certified that Medical Center C has no other financial arrangements, affiliations, or relationships with the County.

The Ambulance Provider will bill patients and insurers, including Medicare and Medicaid, for its services, except that it will not collect any out-of-pocket coinsurance from County residents.⁴ Instead, the County will make an “out-of-pocket payment subsidy” on behalf of its residents. The annual subsidy will equal the greater of \$ [y] or 90% of the total collected household EMS fees. The Requestors have provided certified historical data regarding the annual “out-of-pocket payment subsidy.” Based on this data, the annual subsidy will reasonably approximate the annual total uncollected out-of-pocket coinsurance obligations of County residents.

II. LEGAL ANALYSIS

A. Law

1. The Anti-Kickback Statute

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.), 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.

2. The Civil Monetary Penalty for Inducements to Beneficiaries

⁴The Ambulance Provider will bill residents for any coinsurance amount paid by an insurer directly to the resident.

Section 1128A(a)(5) of the Act provides for the imposition of civil monetary penalties against any person who:

offers or transfers remuneration to any individual eligible for benefits under [Medicare or a State health care program] that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under [Medicare or a State health care program].

See also 42 C.F.R. § 1003.102(b)(13)). For purposes of section 1128A(a)(5) of the Act, "remuneration" includes, inter alia, the waiver of copayment and deductible amounts (or any part thereof). The statute contains certain exceptions to the definition of remuneration for certain waivers of copayment and deductible amounts that are not advertised, that are not routine, and that are made on the basis of individual determinations of financial need or for which reasonable collection efforts have been made. See section 1128A(i)(6) of the Act.

B. Analysis

The Proposed Arrangement is problematic in two respects. First, the contractual prohibition on billing County residents directly raises a waiver of coinsurance issue. Second, along with the exclusive right to provide, and bill for, emergency medical services provided to Federal health care program and private pay patients, the Ambulance Provider provides the same services to indigent and uninsured patients at a reduced cost to the County. In other words, the Proposed Arrangement implicates the anti-kickback statute because the County could be referring Federal health care program business to the Ambulance Provider in exchange for services to the indigent and uninsured – services the County would otherwise have to fund.

We begin by addressing the waiver of coinsurance. Our concerns regarding routine waivers of coinsurance are longstanding. The coinsurance provisions are an integral component of the Medicare program, and payment of the Medicare coinsurance is required by Federal law. See e.g., Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B, 59 Fed. Reg. 65372, 65374 (Dec. 19, 1994). However, in the Proposed Arrangement, the County effectively assumes the copayment obligation owed to the Ambulance Provider for the County residents. The County's out-of-pocket payment subsidy to the Ambulance Provider appears calculated reasonably to approximate the residents' uncollected coinsurance obligations in connection with their use of emergency medical services. Because the subsidy reasonably approximates the coinsurance obligation and because the County is collecting from, and paying coinsurance on behalf of, its residents, the Proposed Arrangement's non-billing of residents does not constitute a routine waiver of coinsurance that would implicate the anti-kickback statute. For these reasons, we would not impose administrative

sanctions arising under the anti-kickback statute on the County in connection with the non-billing feature of the Proposed Arrangement.⁵

With respect to the tying of the indigent business to the paying business (the “exclusivity provision”), we have repeatedly expressed our concerns with arrangements involving the provision of free or discounted goods or services by a vendor in exchange for the opportunity to provide services reimbursable by the Federal health care programs. Notwithstanding, with respect to the proposed contract between the County and the Ambulance Provider, a number of factors present in the Proposed Arrangement mitigate the risk of fraud or abuse.

