



DEPARTMENT OF HEALTH AND HUMAN SERVICES

**OFFICE OF INSPECTOR GENERAL**

WASHINGTON, DC 20201



*[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:** July 20, 2016

**Posted:** July 27, 2016

[Name and address redacted]

**Re: OIG Advisory Opinion No. 16-08**

Dear [Name redacted]:

We are writing in response to your request for an advisory opinion regarding an arrangement in which a hospice would make a supplemental payment to the nursing facilities in which the hospice's dually eligible patients reside when the nursing facilities—instead of the hospice—receive payment for their patients' room and board expenses (the "Proposed Arrangement"). Specifically, you have inquired if 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, although 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, the Office of Inspector General (“OIG”) would not 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. This opinion is limited to the Proposed Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request for an advisory opinion or supplemental submissions.

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**

### **A. The Hospice Benefit for Dually Eligible Beneficiaries**

The Medicare hospice benefit covers palliative care for an individual who is terminally ill, meaning the medical prognosis is that the individual’s life expectancy is six months or less if the illness runs its normal course. The palliative care is provided in the patient’s home environment, *e.g.*, a private residence or a nursing facility. Medicare does not have a long-term custodial nursing facility benefit, either as a standalone benefit or as part of the hospice benefit; in other words, when a patient’s home environment is a nursing facility, Medicare does not cover the patient’s room and board expenses. Consequently, if a patient in a nursing facility elects the Medicare hospice benefit, the patient or a third-party payor is financially responsible for the room and board expenses at the nursing facility.

These third-party payors include states’ Medicaid programs, which are required to provide a benefit for nursing facility services. In cases where a patient who is dually eligible for Medicare and Medicaid elects hospice and resides in a nursing facility (a “Dually Eligible Hospice Patient”), the Medicare program is financially responsible for the hospice care and the state’s Medicaid program is responsible for the nursing facility room and board expenses. For the hospice care, the Medicare program makes a per diem payment to the hospice for each day an eligible Medicare beneficiary is under the hospice’s care. 42 C.F.R. § 418.302. For the nursing facility room and board, the state’s Medicaid program must provide for payment in an amount equal to at least 95 percent of the state’s Medicaid daily nursing facility rate. See section 1902(a)(13)(B) of the Act. The Medicaid daily nursing facility rate is the amount the state pays for nursing facility services furnished to a patient who has not elected to receive hospice care.<sup>1</sup>

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<sup>1</sup> The specific services included in the daily nursing facility rate are determined by a state’s Medicaid program and vary from state to state.

Traditionally, the state's Medicaid program pays the hospice for the Dually Eligible Hospice Patient's room and board expenses and, in turn, the hospice reimburses the nursing facility at a negotiated rate.

## **B. The Proposed Arrangement**

[Name redacted] ("Requestor") is a non-profit corporation licensed by [state redacted] (the "State") to provide hospice care. According to Requestor, the State has developed the [name redacted] demonstration program (the "Demonstration Program") to test a fully integrated care system that manages the continuum of benefits for dually eligible beneficiaries. The State selected several managed care organizations (each a "Participating MCO") to provide services to dually eligible beneficiaries in the Demonstration Program.

Although the State's Medicaid program historically paid Requestor for the nursing facility room and board expenses of its Dually Eligible Hospice Patients, Requestor certified that at least one Participating MCO reimburses nursing facilities directly, meaning payment never flows through Requestor.<sup>2</sup> Under the Proposed Arrangement, Requestor would require a nursing facility to provide evidence of the amounts the Participating MCO pays the nursing facility for patients who have, and patients who have not, elected hospice. For a Dually Eligible Hospice Patient, Requestor would pay the nursing facility a standalone amount that, when combined with the payment the nursing facility would receive from the Participating MCO for the Dually Eligible Hospice Patient, would result in the nursing facility receiving the same amount as it would have received if the patient had not elected hospice. Requestor certified that these steps would prevent the nursing facility from being reimbursed more than the Participating MCO pays for a patient who has not elected hospice.<sup>3</sup>

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<sup>2</sup> According to Requestor, at least one Participating MCO previously followed the State's Medicaid program's traditional practice of paying Requestor for the room and board expenses of Dually Eligible Hospice Patients. This Participating MCO paid Requestor 95 percent of the State's Medicaid daily nursing facility rate. Requestor negotiated contracts with nursing facilities that required payment to these facilities in an amount equal to 100 percent of the State's Medicaid daily nursing facility rate for Requestor's Dually Eligible Hospice Patients. In other words, the negotiated contracts required Requestor to pay the nursing facilities a supplement of five percent of the State's Medicaid daily nursing facility rate, in addition to the amount Requestor received from the Participating MCO.

<sup>3</sup> Requestor further certified that in no event would this payment result in the nursing facility receiving more than the State's Medicaid daily nursing facility rate.

