Some Considerations for Contracting in Light of Medicaid Bundling

Ohio’s most recent budget bill adjusted nursing facilities’ Medicaid per diem rate to allow a $3.91 add-on for consolidated services, which include transportation services, skilled therapies, certain over-the-counter drugs, oxygen, and wheelchairs. Because nursing facilities are now responsible for providing these services to residents, many are in the process of revising or supplementing existing agreements to account for the fact that the service provider will no longer directly bill the resident for bundled services.

As nursing facilities are preparing addenda to existing contracts and/or entering into new contracts with providers of bundled services, they may wish to keep in mind the following:

Medicaid Bundling is Akin to Medicare Consolidated Billing

Medicaid’s new bundling requirements are akin to Medicare consolidated billing. Thus, the same considerations for negotiating contracts will apply. Additionally, to the extent existing contracts already address reimbursement and invoicing between the parties in relation to Medicare residents, those same provisions could be applied to Medicaid bundled services.

The Nursing Facility is the Payor

Essentially, consolidated services provided to Medicaid residents are now a private pay service vis a vis the supplier, with the nursing facility as the payor. The law does not specify the amount nursing facilities must pay vendors or suppliers for consolidated services, nor does it impose a methodology to be used in determining pricing for the services. Thus, facilities are free to negotiate a variety of pricing arrangements. As further detailed below, nursing facilities may tie their prices to the Medicaid fee schedule, obtain discounts based on the supplier’s administrative billing savings, or utilize risk-based pricing schemes such as subscription fees and per diem rates, to name just a few.

Application of Bundling

Nursing facilities should also keep in mind that in certain situations, bundling will not apply. For example, services provided to Medicaid residents who have elected the hospice benefit would not be subject to bundling requirements. Additionally, JFS has noted that ambulance services
provided to a resident on the day of discharge are not included in the facility per diem rate, as the nursing facility is not paid for the day of discharge.

**Anti-Kickback & Improper Inducement Concerns**

Some providers of consolidated services have raised concerns over whether certain Medicaid bundling pricing scenarios may violate federal and state anti-kickback statutes. Indeed, nursing facilities should use caution in negotiating alternative pricing arrangements and carefully examine any implication of the anti-kickback statutes.

One of the most common issues raised with regard to alternative pricing is improper “swapping” arrangements.

**What is Swapping?**

Swapping generally arises when a supplier provides the exact same service to two different payors at different prices, and the payor receiving the discounted rate makes a referral of other higher paying federal health care program business.

The Department of Health and Human Services Office of Inspector General (“OIG”) has considered swapping arrangements in past advisory opinions, some of which we have attached for your reference, and which you may wish to review for guidance in examining future agreements. In these opinions, the OIG identified certain arrangements that give rise to an inference that the entities may be swapping discounts in exchange for non-discounted federal health care business:

- Discounted prices are below the supplier’s actual cost of providing the service;
- Discounted prices are lower than prices offered to other buyers that purchase similar volumes of the discounted services, but not any federal-reimbursed services;
- Discounts on facility-reimbursed services are coupled with exclusive supplier agreements; and
- Discounts on facility-reimbursed services are joined with explicit or implicit agreements to refer other business to the supplier.

Because the anti-kickback statute is an intent-based statute, whether the arrangements are prohibited is dependent upon if the discount is, in fact, an inducement for referrals. That is, merely because an arrangement contains one of the prior indicia of swapping, does not

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1 The federal anti-kickback statute makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce the referral of business or services that are covered by a federal healthcare program. (See 42 United States Code § 1320a-7b(b).) Ohio also has a state law prohibiting payments in exchange for referrals that is similar to the federal anti-kickback statute, but also applies to patients covered by private insurance. (See Ohio Revised Code § 3999.22.)

2 See, e.g., OIG Advisory Opinion Nos. 99-2 and 99-13, attached.
necessarily mean that it is illegal. However, nursing facilities should make sure to carefully review all arrangements that may contain one or more of those indicia (preferably with legal counsel).

**Application to Medicaid Bundling**

Whether swapping should be of concern to nursing facilities will depend on whether the nursing facilities refer any business to the supplier of the particular bundled service that is reimbursed by a federal program. For example, the swapping concept would certainly be implicated if a nursing facility referred its residents to a transport provider who in turn billed Medicare Part B for the transports. If, however, no other business is conducted with the supplier other than the bundled service, *i.e.*, no other referrals were made, then swapping should not be an issue.

**Methods of Pricing**

As we stated previously, Medicaid bundling is akin to Medicare consolidated billing. Therefore, nursing facilities may wish to apply the same methods of pricing that they use for addressing Medicare swapping issues to potential Medicaid swapping issues.

For example, the general approaches that have been taken with regard to pricing for Medicare consolidated billing include:

- The nursing facility may require the service provider to charge the same discounted fee to Medicare. This allows the federal government the same benefit as the facility in the discounted rate. Remember that the swapping concern arises because the nursing facility is receiving a discount when the government is not; if the supplier charged the same amounts to all payors, then the swapping issue would not arise.

- The facility may pay a discounted amount off a government fee schedule, *e.g.*, 80% of the relevant fee schedule. The discount is determined and justified by the savings that the supplier will realize in billing the facility, as opposed to having to comply with governmental billing rules.

