



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 21, 2020

Posted: December 28, 2020

[Name and address redacted]

Re: OIG Advisory Opinion No. 20-07

Dear [Name redacted]:

We are writing in response to your request for an advisory opinion regarding a web-based platform where health care facilities and clinicians would, in particular circumstances, remit to patients and the patients' payors a portion of the claims for certain services for which payment may be made by the Medicare program as a secondary payor (the "Proposed Arrangement"). Specifically, you have inquired whether the Proposed Arrangement constitutes 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 on the facts and information presented to us and, in accordance with 42 C.F.R. § 1008.39(d), other publicly available information. We have not undertaken an independent investigation of the certified facts and information presented to

us by [name redacted], the requestor of this opinion. This opinion is limited to the facts presented to us by [name redacted] and other publicly available information. 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, supplemental submissions, and other publicly available information, 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. In addition, the OIG would not impose administrative sanctions on [name redacted] under section 1128A(a)(5) 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 Existing Online Platform and the New Platform

[Name redacted] (“Requestor”) currently operates an online platform that lists, with the exception of certain categories of facilities,¹ all known health care facilities and clinicians with a National Provider Identifier (collectively referred to throughout as “Providers”). The existing platform includes certain information about Providers, such as their locations, specialties, qualifications, services offered, and the rates they generally charge or accept for specified services. Through the existing platform, Providers may offer potential remittances to patients and their non-government third-party payors for diagnostic, procedural, and

¹ Requestor’s platform excludes from its listings skilled nursing facilities, home health agencies, and hospice providers. In addition to these health care facilities, the platform also excludes pharmaceutical manufacturers; suppliers of durable medical equipment, prosthetics, orthotics, and supplies (other than physicians and hospitals); medical device manufacturers; and pharmacies.

surgical care that is both elective and episodic.² Under the Proposed Arrangement, Requestor would establish a separate user pathway exclusively for patients who have Medicare as a secondary payor through which: (i) Providers could offer potential remittances to such patients and their third-party payors for diagnostic, procedural, and surgical care that is both elective and episodic and potentially payable by the Medicare program as a secondary payor; and (ii) patients could enter into agreements with Providers, where the patients and their third-party payors could receive a portion of the remittances from Providers, after Requestor deducts the portion of the remittances it would keep as a fee (the “New Platform”). The New Platform would list the same Providers, and exclude the same entities, as the existing platform.

Requestor certified that it currently uses the following processes, and it would employ the same processes for purposes of the New Platform. Requestor obtains information about Providers, including rate information, from publicly available data and other third-party sources, such as insurance claims submissions data, patients’ explanations of benefits, and all-payor claims databases.³ Providers can submit proposed additions and corrections to their online listings, including information posted about their rates, and Requestor incorporates the changes if it is able to validate the information.

B. Membership

Under the Proposed Arrangement, patients who have Medicare as a secondary payor could join the New Platform as members (“Members”)⁴ by providing their insurance information,

² Requestor certified that the amount of the remittance a patient can receive through the existing platform may be higher than the patient’s cost-sharing obligations for the services the patient receives. We have not been asked to opine, and express no opinion, on the existing platform, and we caution that we likely would reach a different conclusion with respect to the risk presented by the Proposed Arrangement if it involved Requestor distributing remittances to Federal health care program beneficiaries without regard to their cost-sharing obligations.

³ Requestor certified that it obtains all information for the existing platform, and would obtain all information for the New Platform, in a manner compliant with all applicable laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

⁴ The only Federal health care program beneficiaries who could join the New Platform are Federal health care program beneficiaries who have Medicare as a secondary payor. All

including information about their primary insurance and their secondary payor coverage through the Medicare program. Requestor would not charge Members any fee at the time they join the New Platform, and the New Platform would continue to be free to Members who do not ultimately receive a remittance from a Provider.⁵ Requestor would use the Members' insurance information to provide estimates of the Members' anticipated out-of-pocket costs for specified services across the range of Providers from which they may choose to receive care. In addition to searching and comparing Providers on the New Platform, Members could view potential remittances offered by Providers through the New Platform for diagnostic, procedural, and surgical care.⁶ Members also would have access to: (i) a care concierge team that would provide them with a variety of health insurance and cost-related information;⁷ and (ii) a personalized dashboard that would show Members' deductible balances and remaining annual out-of-pocket obligations and the estimated amounts the Members' payors would pay for a specified service, taking into account any potential remittance that may apply to the specified service.

other Federal health care program beneficiaries are excluded from joining the existing platform and would be excluded from joining the New Platform as Members.

