



*[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.]*

Date Issued: November 14, 2001

Date Posted: November 21, 2001

[name and address redacted]

Re: OIG Advisory Opinion No. 01-20

Dear [name redacted]:

We are writing in response to your request for an advisory opinion concerning a payment arrangement between a Medicare-certified hospice and certain nursing facilities for services provided to residents of such facilities who are eligible both for Medicaid and Medicare hospice benefits (“Dually Eligibles”). Specifically, for Dually Eligibles, the hospice pays the nursing facilities the full Medicaid nursing facility per diem rate for non-hospice patients, which covers pharmacy services, plus a separate payment for drugs used by Dually Eligibles in connection with their terminal illness (the “Arrangement”). You have asked whether the 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.

You have certified that all of the information you provided in your request, including all supplementary information, is true and correct, and constitutes a complete description of the material facts regarding the Arrangement. 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.

This opinion may not be relied on by any person other than [name redacted] (the “Requestor”) 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 Nursing Home Residents**

We begin with an overview of the applicable reimbursement scheme for hospice services for dually eligible beneficiaries, which is essential to an understanding of the Arrangement. The Medicare hospice benefit covers palliative care for individuals who are terminally ill. A Medicare beneficiary who elects to enroll in a hospice program waives the right to receive Medicare-funded curative care related to his or her terminal illness as long as the election remains in effect. Medicare reimburses the patient’s hospice a fixed per diem for hospice services, including hospice-related pharmacy services.<sup>1</sup>

Hospice services may be provided in any setting that serves as a Medicare beneficiary’s home, including a private residence or nursing facility. If the patient lives in a nursing facility, the patient is responsible for paying the nursing facility’s room and board charges. (Medicare does not have a long term custodial nursing facility benefit, and the hospice benefit does not include room and board expenses.) Some Medicare patients of limited means are also eligible for Medicaid, which has a nursing facility benefit. If a patient who elects hospice is dually eligible for both Medicare and Medicaid benefits, Medicare pays its regular hospice benefit, and the state Medicaid program covers the room and board charges. However, instead of paying the nursing facility for the room and board, as is done for non-hospice patients, the state Medicaid program pays the hospice, which, in turn, pays the nursing facility a negotiated rate. In New York, the Medicaid daily nursing facility rate includes pharmaceutical services.<sup>2</sup>

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<sup>1</sup>As a condition of Medicare participation “medical supplies and appliances including drugs and biologicals, must be provided as needed for the palliation and management of the terminal illness and related conditions.” 42 C.F.R. § 418.96. Under Medicare’s hospice benefit, “[o]nly drugs as defined in section 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual’s terminal illness are covered.” 42 C.F.R. § 418.202(f).

<sup>2</sup>See 10 NY ADC 86-2.10(c).

State Medicaid programs sometimes pay hospices less for a hospice patient's room and board than they pay nursing facilities for a non-hospice patient's room and board. By law, the state's payment to the hospice must be no less than 95 percent of the state's Medicaid daily nursing facility rate.<sup>3</sup> The "daily nursing facility rate" is the rate the state would otherwise have paid the nursing facility for the resident, had the resident not elected hospice care.<sup>4</sup> New York's room and board payment for each Dually Eligible hospice patient is 95 percent of its Medicaid daily nursing facility rate.<sup>5</sup>

Notwithstanding the potential differential in the state's room and board payments for hospice and non-hospice patients, the Medicaid State Operations Manual provides that "[t]he [nursing facility] must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit."<sup>6</sup>

#### B. The Hospice's Nursing Facility Arrangement

[name redacted] (the "Hospice") is a New York not-for-profit corporation, certified by the State of New York as an approved hospice provider. The Hospice contracts with nursing facilities to provide Medicare-certified hospice services to nursing facility residents.

Under its existing nursing facility contracts, the Hospice pays the nursing facility the same amount for each Dually Eligible's room and board that the nursing facility would have received if the patient had not elected hospice (*i.e.*, 100% of the state's Medicaid *daily nursing facility rate* for non-hospice patients). In other words, the Hospice supplements the room and board payment it receives from the State Medicaid program (*i.e.*, the 95% rate). In addition, even though the Medicaid daily nursing facility rate includes pharmaceutical services, the Hospice pays separately for medications related to a

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<sup>3</sup> See 42 U.S.C. § 1396a(a)(13)(B).

<sup>4</sup> See *Id.* Generally, the services included in the nursing facility daily rate are determined by a state's Medicaid program and may vary from state to state.

<sup>5</sup> See 10 NY ADC 86-6.7(a).

<sup>6</sup> Provider Certification State Operations Manual, SOP § 2082, Election of Hospice Benefit by Resident of SNF, NF, ICF/MR, or Non-Certified Facility, Health Care Financing Administration, Department of Health and Human Services.

beneficiary's terminal condition.<sup>7</sup> The Hospice has represented that these separate payments represent fair market value for the drugs in an arms length transaction.<sup>8</sup>

## 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 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 paid for 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

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<sup>7</sup>According to the Hospice's supplementary information, the Hospice reimburses contracting nursing facilities for drugs related to beneficiaries' palliative care by paying the nursing facilities for invoiced prescription medication (and in some cases, nonprescription medication) or by paying pharmacies directly. Assuming that the nursing facilities accurately reflect the pharmacy costs in their bills to the Hospice (without any markup), that the pharmacies are not related to the nursing facilities, and that the pharmacies and nursing homes are engaged in arms-length transactions, the difference in methodologies is not material for purposes of our analysis.

