



*[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:** January 30, 2008

**Posted:** February 8, 2008

[Name and address redacted]

**Re: OIG Advisory Opinion No. 08-03**

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding a proposed arrangement by which a health care system would provide prompt pay discounts to Federal health care program beneficiaries and other insured patients (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 penalty provision prohibiting inducements to beneficiaries, section 1128A(a)(5) of the Social Security Act (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 (i) 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 [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; and (ii) the Proposed Arrangement would not constitute grounds for the imposition of civil monetary penalties under section 1128A(a)(5) of the Act. 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**

[Name redacted] (the “Health System”) is a health care system that owns and operates two acute care hospitals and one critical access hospital. Under the Proposed Arrangement, the Health System would offer to Medicare, Medicaid and other Federal health care program beneficiaries, along with all other insured patients, a discount for prompt payment of their cost-sharing amounts and amounts owed for non-covered services for which the patients received an advanced beneficiary notice (the “Prompt Pay Discount”). The Prompt Pay Discount is designed to reduce the Health System’s accounts receivables and costs of debt collection, and to boost its cash flow. The Health System has certified that the amount of fees discounted to patients under the Proposed Arrangement would bear a reasonable relationship to the amount of collection costs that would be avoided.

The Prompt Pay Discount would be offered in connection with both inpatient and outpatient services and would be offered to insured patients regardless of their financial status or their ability to pay. Patients would benefit from the Prompt Pay Discount in the following two circumstances: 1) when payments are made on a hospital bill prior to the discharge of the patient; or, 2) when payments are made after discharge, but within thirty (30) days of the patient’s being informed of the discount offer. The size of the Prompt Pay Discount would depend on both the timing of the payment and the size of the remaining balance owed by the patient. The Prompt Pay Discount would be awarded according to the following schedule:

*% of Bill Discounted on Payments Made Prior to Discharge*

Balances \$0 -- \$999	=	10%
Balances ≥ \$1,000	=	15%

*% of Bill Discounted on Payments Made Post-Discharge  
But Within 30 days of Discount Offer*

Balances \$0 -- \$999	=	5%
Balances ≥ \$1,000	=	10%

The Health System has certified that it would not publicly advertise the Prompt Pay Discount opportunity. Instead, the Health System would only notify patients of the Prompt Pay Discount at certain times during the Health System's ordinary course of dealing with patients. These times would include: when the patient registers for outpatient services and the patient pays his or her cost-sharing amount; when the Health System sends written statements to a patient by mail; and when financial arrangements are made between the Health System and the patient, or his or her appointed financial counselor, after admission for inpatient health services.

The Health System has certified that it would disclose the fact of the Prompt Pay Discount to third-party payers, and that the Health System would not claim the waived amount as bad debt or otherwise shift the burden to the Medicare or Medicaid programs or other third-party payers or individuals. Nor would the Prompt Pay Discount be part of a price reduction agreement with third-party payers. The Prompt Pay Discount would be offered without regard to the reason for the patient's admission, length of stay, diagnostic-related group, or ambulatory payment classification. Finally, the costs associated with the Proposed Arrangement would solely be carried by the Health System.

## **II. LEGAL ANALYSIS**

### **A. Law**

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.

The Department of Health and Human Services has promulgated safe harbor regulations that define practices that are not subject to the anti-kickback statute because such practices would be unlikely to result in fraud or abuse. See 42 C.F.R. § 1001.952. The safe harbors set forth specific conditions that, if met, assure entities involved of not being prosecuted or sanctioned for the arrangement qualifying for the safe harbor. However, safe harbor protection is afforded only to those arrangements that precisely meet all of the conditions set forth in the safe harbor. The safe harbor for waivers of beneficiary coinsurance and deductible amounts, 42 C.F.R. § 1001.952(k), is potentially applicable to the Proposed Arrangement.

Section 1128A(a)(5) of the Act provides for the imposition of civil monetary penalties against any person who gives something of value 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 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 may also 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) as including, among other things, the waiver of coinsurance and deductible amounts (or any part thereof). However, remuneration under section 1128A(a)(5) does not include a waiver of cost-sharing amounts that fits in a safe harbor under the anti-kickback statute. See section 1128A(i)(6)(B).