## II. LEGAL ANALYSIS

### A. Law

The anti-kickback statute makes it a criminal offense to knowingly and willfully 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. See, e.g., United States v. Borrasi, 639 F.3d 774 (7th Cir. 2011); United States v. McClatchey, 217 F.3d 823 (10th Cir. 2000); United States v. Davis, 132 F.3d 1092 (5th Cir. 1998); 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. 1998 Special Fraud Alert

In a 1998 Special Fraud Alert,<sup>4</sup> we focused on potentially illegal arrangements between nursing homes and hospices. We explained that a nursing facility’s population represents a sizeable pool of potential hospice patients, and therefore may be particularly desirable from a hospice’s financial standpoint. Dually Eligible Hospice Patients may generate higher gross revenues for hospices because they have, on average, longer lengths of stay than hospice patients residing in their own homes. Due to this financial incentive, among others, some nursing facility operators may request, or some hospices may offer, illegal inducements to influence the selection of a hospice.

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<sup>4</sup> See Fraud and Abuse in Nursing Home Arrangements with Hospices, available at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice.pdf> (Mar. 1998).

Notwithstanding these concerns, in the 1998 Special Fraud Alert we indicated that a hospice generally may pay a nursing facility for the room and board expenses of a Dually Eligible Hospice Patient in an amount not to exceed what the nursing facility would have received directly from a state's Medicaid program if the patient had not been enrolled in hospice. We warned, however, that we might view as suspected kickbacks any payments for room and board that were to exceed what the nursing facility would have received from the state's Medicaid program had the patient not been enrolled in hospice.

### **C. Analysis**

The Proposed Arrangement would involve the transfer of remuneration by Requestor to potential referral sources, the nursing facilities, in the form of the supplemental payment. Our 1998 Special Fraud Alert covered a situation in which a hospice remits payment to nursing facilities for Dually Eligible Hospice Patients' room and board expenses only after first receiving payment for such expenses from a state's Medicaid program. Requestor's prior arrangement—in which the Participating MCO paid Requestor for the room and board expenses of its Dually Eligible Hospice Patients—closely aligned with the situation described in the 1998 Special Fraud Alert. In the Proposed Arrangement, however, payment for Requestor's Dually Eligible Hospice Patients' room and board expenses would not flow through Requestor. Instead, the Participating MCO would remit payment directly to the nursing facility, and then Requestor would make a payment to the nursing facility for its Dually Eligible Hospice Patients separate and apart from the negotiated rate between the nursing facility and the Participating MCO. Through Requestor's supplemental payment, these nursing facilities would receive, in total, more than they would be paid by the Participating MCO for Dually Eligible Hospice Patients' room and board expenses.

Nonetheless, we believe that the Proposed Arrangement is consistent with our statement in the 1998 Special Fraud Alert that a hospice may pay a nursing facility for a Dually Eligible Hospice Patient's room and board expenses in an amount not to exceed what the nursing facility would have received from a state's Medicaid program if the patient had not been enrolled in hospice. The supplemental payment in the Proposed Arrangement would result in the nursing facility receiving, in total, the same amount that it would have received had the Dually Eligible Hospice Patient not elected hospice. The supplemental payment would never result in the nursing facility receiving more for Requestor's Dually Eligible Hospice Patients than it receives from the Participating MCO for patients who have not elected hospice and, moreover, the total reimbursement to the nursing facility would never exceed the State's Medicaid daily nursing facility rate. We believe the Proposed Arrangement would help to ensure that the nursing facility has no incentive to provide a lower level of room and board services to Requestor's Dually Eligible Hospice Patients or to discourage patients from electing hospice. For the combination of these

reasons, we believe that the Proposed Arrangement presents a low risk of fraud and abuse under the Federal anti-kickback statute.<sup>5</sup>

We caution that we reach this conclusion with respect to the supplemental payment because of the unique circumstances of Participating MCOs in the Demonstration Program reimbursing nursing facilities directly for Dually Eligible Hospice Patients' room and board expenses. For instance, we might reach a different conclusion if an individual or entity other than a hospice furnishing care to a Dually Eligible Hospice Patient in the Demonstration Program were to offer a standalone payment to the nursing facility in which that patient resides.

### **III. CONCLUSION**

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that, although 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, the OIG would not 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.

### **IV. LIMITATIONS**

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to [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 by a person or entity other than [name redacted], to prove that the person or entity did not violate the provisions of sections 1128, 1128A, or 1128B of the Act or any other law.
- 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

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<sup>5</sup> We express no opinion on whether the Proposed Arrangement would violate: (1) any other Federal laws or regulations administered by the Centers for Medicare & Medicaid Services, or (2) any Federal or state laws or regulations related to, or contractual obligations of Requestor or the nursing facilities under, the Demonstration Program.

Arrangement, including, without limitation, the physician self-referral law, section 1877 of the Act (or that provision's application to the Medicaid program at section 1903(s) 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 arrangements 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 will not proceed against [name redacted], 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 [name redacted], with respect to any action that is part of the Proposed Arrangement 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 rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/Gregory E. Demske/

Gregory E. Demske  
Chief Counsel to the Inspector General