



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: December 18, 2020

Posted: December 23, 2020

[Name and address redacted]

Re: OIG Advisory Opinion No. 20-06

Dear [Name redacted]:

We are writing in response to your request for an advisory opinion regarding a management company's provision of below fair market value Medicaid enrollment application assistance services to certain individuals and affiliated skilled nursing facilities' payments for those services in particular circumstances (the "Proposed Arrangement"). Specifically, you have inquired whether the Proposed Arrangement would constitute grounds for the imposition of sanctions under the civil monetary penalty provision prohibiting inducements to beneficiaries, section 1128A(a)(5) of the Social Security Act (the "Act"), or under the exclusion authority at section 1128(b)(7) of 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: (i) the Proposed Arrangement would not constitute grounds for the imposition of civil monetary penalties under section 1128A(a)(5) of the Act; and (ii) although the Proposed Arrangement could potentially generate prohibited remuneration under the Federal 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 [names 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 [names redacted], 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

[Name redacted] (the “Management Company”) is a management company that provides financial, marketing, and other administrative services to skilled nursing facilities (“SNFs”) and home health agencies (“HHAs”). It offers such services to, among other entities, two SNFs affiliated with the Management Company, [names redacted] (the “Affiliated SNFs”), as well as an HHA affiliated with the Management Company, [name redacted] (the “Affiliated HHA,” and together with the Management Company and the Affiliated SNFs, “Requestors”).¹ Under the Proposed Arrangement, the Affiliated SNFs and the Affiliated HHA would refer current patients, and in rare circumstances, individuals who are not yet patients but who have already selected an Affiliated SNF or the Affiliated HHA, to the Management Company for its provision of [state redacted] Medicaid enrollment application assistance services (the “Services”).² The Affiliated SNFs and the Affiliated HHA would refer only individuals seeking to enroll in the Medicaid program who are 65 years of age or older or blind or disabled and who the referring entity believes are eligible for Medicaid

¹ Other than the Proposed Arrangement described herein, we have not been asked to opine, and express no opinion, on the Management Company’s arrangements, such as administrative services arrangements, with any SNFs or HHAs, including, but not limited to, the Affiliated SNFs and the Affiliated HHA.

² Requestors certified that the Management Company would comply with all applicable laws in performing the Services.

enrollment. The Services would include assistance completing the application questionnaire, compiling necessary documentation, meeting the application deadlines, and complying with all applicable laws and application guidelines. The Services would not involve the provision of any health care items or services.

When an Affiliated SNF refers an individual for the Services, it would pay the Management Company for the Services on behalf of the individual and would not charge the individual (i.e., the individual would receive the Services for free), unless the individual must reduce or “spend down” his or her assets to qualify for Medicaid enrollment, as permitted by State regulations, in which case the individual would be responsible for paying the cost of the Services directly to the Management Company. When the Affiliated HHA refers an individual for the Services, the individual would pay the Management Company directly for the Services.

Requestors certified that the Management Company would determine the fees it would charge for the Services based on a written policy setting forth a fee schedule, and while the fees the Management Company would charge for the Services would be below fair market value, the fees would not vary based on the individual or entity paying the Management Company for the Services. Additionally, the Management Company would advertise the Services on its website and in other marketing materials targeting unaffiliated SNFs and unaffiliated HHAs,³ but it would not target other parties, including referral sources for the Affiliated SNFs or the Affiliated HHA or prospective patients, when advertising the Services. Neither the Affiliated SNFs nor the Affiliated HHA would advertise the Services.

Lastly, while Requestors certified that the Management Company would not provide any items or services under the Proposed Arrangement that would be directly reimbursable by a Federal health care program, the Affiliated SNFs would include the cost of the Services in their annual cost reports to the Centers for Medicare and Medicaid Services (“CMS”). In particular, when the Affiliated SNFs would pay for the Services on behalf of individuals who do not have to spend down assets in order to qualify for Medicaid enrollment, the Affiliated SNFs would list the fees they paid to the Management Company on the social services line in their annual cost reports submitted to CMS.⁴ According to Requestors, the

³ Requestors certified that the Management Company would offer the Services to individuals referred by unaffiliated SNFs and unaffiliated HHAs. Because no SNFs or HHAs, other than the Affiliated SNFs and the Affiliated HHA, are requestors of this advisory opinion, we are not opining on the Services arrangements with any other entities.

⁴ We express no opinion on the items and services that are appropriate for inclusion as social services line items on a SNF’s annual cost report.

reimbursement rate for social services line items on an annual cost report is based on national averages and is a *de minimis* amount per patient.

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.⁵ The anti-kickback statute specifically prohibits the offer, payment, solicitation, or receipt of any remuneration to induce or reward referrals for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or the purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under Federal health care program.⁶ 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.⁷ Violation of the statute constitutes a felony punishable by a maximum fine of \$100,000, imprisonment up to ten years, or both. Conviction also will 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.