- The facility may choose to enter into risk-based pricing arrangements, such as per diem rates or monthly subscription fees. The service provider can then calculate the per diem rate or subscription fee considering that it bears the risk of the number of services to be provided. Not only do these arrangements allow the nursing facility to predict its charges for consolidated services, but it is generally held that a true comparison cannot be made between a per-service charge and a per diem or subscription fee. Consequently, the argument can be made that swapping is totally inapplicable to such arrangements.
Addenda vs. New Agreements

While executing an addendum to an existing contract may be the easiest method of addressing new Medicaid bundling requirements, nursing facilities may wish to use this opportunity to review the entirety of their agreements, and perhaps to consider other suppliers for their services.

If you have not examined or renegotiated the terms of your provider and vendor agreements in some time, Rolf & Goffman has template agreements that can facilitate this process fairly easily. If you are interested in additional information about Medicaid bundling or in updating agreements with your consolidated services providers or vendors, please let us know.

This alert is intended to be informational only, and it is not intended to be nor should it be relied upon as legal advice. Indeed, Rolf & Goffman Co., L.P.A. shall not be responsible for any actions taken or arrangements structured based upon this alert. The receipt of this alert by an organization that is not a current client of our firm does not create an attorney-client relationship between the reader and Rolf & Goffman Co., L.P.A.
We are writing in response to your request for an advisory opinion regarding certain arrangements for discounted ambulance services provided to residents of Medicare skilled nursing facilities (collectively, the "Arrangement"). You have asked whether the Arrangement would result in prohibited remuneration under the anti-kickback statute, section 1128B(b) of the Social Security Act (the "Act") or would constitute grounds for the imposition of sanctions under the anti-kickback statute, section 1128B(b) of the Act, the exclusion authority related to kickbacks, section 1128(b)(7) of the Act, or the civil monetary penalty provision for kickbacks, section 1128A(a)(7) of the Act.

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.

Based on the facts certified in your request for an advisory opinion, we conclude that the Arrangement might constitute prohibited remuneration under the anti-kickback statute if the requisite intent to induce referrals of Federal health care program business were present and might be subject to sanctions arising under sections 1128B(b), 1128(b)(7), and 1128A(a)(7) of the Act, as well as section 1128(b)(6)(A) of the Act.

This opinion may not be relied on by any person other than the addressee and is further qualified as set out in Part III below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

Ambulance Reimbursement Under the SNF Prospective Payment System

The genesis of the Arrangement is Medicare's new prospective payment system for Medicare-certified skilled nursing facilities ("SNFs"). In 1997, Congress significantly changed the way SNFs are reimbursed for services to patients covered under Medicare Part A, the hospital benefit. Specifically, the Balanced Budget Act of 1997 enacted a prospective payment system ("PPS") for SNFs covering all costs (routine, ancillary, and capital) related to services furnished to beneficiaries covered under Part A, including certain Part B services. Other Part B services will continue to be reimbursed separately to the providers of such services pending implementation of a new consolidated billing system.
The basic PPS methodology is a prospectively fixed per diem payment adjusted to reflect the patient's health status and needs and the regional wage rate (the "Federal case mix adjusted rate"). Under PPS, the SNF per diem payment will include payment for certain ancillary Part B services previously reimbursed by Medicare directly to the providers of such services. This new payment scheme shifts risk to the SNFs, giving them a significant financial incentive to reduce costs, and may indirectly result in lower payments to suppliers and providers of items and services covered by the PPS payment.

Among the Part B services affected by the change in SNF reimbursement are ambulance services. Traditionally, ambulance services rendered to Medicare patients residing in SNFs have been covered by Medicare Part B and reimbursed on a reasonable charge basis. Under PPS, ambulance services that are within the normal scope of the patient's plan of care ("Plan of Care Ambulance Services") are included in the fixed PPS per diem payment. SNFs must provide the Plan of Care Ambulance Services directly or "under arrangement" with an ambulance company. Plan of Care Ambulance Services comprise a relatively small portion of the ambulance services required by most SNF Part A patients, and an even smaller portion of the total ambulance services required by SNF patients generally. Pending full implementation of consolidated billing, Medicare will continue to reimburse ambulance providers for non-PPS covered ambulance services for Part A patients and for services for Medicare patients whose stays are not covered under Part A, based on reasonable charges for services provided until January 1, 2000, and on a fee schedule thereafter.

In sum, pursuant to SNF PPS, Medicare will pay SNFs a fixed per diem amount for patients during a covered Part A stay, and the SNFs will be responsible for paying for virtually all patient care services -- including Plan of Care Ambulance Services -- out of that fixed payment. These PPS-covered ambulance services are the subject of the Arrangement at issue here.

The Arrangement

The Arrangement involves an agreement for PPS-covered ambulance services between Ambulance Company X ("Ambulance Company X") and Nursing Home Y (the "Nursing Home"). Ambulance Company X is a Medicare-certified ambulance supplier operating in the State A market. The Nursing Home is a Medicare-certified SNF paid under PPS for patients covered by Medicare Part A. With the advent of PPS, the Nursing Home has arranged for Ambulance Company X to provide Plan of Care Ambulance Services for its PPS-covered patients "under arrangement". In addition to its PPS-covered patients, the Nursing Home has patients who require ambulance services that are not covered by a PPS payment and that are reimbursed to the ambulance services provider by Medicare under Part B or by other payers.