⁵ In our assessment, the New Platform would not be free to Members who receive remittances because, as explained further below, Requestor would keep 33 percent of each remittance as payment from Members for the services Requestor renders to the Members.

⁶ The potential remittances displayed on the New Platform would include the total potential remittance that would be issued to Requestor, upon the satisfaction of certain payment conditions described below, for distribution to the Member and the Member's payors, after Requestor deducts the portion of the remittance that it would keep as a fee. In other words, the potential remittances shown to Members on the New Platform would not be solely the portion of the remittances allocable to Members.

⁷ Requestor explained that the care concierge team would assist Members with: (i) identifying available Providers; (ii) confirming Providers' in-network status; (iii) determining the current status of Members' cost-sharing obligations; (iv) comparing rates, qualifications, potential remittances offered, and other information requested by Members to assist in their selection of Providers; (v) confirming potential remittance offers with Members' chosen Providers; (vi) booking appointments as directed by Members; and (vii) identifying the documentation and information Members need for their Provider visits. However, the care concierge team would not negotiate potential remittances with Providers on behalf of Members.

On the New Platform, Members would be able to select from a dropdown menu to sort Providers listed in search results based upon distance from the Member’s designated address, lowest-to-highest estimated Provider rates, and lowest-to-highest estimated final rates, taking into account a Member’s plan network rates and any potential remittances offered by the Provider. The New Platform would not provide an option to sort or filter results to list only Providers offering potential remittances. If a Member does not select a sort order, the New Platform would sort Providers based upon their distance from the Member’s designated address. The New Platform would not prioritize Providers’ placement in search results based on whether they offer a potential remittance. For example, if Provider A offers a lower overall rate for a specified service than Provider B, but Provider A does not offer a potential remittance for the specified service and Provider B does, Provider A would be listed before Provider B in search results sorted by lowest-to-highest estimated final rates. Requestor further certified that it (through the New Platform, the care concierge team available to Members, or otherwise) would not give priority to any Providers in any manner or steer or influence any Member’s choice of Provider.

C. Remittance Process for Members

Any Provider health care facility that is accredited by a nationally recognized accrediting organization and any Provider clinician with state licensure could use the New Platform at no charge to post amounts for specified services that, upon the satisfaction of certain payment requirements described below, the Provider would remit to the Member and the Member’s payors through a check sent to Requestor. The services for which Providers would offer potential remittances would be limited to diagnostic, procedural, and surgical services that are both elective and episodic and that a practitioner has already determined are medically necessary for the Member. Providers could offer potential remittances on the New Platform through one of three methodologies: (i) as a percentage remittance calculated using the total amount the Provider would be entitled to receive for the specified services from the Member’s primary payor, the Medicare program (as a secondary payor), and the Member (through cost-sharing amounts owed pursuant to the Member’s contracts with his or her payors) (collectively, the “Provider Contracted Amount”)⁸; (ii) using a set dollar amount that would be subtracted from the Provider Contracted Amount, where the remittance would equal the difference between the Provider Contracted Amount and the set dollar amount (e.g., if the Provider Contracted Amount for a particular service is \$650, and a Provider’s set dollar amount is \$500 for that service, the remittance would be \$150); or (iii) as a set dollar amount that would not vary by payor (e.g., \$50 regardless of payor). Providers could change the posted potential remittances and applicable methodology for

⁸ Remittances would be calculated with respect to the Provider Contracted Amount, which may be lower than the amount billed by the Provider.

calculating potential remittances at any time by updating their agreements with Requestor, which would set forth the terms of the potential remittances.

If a Member wants to receive a service for which a Provider has listed a potential remittance, the Member would notify the Provider through the New Platform. If the Provider agrees to provide the requested service with the potential remittance, the Provider and Member would enter into an agreement through the New Platform that obligates the Provider to send the remittance to Requestor upon the satisfaction of certain payment requirements related to hassle-free processing and prompt payment of all amounts owed by the Member, the Member's primary payor, and the Medicare program, as a secondary payor. Once the Member receives the requested service, the Provider would submit a claim for the service it rendered to the Member's primary payor and, if applicable, the Medicare program. The primary payor and, if applicable, the Medicare program would pay the claims under their normal processes. If all payors responsible for payment pay the claims, and the payment requirements related to hassle-free processing and prompt payment are satisfied, the Provider would remit a check to Requestor.