## **B. Analysis**

Under its explicit terms, the relevant portion of the safe harbor for waivers of beneficiary coinsurance and deductible amounts only extends to amounts owed by patients for inpatient hospital services. In relevant part, for the purposes of this opinion, the safe harbor for waivers of beneficiary coinsurance and deductible amounts, 42 C.F.R. § 1001.952(k), requires fulfillment of the following conditions: the facility cannot claim the waived amount as bad debt or otherwise shift the burden to the Medicare or Medicaid programs, other third-party payers, or individuals; the facility must make the waiver without regard to the patient's reason for admission, length of stay, or diagnostic related group; and the waiver may not be a part of a price reduction agreement between the facility and a third party payer.

Under the Proposed Arrangement, the Health System has certified that it would adhere to all these conditions. It would not claim the Prompt Pay Discount as debt or otherwise shift the

burden to the Medicare or Medicaid programs, other third-party payers, or individuals. The Prompt Pay Discount would be offered by the Health System without regard to the reason for the patient's admission, length of stay, diagnostic-related group, or ambulatory payment classification. The Prompt Pay Discount, moreover, would not be part of a price reduction agreement between the Health System and any third-party payer. In sum, to the extent that the Prompt Pay Discount is granted with regard to inpatient hospital services, it complies with the safe harbor for waivers of beneficiary coinsurance and deductible amounts owed by patients.

The Proposed Arrangement, however, extends to outpatient services. Consequently, we must evaluate that part separately. In the preamble to the 1991 final safe harbor regulations, we responded to a public comment asking about outpatient providers that offer patients the option of reduced payment at time of service as a strategy for more successful bill collection:

For [local government health care providers for extremely indigent patient populations], this [discounting] practice, while not protected by [the waiver of beneficiary deductible and coinsurance amounts] safe harbor regulation, would not likely violate the statute so long as the partial forgiveness of the copayment obligation was strictly a pragmatic financial decision and not an inducement to patients to purchase medical services.

56 Fed. Reg. 35952, 35962-63 (July 29, 1991).<sup>1</sup> Thus, we must examine the Prompt Pay Discount to determine whether it may be a disguised payment for referrals.

The Health System has incorporated various commitments that suggest that the Prompt Pay Discount would be a legitimate prompt payment incentive and not a means to induce patients to self-refer. The Health System certified that it would not advertise the discount opportunity. Patients and their representatives would only be informed of the Prompt Pay Discount's availability during the course of the actual billing process. The Health System has certified that other third-party payers would be notified of the prompt payment policies. In addition, the Health System has certified that all the costs of the arrangement would be borne by the Health System. Finally, the Health System has certified that the amount of fees discounted to patients

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<sup>1</sup> See 56 Fed. Reg. 35952, 35979 (July 29, 1991) (“ . . . by definition, [prompt pay discounts] are designed to induce prompt payment, and thus do not appear to violate the [anti-kickback] statute. Of course, we will continue to scrutinize closely “prompt pay” discounts to make sure that they are not payments made for an illegal purpose cloaked under a legitimate label”).

under the Proposed Arrangement would bear a reasonable relationship to the amount of avoided collection costs. We believe that these features reduce the likelihood that the Proposed Arrangement would be used as a means to draw additional patient referrals to the Health System and is consistent with the characterization of the Proposed Arrangement as a prompt payment discount implemented for the purpose of more successful bill collection.

In light of the totality of facts and circumstances presented, we conclude that we would not subject the Health System to administrative sanctions 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 Arrangement. For the same reasons, we would not subject the Health System to administrative sanctions under section 1128A(a)(5) of the Act, the civil monetary penalty provision prohibiting beneficiary inducements.

### **III. CONCLUSION**

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

### **IV. LIMITATIONS**

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to the Health System, 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 Proposed Arrangement, including, without limitation, the physician self-referral law, section 1877 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 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 the Health System 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 Health System 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 rescinded only if the relevant and material facts have not been fully, completely, and accurately disclosed to the OIG.

Sincerely,

/s/

Lewis Morris  
Chief Counsel to the Inspector General