Ambulance Company X and the Nursing Home have entered into a Medical Transportation Services Agreement (the "Agreement") for the provision of Plan of Care Ambulance Services and chair car services to Nursing Home residents who are covered under the PPS system. The Agreement also applies to Nursing Home residents for whom the Nursing Home is reimbursed by other public or private reimbursement systems under a capitated, per-diem, or other all-inclusive payment that includes ambulance services and residents for whom the Nursing Home otherwise agrees to be financially responsible. In other words, the Agreement applies when the Nursing Home bears the risk for providing ambulance services.

Pursuant to the Agreement, Ambulance Company X will charge the Nursing Home fixed per-transport rates for basic life support ("BLS"), advanced life support ("ALS"), and chair car services. The contractual rates for BLS and ALS services represent discounts of up to 50% of the "reasonable charge"
established by Medicare for Ambulance Company X's services in the State A area. Ambulance Company X will charge Medicare its full usual and customary amount for transporting Nursing Home residents for whom ambulance services are covered under Medicare Part B.

With respect to the amount of the discount, Ambulance Company X has represented that part of the proposed discount would be directly attributable to cost savings Ambulance Company X can achieve when providing services for PPS residents. For example, Ambulance Company X has certified that its billing costs should be substantially less for services for PPS-covered residents because Ambulance Company X will submit a single, consolidated bill to each SNF at the end of each month and because Ambulance Company X will not need to bill residents for copayments or deductibles. Ambulance Company X also believes its collection rate will generally be higher for PPS residents. Ambulance Company X estimates that these factors can reasonably be expected to result in savings equal to approximately 10% of the Medicare reasonable charge for each transport rendered to a PPS resident, depending on the circumstances. Nonetheless, in light of the competitive market, Ambulance Company X is offering discounts in excess of anticipated savings attributable substantially to SNF PPS.

Ambulance Company X proposes entering into similar discount arrangements with other SNFs in its service area. Like Ambulance Company X’s arrangement with the Nursing Home, these proposed discount arrangements would be with SNFs that are being reimbursed for Medicare Part A services under PPS and would apply to ambulance transports provided to the Medicare residents during a covered Part A stay. The discounts would not apply to Part B services. The discount arrangement between Ambulance Company X and the Nursing Home and the proposed discount arrangements between Ambulance Company X and other SNFs described in the request letter are collectively referred to in this opinion letter as the "Arrangement".

II. LEGAL ANALYSIS

The Anti-Kickback Statute

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce 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 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, in cash or in-kind, directly or indirectly, covertly or overtly.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain money for 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 (3rd Cir.), cert. denied, 476 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. This Office may also initiate administrative proceedings to exclude persons from Federal health care programs or to impose civil monetary penalties for fraud, kickbacks, and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act.

The anti-kickback statute contains a statutory exception for "a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program." 42 U.S.C. § 1320a-7b(b)(3)(A). This discount
exception reflects the intent of Congress to encourage price competition that benefits the Medicare and Medicaid programs. The Department of Health and Human Services has published regulations implementing this discount "safe harbor" exception. See 42 C.F.R. § 1001.952(h).

The Discount Pricing Arrangement

Our initial inquiry is whether the Arrangement fits within the discount safe harbor. We conclude it does not. The statutory exception for discounts, as implemented by the regulatory safe harbor, does not protect price reductions -- like those at issue here -- offered to one payer but not offered to Medicare or Medicaid. In the preamble to the discount safe harbor, we illustrated the potential problem with such price reductions:

[W]e are aware of cases where laboratories offer a discount to physicians who then bill the patient, but do not offer the same discount to the Medicare program. In some of these cases, the discount offered to the physician is explicitly conditioned on the physician's referral of all of his or her laboratory business. Such a "discount" does not benefit Medicare, and is therefore inconsistent with the statutory intent for discounts to be reported to the programs with costs and charges reduced appropriately to reflect the discounts.

56 Fed. Reg. 35977 (July 29, 1991). In essence, such price reductions create a risk that a supplier may be offering remuneration in the form of discounts on business for which the purchaser pays the supplier, in exchange for the opportunity to service and bill for higher paying Federal health care program business reimbursed directly by the program to the supplier. In such circumstances, neither Medicare nor Medicaid benefits from the discount; to the contrary, Medicare and Medicaid may, in effect, subsidize the other payer's discounted rates. Moreover, suppliers may have an incentive to inappropriately increase utilization or engage in abusive billing practices to recoup losses on the discounted business. Accordingly, the discount safe harbor specifically excludes "[a] reduction in price applicable to one payor but not to Medicare or a State health care program." See 42 C.F.R. § 1001.952(h)(3)(iii).

Having concluded that the Arrangement does not fit in the safe harbor, we must consider whether the discount arrangement between Ambulance Company X and the Nursing Home and similar arrangements with other SNFs may involve illegal remuneration for the SNFs' referrals of ambulance business not covered by the PPS payment and not subject to the discount. We conclude that they may.

The circumstances surrounding the Arrangement suggest that a nexus may exist between the discount to the SNFs for PPS-covered transports and referrals of other Federal health care program business. First, the SNFs are in a position to direct a significant amount of business to Ambulance Company X that is not covered by the PPS payment. Second, both parties have obvious motives for agreeing to trade discounts on PPS business for referrals of non-PPS business: the SNFs to minimize risk of losses under the PPS system and Ambulance Company X to secure business in a highly competitive market. Third, Ambulance Company X's request for an advisory opinion comes amidst a considerable number of informal inquiries and anecdotal reports regarding discounts to SNFs that this Office has received since enactment of SNF PPS. These inquiries and reports suggest that suppliers of a wide range of SNF services are giving SNFs discounts for PPS-covered business that are linked, directly or indirectly, to referrals of Part B business.