Requestor would retain 33 percent of each remittance as payment for the services it renders to the Member to facilitate the Proposed Arrangement, and then it would distribute 50 percent of the balance of the remittance to the Member, subject to the cap described below, and the remaining 50 percent of the balance to the Member's payor(s), subject to the conditions described below. With respect to the remittances distributed to Members, Requestor would cap the share of the remittances Members could receive at the total amount of a Member's cost-sharing obligations for the services. Therefore, Members could receive up to, but no more than, the full amount of their cost-sharing obligations for the services for which a Provider has issued a remittance. Requestor would use the amount of a Member's share of a remittance that exceeds his or her cost-sharing obligations to make charitable donations to health-care-related nonprofit organizations.

With respect to the remittances distributed to the Member's payor(s), if the Medicare program pays a portion of the claim, Requestor would make a priority distribution to the Medicare program, through administrative contractors, to repay in full the amount the Medicare program paid on the claim, and then Requestor would remit the remaining balance, if any, to the Member's primary payor. Additionally, Requestor certified that it would: (i) provide written disclosure of the remittances to Members' payors, including the Medicare program; and (ii) confirm Providers' calculations, and maintain a record, of the remittances on behalf of Members and their payors.

II. LEGAL ANALYSIS

A. Law

The Federal anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward, among other things, referrals for, or purchases of, items or services reimbursable by a Federal health care program.⁹ 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.¹⁰ 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.¹¹ Violation of the statute constitutes a felony punishable by a maximum fine of \$100,000, imprisonment up to ten 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 U.S. Department of Health and Human Services has promulgated safe harbor regulations that define practices that are not subject to sanctions under the anti-kickback

⁹ See section 1128B(b) of the Act.

¹⁰ Id.

¹¹ 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).

statute, even though they potentially may be capable of inducing referrals of federally reimbursable business.¹² 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 personal services and management contracts, 42 C.F.R. § 1001.952(d), is potentially applicable to the Proposed Arrangement. In relevant part for purposes of this advisory opinion, the personal services and management contracts safe harbor requires that the compensation paid not be determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs. See 42 C.F.R. § 1001.952(d)(5).

The safe harbor for discounts, 42 C.F.R. § 1001.952(h), is also potentially applicable to the Proposed Arrangement. The discount safe harbor excludes from the definition of “remuneration” a discount on an item or service for which payment may be made in whole or in part under a Federal health care program. A “discount” means, subject to certain exceptions, “a reduction in the amount a buyer (who buys either directly or through a wholesaler or a group purchasing organization) is charged for an item or service based on an arms-length transaction.” Relevant to the Proposed Arrangement, a “discount” does not include: “[s]ervices provided in accordance with a personal or management services contract.”

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 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) of the Act as including “transfers of items or services for free or for other than fair market value.”

B. Analysis

The Proposed Arrangement would result in several remuneration streams that implicate the Federal anti-kickback statute, some of which also implicate the Beneficiary Inducements

¹² See 42 C.F.R. § 1001.952.

CMP. First, under the Proposed Arrangement, Providers that render specified services to Members would, in circumstances where certain payment requirements are satisfied, remit a portion of the Provider Contracted Amount. These remittances offered by Providers would constitute remuneration from Providers to Members and their primary payors. Second, Requestor would keep 33 percent of each remittance as payment from Members for the services Requestor would provide to Members, and this administrative services fee would constitute remuneration from Members to Requestor. Finally, the free use of the New Platform to search, compare, and enter into agreements with Providers, as well as Requestor's provision of services through the care concierge team and the availability of a personalized dashboard that would show a Member's deductible balance, among other information, would constitute remuneration from Requestor to Members who do not receive a remittance through the New Platform. We analyze the Proposed Arrangement, in turn, under the Federal anti-kickback statute and the Beneficiary Inducements CMP.

1. Federal Anti-Kickback Statute

We conclude that each of these streams of remuneration would implicate the anti-kickback statute. First, the remittances that Providers would offer or send to Members would implicate the anti-kickback statute because the offer or payment of such remittances may be made to induce Members to self-refer to the Providers for services for which payment may be made in whole or in part under a Federal health care program. Additionally, the remittances that Providers would offer or send to the Members' primary payors through Requestor would implicate the anti-kickback statute because such offers or payments may be inducements for the payors to arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program.

Additionally, the amounts Members who receive remittances would pay Requestor for its services would implicate the anti-kickback statute because such amounts would be paid for Requestor to arrange for the purchasing or ordering of services for which payment may be made in whole or in part under a Federal health care program. Lastly, Requestor's provision of the New Platform for free to certain Members could be an inducement for Members to purchase services through the New Platform in the future, some of which may be reimbursable in whole or in part by a Federal health care program.