⁵ See section 1128B(b) of the Act.

⁶ Id.

⁷ See, e.g., United States v. Nagelvoort, 856 F.3d 1117 (7th Cir. 2017); 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).

Section 1128A(a)(5) of the Act (the “Beneficiary Inducements CMP”) provides for the imposition of civil monetary penalties against any person who offers or transfers remuneration to a Medicare or State health care program (including Medicaid) beneficiary that the benefactor knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier for the order or receipt of any item or service for which payment may be made, in whole or in part, by Medicare or a State health care program (including Medicaid). The OIG also may initiate administrative proceedings to exclude such party from the Federal health care programs. Section 1128A(i)(6) of the Act defines “remuneration” for purposes of section 1128A(a)(5) of the Act as including “transfers of items or services for free or for other than fair market value.”⁸ Section 1128A(i)(6)(F) of the Act provides that, for purposes of the Beneficiary Inducements CMP, the term “remuneration” does not apply to “remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) and designated by the Secretary under regulations)” (the “Promotes Access to Care Exception”). We have interpreted this provision to apply to:

[i]tems or services that improve a beneficiary’s ability to obtain items and services payable by Medicare or Medicaid, and pose a low risk of harm to Medicare and Medicaid beneficiaries and the Medicare and Medicaid programs by — (i) [b]eing unlikely to interfere with, or skew, clinical decision making; (ii) [b]eing unlikely to increase costs to Federal health care programs or beneficiaries through overutilization or inappropriate utilization; and (iii) [n]ot raising patient safety or quality-of-care concerns[.]⁹

B. Analysis

Under the Proposed Arrangement, the Management Company’s provision of the Services at below fair market value would constitute remuneration to the individuals paying the Management Company directly for the Services (i.e., individuals referred by the Affiliated HHA and individuals referred by an Affiliated SNF who must spend down assets in order to qualify for Medicaid enrollment). Additionally, the Affiliated SNFs’ payments for the Services on behalf of individuals who do not have to spend down assets in order to qualify for Medicaid enrollment would constitute remuneration to those individuals. In either case,

⁸ See also 42 C.F.R. § 1003.110 (defining “remuneration,” for purposes of the regulations implementing the Beneficiary Inducements CMP, to be consistent with the definition of “remuneration” set forth at section 1128A(i)(6) of the Act).

⁹ 42 C.F.R. § 1003.110 (defining “remuneration”).

the remuneration could induce such individuals to purchase federally reimbursable items or services from one of the Affiliated SNFs or the Affiliated HHA. Therefore, we must examine the Proposed Arrangement under the Federal anti-kickback statute. Likewise, because the individuals to whom the Management Company and the Affiliated SNFs would offer or provide remuneration pursuant to the Proposed Arrangement could be individuals eligible for benefits under Medicare or a State health program, we must examine the Proposed Arrangement under the Beneficiary Inducements CMP.

1. Beneficiary Inducements CMP

As an initial matter, while the Management Company's provision of the Services at below fair market value could induce individuals who would pay the Management Company directly to obtain the Services from the Management Company, this remuneration would not implicate the Beneficiary Inducements CMP. The Beneficiary Inducements CMP applies only with respect to remuneration likely to influence the selection of a provider, practitioner, or supplier, and the Management Company is not a provider, practitioner, or supplier.

However, the Management Company's provision of the Services at below fair market value to individuals who would pay the Management Company directly could influence such individuals to select an Affiliated SNF or the Affiliated HHA for the provision of items and services reimbursable by Medicare or a State health care program. The Services would be valuable because they would facilitate the Medicaid application process for such individuals, which ultimately could improve their access to needed health care items and services. While Requestors certified that the Affiliated SNFs and the Affiliated HHA would refer only individuals who have already selected one of them, these individuals may nonetheless be more likely, as a result of receiving the Services, to continue to select an Affiliated SNF or the Affiliated HHA in order to receive items and services reimbursable by Medicare or a State health care program, particularly because the Affiliated SNFs and the Affiliated HHA would facilitate individuals' receipt of the Services from the Management Company. For the same reasons, the Affiliated SNFs' payments for the Services on behalf of individuals who do not have to spend down assets—which would result in such individuals receiving the Services for free—could influence such individuals to select an Affiliated SNF for items and services reimbursable by Medicare or a State health care program.

Therefore, both the Management Company's provision of below fair market value Services to individuals who would pay the Management Company directly for the Services and the Affiliated SNFs' payments for the Services on behalf of individuals who do not have to spend down assets would implicate the Beneficiary Inducements CMP. However, for the following reasons, we conclude that such remuneration would satisfy the Promotes Access

to Care Exception.