In evaluating whether an improper nexus exists between a discount and referrals of Federal business in a particular arrangement, we look for indicia that the discount is not commercially reasonable in the absence of other, non-discounted business. In this regard, discounts on SNF PPS business that are particularly suspect include, but are not limited to:
• discounted prices that are below the supplier's cost,\(^{(12)}\) and
• discounted prices that are lower than the prices that the supplier offers to a buyer that (i) generates a volume of business for the supplier that is the same or greater than the volume of Part A business generated by the PPS SNF, but (ii) does not have any potentially available Part B or other Federal health care program business.

This is an illustrative, not exhaustive, list of suspect discounts; other arrangements may be equally suspect. Each of the above pricing arrangements independently gives rise to an inference that the supplier and the SNF may be "swapping" discounts on Part A business in exchange for profitable non-discounted Part B business, from which the supplier can recoup losses incurred on the discounted business, potentially through overutilization or abusive billing practices. In connection with items or services provided to PPS SNFs, the presence of either of these discount arrangements is particularly suspect under the anti-kickback statute. Other indicators of suspect discounts include (i) discounts on PPS-covered business that are coupled with exclusive supplier agreements and (ii) discounts on Medicare PPS or other capitated or prospective payment business made in conjunction with explicit or implicit agreements to refer other facility business to the supplier, including Part B or other Federal health care program business.

Based on the limited facts presented here, we are unable to exclude the possibility that Ambulance Company X may be offering improper discounts to the Nursing Home and other SNFs for their PPS-covered Part A business with the intent to induce referrals of more lucrative Part B business. Nor are we able to exclude the possibility that the Nursing Home or other SNFs may be soliciting improper discounts on business for which they bear risk in exchange for referrals of business for which they bear no risk. Indeed, the Arrangement poses a significant risk of such improper "swapping" of business, especially in light of Ambulance Company X's representation that many of its competitors are agreeing to such discounts. These competitor discount arrangements may similarly run afoul of the anti-kickback statute. The risk of improper "swapping" is compounded by the likelihood that SNFs will refer non-PPS business to their contracted PPS provider, both as a matter of practical convenience and because SNF personnel may not always know which patients or transports will be covered by PPS when the services are ordered. In these latter circumstances, the simplest way for a SNF to ensure that it is using its contracted provider for its PPS patients -- and therefore securing the Part A discounts -- is for the SNF to refer most patients to that provider.

Price reductions offered to SNFs that are not offered to Medicare or Medicaid patients residing in the same facility raise additional issues under section 1128(b)(6)(A) of the Act, which provides for permissive exclusion from the Federal health care programs of individuals or entities that submit or cause to be submitted bills or requests for payment (based on charges or costs) under Medicare or Medicaid that are substantially in excess of such individual's or entity's usual charges or costs, unless the Secretary finds good cause for such bills or requests. In determining an individual's or entity's "usual" charges, we will look at the amounts charged to non-Federal payers, including SNFs. If the charge to Medicare substantially exceeds the amount the supplier most frequently expects to receive from non-Federal payers, the supplier may be subject to exclusion under section 1128(b)(6)(A) of the Act.

The limited information submitted by Ambulance Company X is insufficient to make a determination whether the Arrangement may run afoul of section 1128(b)(6)(A). However, Ambulance Company X estimates that its costs for services under Medicare Part B are approximately 11% higher than its costs for services under Part A PPS. Yet Ambulance Company X intends to charge SNFs as much as 50% less than it charges Medicare for Part B services. At the very least, these facts give rise to an inference that Ambulance Company X might be charging Medicare amounts substantially in excess of its usual charges.
III. CONCLUSION

Based on the facts certified in the request for an advisory opinion and supplemental submissions, we conclude that the Arrangement -- like many similar arrangements with PPS SNFs -- might constitute prohibited remuneration under the anti-kickback statute if the requisite intent to induce referrals of Federal health care program business were present and might be subject to sanctions arising under the anti-kickback statute pursuant to sections 1128(b)(6) and (7), 1128A(a)(7), or 1128B(b) of the Act.

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to Ambulance Company X, the requester of this opinion. This advisory opinion has no application, 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 requester to this opinion.

- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is herein expressed or implied 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 raised in this advisory opinion and, where the public interest requires, rescind, modify, or terminate this opinion.

Sincerely,

/s/

D. McCarty Thornton

Chief Counsel to the Inspector General

FOOTNOTES:

1. Medicare Part A covers up to 100 days of post-hospital SNF charges. See 42 U.S.C. § 1395d. In addition, Medicare Part B, the supplementary benefit, covers certain ancillary services provided to SNF patients, both during a covered Part A stay and afterwards.
2. See Section 4432 of the Balanced Budget Act of 1997, Pub. Law 105-33. The PPS system for SNFs is being implemented for cost reporting periods beginning after July 1, 1998. There is a transition phase during the first three cost reporting years, during which SNFs will receive a blend of a new Federal case mix adjusted rate and a facility specific rate based on the facility's allowable costs for SNF services for the fiscal 1995 cost reporting period.