We next determine whether one or more safe harbors to the Federal anti-kickback statute would apply to the Proposed Arrangement. For the Proposed Arrangement to have safe harbor protection, each stream of remuneration would have to squarely fit in one or more safe harbors. We conclude that, based on the facts certified by Requestor, safe harbor protection would not be available to all of the Proposed Arrangement's streams of remuneration. For example, the remuneration from Members to Requestor—in the form of

a percentage of the remittance retained by Requestor as compensation for its provision of services to Members—would not be protected by any safe harbor.

The personal services and management contracts safe harbor would not apply. Under the Proposed Arrangement, Requestor would keep 33 percent of each remittance, where the remittances would be paid with respect to services for which payment may be made by the Medicare program as a secondary payor. Among other potential reasons, the remuneration would not be protected by this safe harbor because the amount Requestor would keep would be determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid, or other Federal health care programs (*e.g.*, the amounts Requestor would keep would increase with the number of times Members use the New Platform to arrange for services—that may be reimbursed by Medicare as a secondary payor—for which Providers ultimately issue remittances).

Additionally, the discount safe harbor would not protect the remuneration from Members to Requestor. Under the safe harbor, a “discount” cannot be “[s]ervices provided in accordance with a personal or management services contract.” Because the remuneration from Members to Requestor would be payments for services, this remuneration would not qualify for protection.

Arrangements that implicate the anti-kickback statute and do not have safe harbor protection are evaluated on a case-by-case basis, based on the totality of the facts and circumstances. For purposes of this advisory opinion’s analysis, we assess the Proposed Arrangement in its totality, inclusive of the aforementioned remuneration streams. Based on this assessment, and for the combination of the following reasons, we conclude that the Proposed Arrangement would present a minimal risk of fraud and abuse under the anti-kickback statute.

First, we believe the risk that the Proposed Arrangement would result in increased costs to Federal health care programs through overutilization or inappropriate utilization would be low. The Proposed Arrangement would involve potential remittances to Members of an amount up to the cost-sharing amounts Members owe pursuant to their contracts with their payors for services potentially payable, in part, by the Medicare program. While such potential remittances could lead to overutilization or inappropriate utilization, we believe the Proposed Arrangement includes safeguards that would sufficiently mitigate this risk. The only services for which Providers would offer potential remittances would be diagnostic, procedural, and surgical services that are both elective and episodic and that a practitioner has determined are medically necessary for the Member. Additionally, the remittances that would be facilitated by Requestor and made to Members under the Proposed Arrangement would differ in important respects from routine waivers of Medicare

cost-sharing amounts, with which the OIG has had longstanding concerns. Unlike cost-sharing waivers, which waive the cost-sharing obligations patients otherwise would pay at the time of the service, Members would pay their cost-sharing obligations and would not receive any remittances of their cost-sharing obligations unless the requirements related to hassle-free processing and prompt payment are met with respect to all amounts owed by the Member, the Member's primary payor, and the Medicare program, as a secondary payor. Therefore, if one or more payors does not meet the hassle-free processing and prompt-pay requirements after a Provider rendered a service, the Member would not receive any remittances of their cost-sharing obligations.

Further, Requestor would provide written disclosure of the remittances to Members' payors, including the Medicare program, and would offer a large portion of the remittances to the payors. Therefore, unlike routine cost-sharing waivers that may not be transparent to payors and may reduce only patients' cost-sharing obligations, Requestor would disclose remittances to the Members' payors and remit certain amounts to both Members and their payors. For this reason, concerns related to the potential for cost-sharing waivers to distort payors' understanding of charges by a provider for a specific service—which include any patient cost-sharing—would not be present in the Proposed Arrangement. Relatedly, the Proposed Arrangement would extend only to the comparatively limited patient population of Federal health care beneficiaries who have Medicare as a secondary payor, as compared with all Federal health care program beneficiaries.¹³ As a consequence, a Member's primary payor could still benefit from any remittance even if the Medicare program could not accept one or more remittances offered under the Proposed Arrangement.