<sup>8</sup>We are not authorized to opine on "fair market value." See section 1128D(b)(3) of the Act. Therefore, for purposes of this opinion, we assume the truth of Hospice's fair market value certification.

may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.

The threshold inquiry here is whether the Arrangement involves any transfer of remuneration to a potential referral source. In other words, does the Hospice give something of value to the nursing facilities that could induce the nursing facilities to refer patients for hospice services?

In 1998, we issued a Special Fraud Alert describing certain practices related to the provision of hospice benefits to dually eligible nursing facility residents.<sup>9</sup> There, we expressed our concern that some financial arrangements between hospices and nursing facilities resulted in nursing facilities receiving more money (or other economic benefit) for patients enrolled in hospice than for non-hospice patients. This excess benefit increases the risk that the arrangement may be intended to induce hospice referrals. To mitigate the risk of fraud or abuse, the Special Fraud Alert cautioned that any additional or supplemental payment from the hospice to a nursing facility on behalf of a hospice patient should represent the fair market value of additional items or services actually provided by the nursing facility for the hospice patient that are *not* included in the *Medicaid daily nursing facility rate* for non-hospice residents (*i.e.*, the amount the state Medicaid program would pay the nursing facility for non-hospice patients). Depending on the circumstances, including the intent of the parties, the payment of additional amounts to nursing facilities for services included in the Medicaid daily nursing facility rate for non-hospice residents may constitute remuneration for purposes of the anti-kickback statute.

As indicated in the Special Fraud Alert, a hospice generally may pay a nursing facility for a hospice patient's room and board an amount equal to 100% of the Medicaid daily nursing facility rate for non-hospice patients without running afoul of the anti-kickback statute. The Arrangement, however, with its separate payments for drugs (including drugs that may be covered by the Medicaid daily nursing facility rate), poses a more difficult question. We recognize that palliative drugs are an essential component of the hospice benefit and are necessary to the provision of effective hospice services. We are mindful of the responsibility borne by hospices for ensuring that all hospice patients receive appropriate palliative drugs, whether they live in a private residence or a nursing facility. However, as outlined in the Special Fraud Alert, separate payment for

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<sup>9</sup>See Special Fraud Alert, Fraud and Abuse in Nursing Home Arrangements With Hospices (Office of Inspector General, March 1998).

pharmaceutical services already covered by the Medicaid daily nursing facility rate may implicate the anti-kickback statute if the payments are intended to induce or reward referrals. In such circumstances, there may be a potential benefit for the nursing facility, which appears to collect an amount equal to the full per diem payment without having to provide the full panoply of services typically covered by that payment. In short, the nursing facility is no longer providing the same services for its residents who have elected hospice as it furnishes to its residents who have not elected hospice.

In this case, we have been provided insufficient facts to evaluate the magnitude of the potential benefit to the nursing facilities or the appropriateness of the separate payments. Simply put, the Hospice is unable to provide an adequate accounting of the drugs for which separate payments are made under the Arrangement. In some situations, separate payments for drugs may be appropriate.<sup>10</sup> For example, some drugs used for hospice patients may not be included in the State's Medicaid daily nursing facility rate. In addition, there may be certain outlier drugs that are included in the State's Medicaid daily nursing facility rate for non-hospice patients, but which present little risk of program abuse. We simply cannot tell on these facts. We do not have enough information to ascertain the level of risk of fraud or abuse presented by the Arrangement with respect to separate payments for specific drugs, nor has the Hospice presented the question of separate payments for specific drugs.

In sum, while the payment of 100% of the Medicaid daily nursing facility rate without separate payment for drugs would pose a minimal risk of fraud or abuse, we cannot be assured, based on limited information, that the current Arrangement is similarly low-risk. We note that, because services included in the Medicaid daily nursing facility rate for non-hospice patients vary by state, apparently similar arrangements in other states may not raise the same concerns present here.

### **III. CONCLUSION**

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we cannot be confident that the Arrangement poses no more than a minimal risk of fraud or abuse, and thus we conclude that the Arrangement may involve prohibited

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<sup>10</sup>If separate payment is appropriate, the payment should reflect fair market value in an arms-length transaction. Moreover, if the nursing facility purchases the drug from a pharmacy or other supplier, the nursing facility should not mark-up its charge to the hospice.

remuneration under the anti-kickback statute and that the OIG could potentially impose administrative sanctions on [name redacted] related to the commission of acts described in section 1128B(b) of the Act. 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.

#### **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 in any matter involving an entity or individual that is not a requestor of this opinion.
- 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 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

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raised in this advisory opinion and, where the public interest requires, to rescind, modify, or terminate this opinion.

Sincerely,

/s/

D. McCarty Thornton  
Chief Counsel to the Inspector General