The first step in an analysis under the Promotes Access to Care Exception is to determine whether the remuneration would promote access to care, *i.e.*, whether it would improve a beneficiary's ability to obtain items and services payable by Medicare or a State health care program. We believe the remuneration described above would facilitate the Medicaid application process for individuals who otherwise may struggle to navigate the process independently or afford assistance with the process. By doing so, the Proposed Arrangement would improve the ability of individuals in a Medicaid-eligible patient population to obtain items and services payable by Medicaid.

The second step is to determine whether the remuneration would pose a low risk of harm by: (i) being unlikely to interfere with clinical decision making; (ii) being unlikely to increase costs to Federal health care programs or beneficiaries through overutilization or inappropriate utilization; and (iii) not raising patient safety or quality-of-care concerns. We conclude that the Management Company's provision of the Services at below fair market value and the Affiliated SNFs' payments for the Services would satisfy these requirements.

The Proposed Arrangement appears unlikely to interfere with clinical decision making. While the Proposed Arrangement could help individuals access, or continue to access, items and services offered by the Affiliated SNFs or the Affiliated HHA, nothing in the facts certified by Requestors suggests that the Management Company's provision of the Services at below fair market value or the Affiliated SNFs' payments for the Services would result in the Affiliated SNFs or the Affiliated HHA providing medically unnecessary items or services to such individuals or otherwise would skew the clinical decision-making of medical professionals at the Affiliated SNFs or the Affiliated HHA. Instead, the remuneration appears designed to assist individuals who are entitled to enroll in the Medicaid program to do so.

Further, the Proposed Arrangement would be unlikely to increase costs to Federal health care programs or beneficiaries through overutilization or inappropriate utilization. The Services would be offered only to individuals who the Affiliated SNFs or the Affiliated HHA refer to the Management Company based on their belief that such individuals are eligible to enroll in Medicaid, and further, the Services would facilitate access to Medicaid benefits only for individuals who the Medicaid program independently determines are entitled to enroll in Medicaid. While the remuneration could result in increased costs to the Medicaid program, there is nothing in the Proposed Arrangement to suggest that any such increase in costs would be caused by overutilization or inappropriate utilization. Instead, any increase in costs likely would result from individuals gaining access to Medicaid benefits after the Medicaid program independently determines they are eligible for such benefits. Additionally, Requestor certified that the Affiliated SNFs would receive a per-

patient amount as a result of listing the costs of the Services in their annual cost reports submitted to CMS. However, according to Requestor, the reimbursement rate for such social services line items is based on national averages and is a *de minimis* amount per patient. In these circumstances, we believe the risk would be extremely low that any increase in Federal health care program costs would be the result of overutilization or inappropriate utilization of items or services.

Finally, we do not believe that the Management Company's provision of the Services at below fair market value or the Affiliated SNFs' payments for the Services would pose patient safety or quality-of-care concerns. In fact, the remuneration would facilitate the Medicaid application process, which would improve the ability of Medicaid-eligible individuals to access medically necessary items and services payable by Medicaid that may promote patient health and safety.

2. Federal Anti-Kickback Statute

The Management Company's provision of the Services at below fair market value to individuals who would pay the Management Company directly for the Services would implicate the anti-kickback statute because the provision of the Services at below fair market value would constitute remuneration that could induce such individuals to purchase federally reimbursable items or services from one of the Affiliated SNFs or the Affiliated HHA. Similarly, the Affiliated SNFs' payments for the Services on behalf of individuals who do not have to spend down assets would implicate the anti-kickback statute because the Affiliated SNFs' payments would constitute remuneration that could induce those individuals to purchase federally reimbursable items or services from the Affiliated SNFs.

However, the Proposed Arrangement includes a number of safeguards that would sufficiently mitigate the risks of fraud and abuse associated with the Proposed Arrangement. For example, the Proposed Arrangement would involve the offer of remuneration only to individuals who have already selected an Affiliated SNF or the Affiliated HHA for their health care needs, and the Proposed Arrangement would facilitate access to Medicaid benefits only for individuals who the Medicaid program independently determines are eligible for Medicaid benefits. Additionally, the Management Company would not target prospective patients of the Affiliated SNFs or the Affiliated HHA or referral sources for those entities when advertising the Services, and neither the Affiliated SNFs nor the Affiliated HHA would advertise the Services. Based on these safeguards, in combination with the other safeguards present in the Proposed Arrangement, we conclude that the Proposed Arrangement would present no more than a minimal risk of fraud and abuse under the Federal anti-kickback statute.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that: (i) the Proposed Arrangement would not constitute grounds for the imposition of civil monetary penalties under section 1128A(a)(5) of the Act; and (ii) 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 [names 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.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to [names redacted], the requestors 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 [names 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 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 Proposed 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 will not proceed against 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 Requestors 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,

/Robert K. DeConti/

Robert K. DeConti
Assistant Inspector General for Legal Affairs