



## **MEMBERSHIP ALERT**

*(Posted March 15, 1999)*

# **OIG Advisory Opinion No. 99-2**

## **DISCOUNTS**

**[We have redacted specific information regarding the requester and certain potentially privileged, confidential or financial information associated with the individual or entity, unless otherwise specified by the requestor.]**

Posted: March 4, 1999

Issued: February 26, 1999

[name and address redacted]

Re: [company name redacted]

OIG Advisory Opinion No. 99-2

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding certain arrangements for discounted ambulance services provided to residents of Medicare skilled nursing facilities (collectively, the "Arrangement"). You have asked whether the Arrangement would result in prohibited remuneration under the anti-kickback statute, section 1128B(b) of the Social Security Act (the "Act") or would constitute grounds for the imposition of sanctions under the anti-kickback statute, section 1128B(b) of the Act, the exclusion authority related to kickbacks, section 1128(b)(7) of the Act, or the civil monetary penalty provision for kickbacks, section 1128A(a)(7) of the Act.

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, this opinion is without force and effect.

Based on the facts certified in your request for an advisory opinion, we conclude that the Arrangement might constitute prohibited remuneration under the anti-kickback statute if the requisite intent to induce referrals of Federal health care program business were present and might be subject to sanctions arising under sections 1128B(b), 1128(b)(7), and 1128A(a)(7) of the Act, as well as section 1128(b)(6)(A) of the Act.

This opinion may not be relied on by any person other than the addressee and is further qualified as set out in Part III below and in 42 C.F.R. Part 1008.

## I. FACTUAL BACKGROUND

### Ambulance Reimbursement Under the SNF Prospective Payment System

The genesis of the Arrangement is Medicare's new prospective payment system for Medicare-certified skilled nursing facilities ("SNFs"). In 1997, Congress significantly changed the way SNFs are reimbursed for services to patients covered under Medicare Part A, the hospital benefit.<sup>(1)</sup> Specifically, the Balanced Budget Act of 1997 enacted a prospective payment system ("PPS") for SNFs covering all costs (routine, ancillary, and capital) related to services furnished to beneficiaries covered under Part A, including certain Part B services.<sup>(2)</sup> Other Part B services will continue to be reimbursed separately to the providers of such services pending implementation of a new consolidated billing system.<sup>(3)</sup> The basic PPS methodology is a prospectively fixed per diem payment adjusted to reflect the patient's health status and needs and the regional wage rate (the "Federal case mix adjusted rate"). Under PPS, the SNF per diem payment will include payment for certain ancillary Part B services previously reimbursed by Medicare directly to the providers of such services. This new payment scheme shifts risk to the SNFs, giving them a significant financial incentive to reduce costs, and may indirectly result in lower payments to suppliers and providers of items and services covered by the PPS payment. Among the Part B services affected by the change in SNF reimbursement are ambulance services. Traditionally, ambulance services rendered to Medicare patients residing in SNFs have been covered by Medicare Part B and reimbursed on a reasonable charge basis. Under PPS, ambulance services that are within the normal scope of the patient's plan of care ("Plan of Care Ambulance Services") are included in the fixed PPS per diem payment. SNFs must provide the Plan of Care Ambulance Services directly or "under arrangement" with an ambulance company.<sup>(4)</sup>

Plan of Care Ambulance Services comprise a relatively small portion of the ambulance services required by most SNF Part A patients, and an even smaller portion of the total ambulance services required by SNF patients generally.<sup>(5)</sup> Pending full implementation of consolidated billing, Medicare will continue to reimburse ambulance providers for non-PPS covered ambulance services for Part A patients and for services for Medicare patients whose stays are not covered under Part A.<sup>(6)</sup> Based on reasonable charges for services provided until January 1, 2000, and on a fee schedule thereafter.<sup>(7)</sup> In sum, pursuant to SNF PPS, Medicare will pay SNFs a fixed per diem amount for patients during a covered Part A stay, and the SNFs will be responsible for paying for virtually all patient care services -- including Plan of Care Ambulance Services -- out of that fixed payment. These PPS-covered ambulance services are the subject of the Arrangement at issue here.