First, the exclusivity provision in the contract is unlikely to increase Federal health care program costs appreciably. With respect to the cost per ambulance run, the State B Medicaid Program pays for ambulance services on a uniform fee schedule. While current Medicare reimbursement for hospital-based ambulance services is based on the ambulance provider’s costs, those costs are constrained by various caps that generally result in a relatively uniform payment by Medicare within a given geographic area for comparable ambulance runs.⁶ Accordingly, Federal payment will be approximately the same amount per service regardless of the Proposed Arrangement. With respect to the number of runs, the Proposed Arrangement is limited to emergency medical services, the utilization of which is determined primarily by patient “911” calls. Neither the County nor the Ambulance Provider has significant ability to affect utilization of “911” services. The Ambulance Provider has certified that it has no other financial arrangements, affiliations, or relationships with the County, so there is no opportunity for the Ambulance Provider to generate offsetting revenue. Since the exclusivity provision will have a minimal effect on the cost per run or the number of runs, the exclusivity provision’s effect on Federal program costs, if any, should be minor.

⁵With respect to section 1128A(a)(5), which prohibits inducements to beneficiaries in order to influence their selection of a provider for Medicare or Medicaid covered services, we would not impose administrative sanctions under section 1128A(a)(5). Simply put, County residents who call “911” have no choice of EMS provider, and there is nothing in the facts presented here to suggest that the non-billing provision is intended, or likely, to influence residents to use Medical Center C, or its ambulance services, for Medicare or Medicaid services.

⁶The Balanced Budget Act of 1997 mandated a national fee schedule for payment of ambulance services furnished under Medicare Part B. The Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) has published a proposed rule to create a fee schedule, but the final rule is still pending. See Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Non-emergency Ambulance Services, 65 Fed. Reg. 55078 (Sept. 12, 2000). The national fee schedule will result in uniform payment for comparable services, subject to certain geographic adjustments.

Second, the putative prohibited remuneration (i.e., the County's avoided costs for the indigent and uninsured transports) inures to the public, not private, benefit. One of the core evils addressed by kickback or bribery statutes, whether involving public or private business, is the abuse of a position of trust, such as the ability to award contracts or business on behalf of a principal for personal financial gain. Here, the public receives the financial benefit of the exclusivity provision by getting the best possible price for emergency medical services. A contrary result would require the County to pay the Ambulance Provider additional revenues for ambulance services provided to uninsured and indigent patients.

Third, the organization of a local emergency medical transportation system, including a local government's decision whether to provide EMS directly or indirectly through the selection of a private provider, is within the police powers traditionally delegated to local government. In other words, the decision is primarily a governmental, not medical, decision. As with the exercise of any police power, the local government is ultimately responsible for the quality of the services delivered and is accountable to the public through the political process. Counties and municipalities should have sufficient flexibility to organize local emergency medical transport systems efficiently and economically.

Fourth, the exclusivity provision will not have an adverse impact on competition. The County employed an open competitive bidding process consistent with the relevant government contracting laws. The contract is limited to a two-year period. Public policy favors open and legitimate price competition.⁷

In light of these factors, the tying of the indigent business to the paying businesses in the Proposed Arrangement poses a minimal risk of Federal health care program fraud or abuse.

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, if the requisite intent to induce or reward referrals of Federal health care program business were present, but that the OIG would not impose administrative sanctions on County A, State B or Medical Center C, 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. In addition, the OIG would not impose administrative sanctions on the Requestors, under section 1128A(a)(5) of the Act in connection with the Proposed Arrangement.

IV. LIMITATIONS

⁷Although it received only one bid in this instance, the County has certified that it selects among bids based on price and other features contained in the bid.

The limitations applicable to this opinion include the following:

- C This advisory opinion is issued only to County A, State B and Medical Center C, which are the Requestors of this opinion. This advisory opinion has no application to, and cannot be relied upon by, any other individual or entity.
- C 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.
- C 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.
- C This advisory opinion will not bind or obligate any agency other than the U.S. Department of Health and Human Services.
- C 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.
- C 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 will not proceed against the Requestors with respect to any action that is part of the Proposed Arrangement taken in good faith reliance upon this advisory opinion, as long as all of the material facts have been fully, completely, and accurately presented, and the Proposed Arrangement in practice comports with the information provided. 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. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the Requestors with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion. An advisory opinion may be

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rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/s/

D. McCarty Thornton
Chief Counsel to the Inspector General