MEMORANDUM

To: **Charmian Foster/MTANJ**

From: **Brian S. Werfel, Esq.**

Date: **February 18, 2011**

Subject: **Legal Issues Associated with Facility Contracting**

On behalf of the members of the Medical Transportation Association of New Jersey, you have asked for a summary of the legal issues associated with facility contracts for medical transportation services. Specifically, you have asked for an explanation of the potential compliance issues raised by a medical transportation service offering discounted services to hospitals or nursing homes.

Applicable Law

There are two potential statutory prohibitions that can apply to discounted ambulance services. These are: (1) the prohibition on billing Medicare or Medicaid "substantially in excess" of the provider's usual charges and (2) the federal anti-kickback statute.

Prohibition on Billing Substantially in Excess

Section 1128(b)(6) of the Social Security Act prohibits a provider or supplier from submitting bills to Medicare or Medicaid that are "substantially in excess" of the provider's usual charges. For these purposes, the provider's "usual charge" is the amount typically billed to non-federal payers, including commercial insurance, facilities, hospices, etc. In applying this requirement, the Office of Inspector General (OIG) looks not to the actual charge itself, but rather the amount the company "most frequently expects to receive" from these non-federal payers. The penalty for violation of this statutory prohibition can be exclusion from the Medicare or Medicaid program.

In September 2003, the OIG proposed to define "substantially in excess" to include situations where the provider billed Medicare or Medicaid 20% or more than its average charge to non-federal payers. The effect of this proposed rule would have been to draw a line at discounts of greater than 16 2/3% off the applicable Medicare or Medicaid allowable. However, this proposed rule was withdrawn in June 2007. As a result, the OIG continues to evaluate excessive discounts on a case-by-case basis.

It should be noted that, in calculating a provider's "usual charge" for purposes of determining compliance with the substantially in excess provision, the OIG will not include charges to uninsured or underinsured patients. Similarly, most experts believe that ambulance providers are permitted to discount down to the Medicaid rate for transports of Medicaid patients that are the facility's responsibility under applicable

Medicaid rules. However, this would not apply to dual-eligible patients where the facility is responsible for the transport under the applicable Medicare consolidated billing rules.

Federal Anti-Kickback Statute

Section 1128B(b) of the Social Security Act makes it a crime to knowingly offer to pay any "remuneration" to another person, directly or indirectly, for the purposes of inducing that person to refer services that may be reimbursable by federal health care programs, including Medicare or Medicaid. The statute contains a reciprocal provision that makes it a crime to accept any remuneration in exchange for the referral of services payable by federal health care programs. For these purposes, "remuneration" can include anything of value, including the transfer of services for free or for anything other than fair market value.

OIG Guidance

In OIG Advisory Opinion 10-26, issued December 28, 2010, the OIG declined to permit an arrangement involving below-cost rates offered by an ambulance provider to a skilled nursing facility. This Advisory Opinion is the latest affirmation of the OIG's long-standing position that below-cost rates offered to nursing homes "gives rise to the inference" that the ambulance provider and the SNF are swapping those below cost rates for referrals[1]. The OIG further indicated that these "swapping arrangements may violate the anti-kickback statute.

Analysis

Collectively, these statutory prohibitions place limits on the extent of permissible discounts that can be offered to facilities, including hospitals and nursing homes. Unfortunately, there is no bright-line as to the level of permissible discounting. However, the following general guidelines can help guide members:

- **Discounts off a provider's usual billed charge—but which are still above the corresponding Medicare allowable—are permissible.**

- **Contracted rates that are below a provider's total costs of providing the service give rise to an inference that the supplier and the SNF may be swapping the below-cost rates in exchange for more profitable Medicare or Medicaid business.**

The question then becomes where the line is drawn as to permissible discounts. In a Special Fraud Alert issued in October 1994, the OIG indicated that contracted reimbursement rates should not be made at rates lower than "fair market value", which the OIG defined to be an "arms length transaction…which has not been adjusted to include the additional value which one or both of the parties has attributed to the referral

[1] For ambulance services, the OIG's position on swapping arrangements was first set forth in Advisory Opinion 99-2, issued February 26, 1999.

of business between them." This Special Fraud Alert was intended to address clinical lab services; however, the same reasoning would apply to contracts for ambulance services.

On September 30, 2008, the OIG issued a guidance document for skilled nursing facilities that made clear that fair market value is not the sole test for an impermissible discount; rather, it is simply one factor that the OIG will consider in evaluating contract rates.

Conclusion

Federal law does not prohibit discounts offered to facilities. Rather, federal law prohibits excessive discounts and/or discounts offered for the purpose of inducing the referrals of services that are reimbursable by federal health care programs. However, at the present time, there is no bright-line on what constitutes a permissible discount off the Medicare allowable.

Ambulance providers are permitted to pass along actual, realized cost savings associated with billing the facility rather than Medicare. These cost-savings can result from: (i) so-called "prompt payment" provisions, (ii) reduced administrative requirements (e.g., the ability to bill monthly), (iii) reduced compliance costs (e.g., relief from the PCS and patient signature requirements), etc. A discount can even be justified based on the expected referral of large numbers of patients with commercial health insurance. However, projected cost savings that take into account the referral of Medicare or Medicaid patients may give rise to an inference that the discount is being offered for the express purpose of generating such referrals, which would violate the anti-kickback statute.

For this reason, it is important that ambulance providers properly document the cost savings that are associated with any contractual arrangement. To the extent such cost savings are based on projections of future volume, ambulance providers are advised not to include in their projections the volume of transports reimbursable by federal health programs. Providers should also document that such rates are at-or-above their total costs of providing the expected services.

This memorandum provides a general summary of the legal issues associated with hospital contracting. It is not intended to be and should not be relied upon as legal advice. MTANJ Members are advised to consult their own legal counsel prior to entering into any contractual arrangement for the provision of medical transportation services.