### The Arrangement

The Arrangement involves an agreement for PPS-covered ambulance services between Ambulance Company X ("Ambulance Company X") and Nursing Home Y (the "Nursing Home"). Ambulance Company X is a Medicare-certified ambulance supplier operating in the State A market. The Nursing Home is a Medicare-certified SNF paid under PPS for patients covered by Medicare Part A. With the advent of PPS, the Nursing Home has arranged for Ambulance Company X to provide Plan of Care Ambulance Services for its PPS-covered patients "under arrangement". In addition to its PPS-covered patients, the Nursing Home has patients who require ambulance services that are not covered by a PPS payment and that are reimbursed to the ambulance services provider by Medicare under Part B or by other payers.

Ambulance Company X and the Nursing Home have entered into a Medical Transportation Services Agreement (the "Agreement") for the provision of Plan of Care Ambulance Services and chair car services to Nursing Home residents who are covered under the PPS system. The Agreement also applies to Nursing Home residents for whom the Nursing Home is reimbursed by other public or private reimbursement systems

under a capitated, per-diem, or other all-inclusive payment that includes ambulance services and residents for whom the Nursing Home otherwise agrees to be financially responsible.

In other words, the Agreement applies when the Nursing Home bears the risk for providing ambulance services.

Pursuant to the Agreement, Ambulance Company X will charge the Nursing Home fixed per-transport rates for basic life support ("BLS"), advanced life support ("ALS"), and chair car services. The contractual rates for BLS and ALS services represent discounts of up to 50% of the "reasonable charge" established by Medicare for Ambulance Company X's services in the State A area.<sup>(8)</sup> Ambulance Company X will charge Medicare its full usual and customary amount for transporting Nursing Home residents for whom ambulance services are covered under Medicare Part B.

With respect to the amount of the discount, Ambulance Company X has represented that part of the proposed discount would be directly attributable to cost savings Ambulance Company X can achieve when providing services for PPS residents. For example, Ambulance Company X has certified that its billing costs should be substantially less for services for PPS-covered residents because Ambulance Company X will submit a single, consolidated bill to each SNF at the end of each month and because Ambulance Company X will not need to bill residents for copayments or deductibles. Ambulance Company X also believes its collection rate will generally be higher for PPS residents. Ambulance Company X estimates that these factors can reasonably be expected to result in savings equal to approximately 10% of the Medicare reasonable charge for each transport rendered to a PPS resident, depending on the circumstances. Nonetheless, in light of the competitive market, Ambulance Company X is offering discounts in excess of anticipated savings attributable substantially to SNF PPS.

Ambulance Company X proposes entering into similar discount arrangements with other SNFs in its service area. Like Ambulance Company X's arrangement with the Nursing Home, these proposed discount arrangements would be with SNFs that are being reimbursed for Medicare Part A services under PPS and would apply to ambulance transports provided to the Medicare residents during a covered Part A stay. The discounts would not apply to Part B services. The discount arrangement between Ambulance Company X and the Nursing Home and the proposed discount arrangements between Ambulance Company X and other SNFs described in the request letter are collectively referred to in this opinion letter as the "Arrangement".

## II. LEGAL ANALYSIS

### 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 referrals of items or services reimbursable by Federal health care programs. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce referrals of items or services paid for by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes 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 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 (3rd 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 Federal health care programs or to impose civil monetary penalties for fraud, kickbacks, and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.(9)

The anti-kickback statute contains a statutory exception for "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." 42U.S.C. & sect; 1320a-7b(b)(3)(A). This discount exception reflects the intent of Congress to encourage price competition that benefits the Medicare and Medicaid programs. The Department of Health and Human Services has published regulations implementing this discount "safe harbor" exception. See 42 C.F.R. &sect; 1001.952(h).

### The Discount Pricing Arrangement

Our initial inquiry is whether the Arrangement fits within the discount safe harbor. We conclude it does not. The statutory exception for discounts, as implemented by the regulatory safe harbor, does not protect price reductions -- like those at issue here -- offered to one payer but not offered to Medicare or Medicaid. In the preamble to the discount safe harbor, we illustrated the potential problem with such price reductions: We are aware of cases where laboratories offer a discount to physicians who then bill the patient, but do not offer the same discount to the Medicare program. In some of these cases, the discount offered to the physician is explicitly conditioned on the physician's referral of all of his or her laboratory business. Such a "discount" does not benefit Medicare, and is therefore inconsistent with the statutory intent for discounts to be reported to the programs with costs and charges reduced appropriately to reflect the discounts.