3. Section 4432(b) of the Balanced Budget Act of 1997 amended the Social Security Act to establish a requirement for SNF consolidated billing, effective for items and services furnished on or after July 1, 1998. The SNF consolidated billing is a comprehensive billing requirement pursuant to which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. See 63 Fed. Reg. 26294 (May 12, 1998). Full implementation of SNF consolidated billing has been postponed indefinitely. See HCFA Program Memorandum Transmittal no. AB-98-35.60 (July 1998).


5. The following types of ambulance services are expressly excluded from the PPS payment by regulation: ambulance trips that initially convey an individual to the SNF to be admitted as a resident; trips that convey the individual to a hospital to be admitted as an inpatient; trips that convey an individual in connection with the receipt of services from a Medicare-participating home health agency under a plan of care; trips that convey an individual to a hospital in connection with the receipt of outpatient services that are not furnished pursuant to the individual's comprehensive care plan; and trips that convey an individual from a SNF after formal discharge, unless the individual is readmitted or returns within a specified period of time. Id. These excluded services constitute a significant part of the ambulance services provided to SNF patients.

6. Room and board for these patients is typically covered by Medicaid or through private funds or insurance.


8. Chair car services will be provided at the applicable State Medicaid rates. Chair car services are not covered by Medicare.

9. Because both the criminal and administrative sanctions related to the anti-kickback implications of the Arrangement are based on violations of the anti-kickback statute, the analysis for the purposes of this advisory opinion is the same under both.

10. This is particularly problematic when the contracting payor is a PPS SNF, because Medicare Part B payments essentially may subsidize Part A PPS payments that the government has determined are appropriate and adequate to cover the SNF’s costs.

11. We note that the Agreement contains statements to the effect that remuneration provided under the Agreement is not intended to induce referrals of other business. We find these statements self-serving and not persuasive.

12. In this regard, we do not think it sufficient to consider only a supplier's marginal costs. Rather, in determining whether a discount is below cost, we look, for example, at the total of all costs divided by the total number of ambulance trips.
Re: OIG Advisory Opinion No. 99-13

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding certain arrangements for discounted pathology services provided to physicians (the "Proposed Arrangement"). You have asked whether the Proposed Arrangement would result in prohibited remuneration under the anti-kickback statute, section 1128B(b) of the Social Security Act (the "Act") or would constitute grounds for the imposition of sanctions under the anti-kickback statute, section 1128B(b) of the Act, the exclusion authority related to kickbacks, section 1128(b)(7) of the Act, or the civil monetary penalty provision for kickbacks, section 1128A(a)(7) of the Act. In addition, you have asked whether the Proposed Arrangement would constitute grounds for a permissive exclusion for charging Medicare or Medicaid substantially in excess of the usual charges, section 1128(b)(6)(A) of the Act.

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, we conclude that the Proposed Arrangement might constitute prohibited remuneration under the anti-kickback statute if the requisite intent to induce referrals of Federal health care program business were present and might be subject to sanctions arising under sections 1128B(b), 1128(b)(7), and 1128A(a)(7) of the Act, as well as grounds for a permissive exclusion under section 1128(b)(6)(A) of the Act.

This opinion may not be relied on by any person other than the addressee and is further qualified as set out in Part IV below and in 42 C.F.R. Part 1008.

I. FACTUAL BACKGROUND

A. [Company A]

Company A is a State X professional corporation with three shareholders, all of whom are specialists in pathology and are licensed to practice medicine in State X. Company A employs five pathologists and fourteen technicians. It provides pathology services (including clinical and anatomic pathology services) to five hospitals, as well as to the patients of physicians in private practice.

B. Billing Procedures

Company A has several billing methodologies depending upon the payor. For Federal health care program patients, Company A bills its charges to the government payor and bills the patients for any
applicable copayments or deductibles.

For non-Federal health care program patients, referring physicians have two payment options. One option is for Company A to bill its charges directly to the applicable third-party payor, and bill the patients for any copayments or deductibles. The alternative is for Company A to bill the physicians for the pathology services and accept that payment as payment in full. The physicians then bill the third-party payors and patients for the purchased pathology services. This option is commonly referred to as "account billing".

Under its account billing arrangements, Company A has traditionally offered physicians a discount off its usual charges which reflects the cost savings it realizes. Company A generates a single monthly statement to the referring physician who is required to pay on a prompt basis. Company A has represented that an account billing arrangement saves time and expense because: (i) claims are not submitted to a wide range of payors; (ii) Company A need not consider the claims submission criteria of the various payors; and (iii) Company A is not responsible for determining and collecting applicable copayments and deductibles owed by the patients. In addition, Company A realizes a better collection rate under account billing. Most physicians who have an account billing arrangement with Company A refer virtually all of their patients to Company A, whether the patients' specimens are covered under the account billing arrangement or are directly billed to the Federal health care programs. (2)

C. The Proposed Arrangement

Under the Proposed Arrangement, Company A will offer its account billing customers discounts that are greater than its cost savings, in order to match the prices of its competitors. Some of the discounted charges will be below the actual cost of providing the pathology services. In addition, Company A's profit margin for the non-Federal health care program business under the Proposed Arrangement would be less than the profit margin on the services that it bills directly to Federal health care programs. The discount will not be conditioned upon the physicians sending Company A its Federal health care program business. However, Company A has assumed that the physicians receiving discounts under the Proposed Arrangement will send virtually all of their patients to Company A. If Company A does not match the discounts of its competitors, Company A has represented that it will lose both the account billing business and the Federal health care program business of those clients.