Second, the structure of the payments from certain Members to Requestor—in the form of the percentage of the remittance that Requestor would retain as compensation for its provision of services to Members—also would reduce the potential for overutilization or inappropriate utilization and would reduce the potential for interference with clinical decision making. In contrast to certain arrangements where patients would purchase a pre-paid coupon for a service prior to receiving the service, Requestor would retain a percentage of the remittances as a fee only when Members receive remittances from Providers after the services have been rendered. Therefore, if a Provider determined, for example, that an alternative service would be more appropriate for the Member than the service the Member sought through the New Platform, the Provider would not feel pressured to render the service the Member sought through the New Platform based on the Member's financial

¹³ According to the Kaiser Family Foundation, in 2016, only 2 million of the 60 million Medicare beneficiaries had Medicare as a secondary payor. Juliette Cubanski et al., Sources of Supplemental Coverage Among Medicare Beneficiaries in 2016 (Nov. 28, 2018), available at <https://www.kff.org/medicare/issue-brief/sources-of-supplemental-coverage-among-medicare-beneficiaries-in-2016/>.

investment, given that Members would not pre-pay Requestor under the Proposed Arrangement.

Third, the Proposed Arrangement would mitigate Provider incentives to increase prices to induce Members to receive services. We recognize that some arrangements involving remittances could result in a provider or supplier increasing their sales prices in order to offer larger remittances to certain parties to induce purchases. We also recognize that some arrangements involving a reduction or waiver of cost-sharing amounts could result in increased sales prices because the cost-sharing reductions or waivers could remove a market safeguard that protects against price increases. However, those risks would not be present here. Under the Proposed Arrangement, Providers could offer potential remittances on the New Platform through one of three methodologies. Under the first two remittance methodologies, remittances would be based on the Provider Contracted Amount—not the amount billed by the Provider, which may be higher than the Provider Contracted Amount, and the third remittance methodology would be a set dollar amount that would not vary by payor. Additionally, when the Medicare program would pay Providers as a secondary payor, such payments would be only up to the Medicare-approved amount, which creates a cap to potential Medicare expenditures.

Fourth, we believe the risk that the Proposed Arrangement would have anti-competitive effects is low. Any Provider health care facility that is accredited by a nationally recognized accrediting organization and any Provider clinician with state licensure could use the New Platform at no charge to post potential remittances, which could improve access to this feature of the New Platform for Providers with limited resources. Further, the New Platform would provide transparency to Members with respect to Providers' estimated rates, taking into account Members' plan network rates and any potential remittances offered by Providers, which could promote competition and Members' freedom of choice among Providers.

Lastly, neither Requestor nor the New Platform would steer Members to certain Providers. On the New Platform, Members would be able to select from a dropdown menu to sort Providers listed in search results based upon distance, lowest-to-highest estimated Provider rates, and lowest-to-highest estimated final rates, taking into account a Member's plan network rates and any potential remittances offered by the Provider. If a Member does not select a sort order, the New Platform would sort Providers based upon their distance from the Member's designated address. Requestor certified that the New Platform would not prioritize Providers' placement in search results based on whether they offer a potential remittance and that it would not (through the New Platform, the care concierge team available to Members, or otherwise) give priority to any Providers in any manner or steer or influence any Member's choice of Provider. Requestor further certified that the New Platform would not provide an option for Members to sort or filter results by only Providers

offering potential remittances. While certain information provided by the New Platform’s search-and-compare functionality or through the care concierge team could influence a Member’s selection of a practitioner or health care facility, a Member’s use of this objective information, which would be available on the New Platform for all Providers, would not constitute steering. Further, the care concierge team would not negotiate potential remittances on behalf of Members; doing so could pose a conflict of interest if the care concierge team attempted to negotiate higher remittances for Members in order to increase the amount Requestor would keep upon the payment of any such remittances.

2. Beneficiary Inducements CMP

We also must analyze whether the Proposed Arrangement would be likely to influence a 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. We conclude that Requestor and Providers would know, or should know, that their offer or transfer of remittances to Members, pursuant to the Proposed Arrangement, would be likely to influence a Member to select a Provider offering potential remittances for the order or receipt of services for which payment may be made, in whole or in part, by Medicare or a State health care program. Once we determine that an arrangement could constitute grounds for the imposition of administrative sanctions under the Beneficiary Inducements CMP, we analyze whether an exception would apply, and here, we conclude that no exception would apply. Consequently, the Proposed Arrangement would constitute grounds for the imposition of sanctions under the Beneficiary Inducements CMP. However, for the same reasons set forth above, in an exercise of our discretion, we would not impose sanctions under the Beneficiary Inducements CMP in connection with the Proposed Arrangement.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that, although the 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. In addition, the OIG would not impose administrative sanctions on [name redacted] under section 1128A(a)(5) 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 [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 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 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 Requestor 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

Requestor 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