56 Fed. Reg. 35977 (July 29, 1991). In essence, such price reductions create a risk that a supplier may be offering remuneration in the form of discounts on business for which the purchaser pays the supplier, in exchange for the opportunity to service and bill for higher paying Federal health care program business reimbursed directly by the program to the supplier. In such circumstances, neither Medicare nor Medicaid benefits from the discount; to the contrary, Medicare and Medicaid may, in effect, subsidize the other payer's discounted rates.(10) Moreover, suppliers may have an incentive to inappropriately increase utilization or engage in abusive billing practices to recoup losses on the discounted business. Accordingly, the discount safe harbor specifically excludes "[a] reduction in price applicable to one payer but not to Medicare or a State health care program." See 42 C.F.R. & sect; 1001.952(h)(3)(iii).

Having concluded that the Arrangement does not fit in the safe harbor, we must consider whether the discount arrangement between Ambulance Company X and the Nursing Home and similar arrangements with other SNFs may involve illegal remuneration for the SNFs' referrals of ambulance business not covered by the PPS payment and not subject to the discount. We conclude that they may.

The circumstances surrounding the Arrangement suggest that a nexus may exist between the discount to the SNFs for PPS-covered transports and referrals of other Federal health care program business.(11) First, the SNFs are in a position to direct a significant amount of business to Ambulance Company X that is not covered by the PPS payment. Second, both parties have obvious motives for agreeing to trade discounts on PPS business for referrals of non-PPS business: the SNFs to minimize risk of losses under the PPS system and Ambulance Company X to secure business in a highly competitive market. Third, Ambulance Company X's

request for an advisory opinion comes amidst a considerable number of informal inquiries and anecdotal reports regarding discounts to SNFs that this Office has received since enactment of SNF PPS.

These inquiries and reports suggest that suppliers of a wide range of SNF services are giving SNFs discounts for PPS-covered business that are linked, directly or indirectly, to referrals of Part B business.

In evaluating whether an improper nexus exists between a discount and referrals of Federal business in a particular arrangement, we look for indicia that the discount is not commercially reasonable in the absence of other, non-discounted business. In this regard, discounts on SNF PPS business that are particularly suspect include, but are not limited to:

- discounted prices that are below the supplier's cost,<sup>(12)</sup> and
- discounted prices that are lower than the prices that the supplier offers to a buyer that (generates a volume of business for the supplier that is the same or greater than the volume of Part A business generated by the PPS SNF, but (ii) does not have any potentially available Part B or other Federal health care program business.

This is an illustrative, not exhaustive, list of suspect discounts; other arrangements may be equally suspect. Each of the above pricing arrangements independently gives rise to an inference that the supplier and the SNF may be "swapping" discounts on Part A business in exchange for profitable non-discounted Part B business, from which the supplier can recoup losses incurred on the discounted business, potentially through over utilization or abusive billing practices. In connection with items or services provided to PPS SNFs, the presence of either of these discount arrangements is particularly suspect under the anti-kickback statute. Other indicators of suspect discounts include (i) discounts on PPS-covered business that are coupled with exclusive supplier agreements and (ii) discounts on Medicare PPS or other capitated or prospective payment business made in conjunction with explicit or implicit agreements to refer other facility business to the supplier, including Part B or other Federal health care program business.

Based on the limited facts presented here, we are unable to exclude the possibility that Ambulance Company X may be offering improper discounts to the Nursing Home and other SNFs for their PPS-covered Part A business with the intent to induce referrals of more lucrative Part B business. Nor are we able to exclude the possibility that the Nursing Home or other 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 Arrangement poses a significant risk of such improper "swapping" of business, especially in light of Ambulance Company X's representation that many of its competitors are agreeing to such discounts. These competitor discount arrangements may similarly run afoul of the anti-kickback statute. The risk of improper "swapping" is compounded by the likelihood that SNFs will refer non-PPS business to their contracted PPS provider, both as a matter of practical convenience and because SNF personnel may not always know which patients or transports will be covered by PPS when the services are ordered.

In these latter circumstances, the simplest way for a SNF to ensure that it is using its contracted provider for its PPS patients -- and therefore securing the Part A discounts -- is for the SNF to refer most patients to that provider.

Price reductions offered to SNFs that are not offered to Medicare or Medicaid patients residing in the same facility raise additional issues under section 1128(b)(6)(A) of the Act, which provides for permissive exclusion from the Federal health care programs of individuals or entities that submit or cause to be submitted bills or requests for payment (based on charges or costs) under Medicare or Medicaid that are substantially in excess

of such individual's or entity's usual charges or costs, unless the Secretary finds good cause for such bills or requests.