II. LEGAL ANALYSIS

A. The Anti-Kickback Statute

The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by Federal health care programs. See section 1128B(b) of the Act. Where remuneration is paid purposefully to induce 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 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, in cash or in-kind, directly or indirectly, covertly or overtly.

The statute has been interpreted to cover any arrangement where one purpose of the remuneration is to obtain money for 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. This Office may also initiate administrative proceedings to
exclude persons from Federal health care programs or to impose civil monetary penalties for fraud, kickbacks, and other prohibited activities under sections 1128(b)(7) and 1128A(a)(7) of the Act. (3)

1. Special Fraud Alert Relating to Arrangements for the Provision of Clinical Laboratory Services

In 1994, we issued a Special Fraud Alert describing certain laboratory practices that implicated the anti-kickback statute. The Special Fraud Alert set forth our analysis that when a laboratory offers or gives to a referral source anything of value for less than fair market value, an inference may be made that the thing of value is offered to induce the referral of business. Specifically, we gave the example of laboratories waiving charges for laboratory tests to physicians for managed care patients, in order to retain the high-paying non-managed care business. In that example, the free laboratory services for managed care patients could be a kickback between the laboratory and the physician for the fee-for-service patients.

2. The Discount Exception and Safe Harbor

The anti-kickback statute contains a statutory exception for "a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program." Section 1128B(b)(3)(A) of the Act. This discount exception reflects the intent of Congress to encourage price competition that benefits the Medicare and Medicaid programs. The Department of Health and Human Services has published regulations implementing this discount "safe harbor" exception. See 42 C.F.R. § 1001.952(h).

To determine whether Company A's proposed discount practice implicates the anti-kickback statute, we must determine whether the Proposed Arrangement fits within the discount safe harbor. We conclude that the Proposed Arrangement does not fit within the safe harbor. The statutory exception for discounts, as implemented by the regulatory safe harbor, does not protect price reductions -- like those at issue here -- offered to one payor but not offered to Medicare or Medicaid. See 42 C.F.R. § 1001.952(h)(3)(iii).

Specifically, the preamble to the discount safe harbor illustrated the potential problem with laboratory price reductions:

[W]e are aware of cases where laboratories offer a discount to physicians who then bill the patient, but do not offer the same discount to the Medicare program. In some of these cases, the discount offered to the physician is explicitly conditioned on the physician's referral of all of his or her laboratory business. Such a "discount" does not benefit Medicare, and is therefore inconsistent with the statutory intent for discounts to be reported to the programs with costs and charges reduced appropriately to reflect the discounts. 56 Fed. Reg. 35977 (July 29, 1991).

Such price reductions create a risk that a laboratory may be offering remuneration in the form of discounts on business for which the purchaser pays the laboratory, in exchange for the opportunity to service and bill for higher paying Federal health care program business reimbursed directly by the program to the laboratory. In such circumstances, neither Medicare nor Medicaid benefits from the discount; to the contrary, Medicare and Medicaid may, in effect, subsidize the other payor's discounted rates. Moreover, laboratories may have an incentive to engage in abusive billing practices to recoup losses on the discounted business. Accordingly, the Proposed Arrangement does not fit in the discount safe harbor.
Having concluded that the Proposed Arrangement does not fit in the safe harbor, we must consider whether the discount arrangement between Company A and physicians utilizing account billing under the Proposed Arrangement may involve illegal remuneration to the physicians for their referrals of Federal health care program business not covered by the account billing arrangement and not subject to the discount. We conclude that it may.

The circumstances surrounding the Proposed Arrangement suggest that a nexus may exist between the discount to the physicians for non-Federal health care program business and referrals of Federal health care program business. First, the physicians are in a position to direct a significant amount of Federal health care program business to Company A that is not covered by the account billing component of the Proposed Arrangement. Second, both parties have obvious motives for agreeing to trade business: the physicians have the opportunity to make a larger profit on the non-Federal health care program business, and Company A is able to secure profitable Federal health care program business in a highly competitive market. Third, Company A has represented that it is likely that physicians who have account billing arrangements with Company A will refer Federal health care program business to Company A as a matter of practical convenience.

In evaluating whether an improper nexus exists between a discount and referrals of Federal business in a particular arrangement, neither the size nor structure of the discount is determinative of an anti-kickback violation. Rather, the appropriate question to ask is whether the discount -- regardless of its size or structure -- is tied or linked directly or indirectly to referrals of other Federal health care program business. Evidence that the discount is not commercially reasonable in the absence of other, non-discounted business is highly probative. In this regard, discounts on account billing business that are particularly suspect include, but are not limited to:

- discounted prices that are below the laboratory's cost,\(^{(4)}\) and
- discounted prices that are lower than the prices that the laboratory offers to a buyer that (i) generates a volume of business for the supplier that is the same or greater than the volume of account billing business generated by the physician, but (ii) does not have any potentially available Federal health care program business.

This is an illustrative, not exhaustive, list of suspect discounts; other arrangements may be equally suspect. Each of the above pricing arrangements independently gives rise to an inference that the laboratory and the physicians may be "swapping" discounts on account billing business in exchange for profitable non-discounted Federal health care program business.

Based on the facts presented here, we are unable to exclude the possibility that Company A may be offering improper discounts under the Proposed Arrangement with the intent to induce referrals of more lucrative Federal health care program business. Nor are we able to exclude the possibility that the physicians may be soliciting improper discounts on business for which they have the opportunity to earn money in exchange for referrals of business for which they have no opportunity, but for which the laboratories can receive additional revenue. Indeed, the Proposed Arrangement poses a significant risk of such improper "swapping" of business, especially in light of Company A's representation that many of its competitors are agreeing to such discounts. These competitor discount arrangements may similarly run afoul of the anti-kickback statute. The risk of improper "swapping" is compounded by the likelihood that physicians will refer Federal health care program business to their account billing laboratory as a matter of practical convenience.

**B. Permissive Exclusion for Billing Medicare Substantially in Excess of Usual Charges**

Price reductions offered to physicians that are not offered to Medicare or Medicaid raise additional

issues under section 1128(b)(6)(A) of the Act, which provides for permissive exclusion from the Federal health care programs of individuals or entities that submit or cause to be submitted bills or requests for payment (based on charges or costs) under Medicare or Medicaid that are substantially in excess of such individual's or entity's usual charges or costs, unless the Secretary finds good cause for such bills or requests. In determining an individual's or entity's "usual" charges, we will look at the amounts charged to non-Federal payors, including physicians. If the charge to Medicare or Medicaid substantially exceeds the amount the laboratory most frequently charges or has contractually agreed to accept from non-Federal payors, the laboratory may be subject to exclusion under section 1128(b)(6)(A) of the Act.

The limited information submitted by Company A is insufficient to make a determination as to whether the Proposed Arrangement may run afoul of section 1128(b)(6)(A). (5)

III. CONCLUSION

Based on the facts certified in the request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement might constitute prohibited remuneration under the anti-kickback statute, if the requisite intent to induce referrals of Federal health care program business were present, and might be subject to sanctions arising under the anti-kickback statute pursuant to sections 1128(b)(7), 1128A(a)(7), or 1128B(b) of the Act, and the permissive exclusion provision under section 1128(b)(6)(A).

IV. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to Company A, the requester 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 requester to this opinion.
- This advisory opinion is applicable only to the statutory provisions specifically noted above. No opinion is herein expressed or implied 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.
- 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 raised in this advisory opinion and, where the public interest requires, rescind, modify, or terminate this opinion.

Sincerely,

/s/
D. McCarty Thornton
Chief Counsel to the Inspector General

1. Throughout this opinion, the term pathology services is synonymous with laboratory services.

2. We express no opinion regarding the legality of their existing account billing arrangement under the anti-kickback statute, permissive exclusion, or any other legal authority.

3. Because both the criminal and administrative sanctions related to the Proposed Arrangement are based on violations of the anti-kickback statute, the analysis for purposes of this advisory opinion is the same for both.

4. In determining whether a discount is below cost, we look, for example, at the total of all costs (including labor, overhead, equipment, etc.) divided by the total number of laboratory tests.

5. We express no opinion regarding the legality of the current account billing arrangement under the permissive exclusion or any other legal authority.
Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding a proposal to provide laboratory employees and related equipment and supplies at no cost to dialysis facilities for the purpose of preparing specimens for delivery to the laboratory (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.

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 the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute and that the Office of Inspector General (“OIG”) could potentially 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. 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.

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.

1. FACTUAL BACKGROUND

[Name redacted] (the “Lab”) provides laboratory testing services to dialysis patients pursuant to service contracts with dialysis facilities (the “Dialysis Facilities”). The Lab provides: (a) composite rate tests, which are included in the composite rate that Medicare pays the Dialysis Facilities and, therefore, are not separately billable;¹ and (b) separately billable laboratory tests that are not covered by the Medicare composite rate reimbursement (“noncomposite rate tests”).

Under the Proposed Arrangement, the Lab would provide the services of laboratory assistants employed by the Lab (the “Lab Assistants”) for free to some of the Dialysis Facilities. The Lab Assistants would be based at the selected Dialysis Facilities and would prepare specimens for delivery to the Lab. The Lab Assistants’ services would be limited to those laboratory test processing services that are necessary to perform the ordered laboratory tests, such as centrifuging, sorting, packing, and shipping. The Lab Assistants would not perform any other activity or service for the Dialysis Facilities. The Lab would supply all equipment and supplies needed for the Lab Assistants to perform their work at no cost to the Dialysis Facilities.

Under the Centers for Medicare & Medicaid Services’s (“CMS’s”) payment regulations, laboratory test preparation services are included in the Medicare composite rate payments received by dialysis facilities, regardless of whether the preparation services are for a composite rate test or a noncomposite rate test. See Provider Reimbursement Manual (CMS

¹Since the composite rate tests (also called “routine laboratory tests”) are covered by the composite rate payments received by the Dialysis Facilities, the Lab bills the Dialysis Facilities for those tests pursuant to the terms of its service contracts.
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.

In fact, if the Proposed Arrangement were implemented, the Dialysis Facilities could not include the costs associated with such tasks on their cost reports, to the extent that such costs were not incurred by the Dialysis Facilities because the services were provided by the Lab.
Although the safe harbor for personal services and management contracts, 42 C.F.R. § 1001.952(d), is potentially applicable to the Proposed Arrangement, the Proposed Arrangement does not qualify under this safe harbor. The personal services safe harbor requires, among other things, that the compensation paid for services be consistent with fair market value in an arm’s-length transaction. See 42 C.F.R. §§ 1001.952(d)(5). Under the Proposed Arrangement, however, the Dialysis Facilities would not pay any compensation to the Lab for the services of the Lab Assistants or for the Lab’s supplies, despite the fact that the services and supplies would have value to the Dialysis Facilities, given that laboratory specimen processing costs are included in the composite rate payments received by the Dialysis Facilities.