In determining an individual's or entity's "usual" charges, we will look at the amounts charged to non-Federal payers, including SNFs. If the charge to Medicare substantially exceeds the amount the supplier most frequently expects to receive from non-Federal payers, the supplier may be subject to exclusion under section 1128(b)(6)(A) of the Act.

The limited information submitted by Ambulance Company X is insufficient to make a determination whether the Arrangement may run afoul of section 1128(b)(6)(A). However, Ambulance Company X estimates that its costs for services under Medicare Part B are approximately 11% higher than its costs for services under Part A PPS. Yet Ambulance Company X intends to charge SNFs as much as 50% less than it charges Medicare for Part B services. At the very least, these facts give rise to an inference that Ambulance Company X might be charging Medicare amounts substantially in excess of its usual charges.

### III. CONCLUSION

Based on the facts certified in the request for an advisory opinion and supplemental submissions, we conclude that the Arrangement -- like many similar arrangements with PPSNFs -- might constitute prohibited remuneration under the anti-kickback statute if the requisite intent to induce referrals of Federal health care program business were present and might be subject to sanctions arising under the anti-kickback statute pursuant to sections 1128(b)(6) and (7), 1128A(a)(7), or 1128B(b) of the Act.

### IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to Ambulance Company X, the requester of this opinion. This advisory opinion has no application, 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 requester to this opinion.
- This advisory opinion is applicable only to the statutory provisions specifically noted above. 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 advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those that 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 Office of Inspector General reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, rescind, modify, or terminate this opinion.

Sincerely,

/s/

D. McCarty Thornton

Chief Counsel to the Inspector General

**FOOTNOTES:**

1. Medicare Part A covers up to 100 days of post-hospital SNF charges. See 42 U.S.C. § 1395d. In addition, Medicare Part B, the supplementary benefit, covers certain ancillary services provided to SNF patients, both during a covered Part A stay and afterwards.
2. See Section 4432 of the Balanced Budget Act of 1997, Pub. Law 105-33. The PPS system for SNFs is being implemented for cost reporting periods beginning after July 1, 1998. There is a transition phase during the first three cost reporting years, during which SNFs will receive a blend of a new Federal case mix adjusted rate and a facility specific rate based on the facility's allowable costs for SNF services for the fiscal 1995 cost reporting period.
3. Section 4432(b) of the Balanced Budget Act of 1997 amended the Social Security Act to establish a requirement for SNF consolidated billing, effective for items and services furnished on or after July 1, 1998. The SNF consolidated billing is a comprehensive billing requirement pursuant to which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. See 63 Fed. Reg. 26294 (May 12, 1998). Full implementation of SNF consolidated billing has been postponed indefinitely. See HCFA Program Memorandum Transmittal no. AB-98-35.60 (July 1998).
4. See 63 Fed. Reg. 26252 (May 12, 1998).
5. The following types of ambulance services are expressly excluded from the PPS payment by regulation: ambulance trips that initially convey an individual to the SNF to be admitted as a resident; trips that convey the individual to a hospital to be admitted as an inpatient; trips that convey an individual in connection with the receipt of services from a Medicare-participating home health agency under a plan of care; trips that convey an individual to a hospital in connection with the receipt of outpatient services that are not furnished pursuant to the individual's comprehensive care plan; and trips that convey an individual from a SNF after formal discharge, unless the individual is readmitted or returns within a specified period of time. *Id.* These excluded services constitute a significant part of the ambulance services provided to SNF patients.
6. Room and board for these patients is typically covered by Medicaid or through private funds or insurance.
7. See Section 4531 of the Balanced Budget Act of 1997, Pub. Law 105-33.
8. Chair car services will be provided at the applicable State Medicaid rates. Chair car services are not covered by Medicare.
9. 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 the purposes of this advisory opinion is the same under both.
10. This is particularly problematic when the contracting payor is a PPS SNF, because Medicare Part B payments essentially may subsidize Part A PPS payments that the government has determined are appropriate and adequate to cover the SNF's costs.
11. We note that the Agreement contains statements to the effect that remuneration provided under the Agreement is not intended to induce referrals of other business. We find these statements self-serving and not persuasive.
12. In this regard, we do not think it sufficient to consider only a supplier's marginal costs. Rather, in determining whether a discount is below cost, we look, for example, at the total of all costs divided by the total number of ambulance trips.