B. Analysis

The OIG’s position on the provision of free or below-market goods or services to actual or potential referral sources is longstanding and clear: such arrangements are suspect and may violate the anti-kickback statute, depending on the circumstances. For example, in 1994, the OIG issued a Special Fraud Alert describing certain laboratory practices that implicate the anti-kickback statute. See Special Fraud Alert, “Arrangements for the Provision of Clinical Laboratory Services,” 59 Fed. Reg. 65372, 65377 (Dec. 19, 1994). The Special Fraud Alert explained that when a laboratory offers or gives an item or service for free or less than fair market value to a referral source, an inference arises that the item or service is offered to induce the referral of business. Also, with respect to laboratory pricing at dialysis facilities, the Special Fraud Alert identified suspect “swapping” arrangements where a laboratory offers discounts to a dialysis facility for composite rate tests payable out of the facility’s pocket, in exchange for referrals of all or most of a dialysis facility’s noncomposite rate tests billable by the laboratory directly to Medicare or other Federal health care programs.3 For the reasons set forth below, the Proposed Arrangement has all the hallmarks of the disfavored arrangements described in the Special Fraud Alert.

First, the provision of the Lab Assistants, along with all necessary testing supplies, to the Dialysis Facilities at no cost would be a tangible benefit to the Dialysis Facilities. It is likely that most, if not all, of the services provided by the Lab Assistants would substitute for services currently provided by the Dialysis Facilities at their own expense and for which they would be receiving reimbursement through their composite rate payments. Thus, there

3The safe harbor for discounts does not protect price reductions – like those at issue here – that are offered to induce the referral of other tests or that are offered to one payor but not offered to Medicare or Medicaid. See 42 C.F.R. §§ 1001.952(h)(5)(ii)-(iii); 64 Fed. Reg. 63518, 63528 (Nov. 19, 1999).
would be a financial benefit to the Dialysis Facilities – the receipt of free services and supplies for which the Dialysis Facilities would otherwise be obligated to incur costs. In these circumstances, an inference arises that the free services and supplies are intended to influence the Dialysis Facilities’ selection of a laboratory. By capturing referral streams from the Dialysis Facilities, the Lab would likely be able to generate substantial revenue, because dialysis patients typically need lifetime laboratory testing services associated with their receipt of dialysis services. Furthermore, we discern no safeguards in the Proposed Arrangement to rebut the inference that the free goods and services would be intended to induce referrals or to reduce the risk that the arrangement is designed to induce referrals.

Second, the free services and supplies may be viewed, functionally, as a price reduction or discount on the Lab’s composite rate tests. There is a risk that the Lab would be offering a functional “discount” to the Dialysis Facilities in exchange for the referral of noncomposite rate tests to the Lab. In fact, the circumstances surrounding the Proposed Arrangement suggest that a nexus may exist between the free services and supplies and referrals of other Federal health care program business. Both parties have obvious motives for agreeing to swap nonmonetary “discounts” on composite rate business for referrals of noncomposite rate business: the Dialysis Facilities to maximize expense recoupment under the composite rate system and the Lab to secure lucrative business in a highly competitive market. Any evaluation to determine whether the effect of such a “discount” would result in swapping is more difficult where the discount is nonmonetary, as it would be here with the provision of free services and supplies. Thus, in this case, there is greater risk that the arrangement as a whole could involve a nexus between the composite rate business and the noncomposite rate business. In connection with items or services provided to the Dialysis Facilities, the presence of such a “discount” arrangement is particularly suspect under the anti-kickback statute.

Based on the facts presented here, we are unable to exclude the possibility that the Lab may be offering improper nonmonetary “discounts” to the Dialysis Facilities for their composite rate-covered business with the intent to induce referrals of more lucrative noncomposite rate business. Nor are we able to exclude the possibility that the Dialysis Facilities may be soliciting improper nonmonetary “discounts” on business for which they bear risk in exchange for referrals of business for which they bear no risk. Indeed, the Proposed Arrangement poses a significant risk of such improper “swapping” of business, especially in light of the Lab’s representation that many of its competitors are agreeing to such “discounts.” These competitor “discount” arrangements may similarly run afoul of the anti-kickback statute.
III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute and that the OIG could potentially 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. 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 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 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.

Sincerely,

/s/

Lewis Morris
Chief Counsel to the Inspector General
Re: OIG Advisory Opinion No. 08-06

Dear [name redacted]:

We are writing in response to your request for an advisory opinion regarding a laboratory’s proposal to provide services consisting of the labeling of test tubes and specimen collection containers at no cost to dialysis facilities (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, the Federal anti-kickback statute.

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 the Proposed Arrangement could potentially generate
prohibited remuneration under the anti-kickback statute and that the Office of Inspector General (“OIG”) could potentially 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. 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.

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 letter 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

[Name redacted] (the “Lab”), provides laboratory testing services to dialysis patients pursuant to service contracts with dialysis facilities (individually a “Dialysis Facility” and collectively, the “Dialysis Facilities”).¹ The Lab provides: (a) composite rate tests, which are included in the composite rate that Medicare pays the Dialysis Facilities and, therefore, are not separately billable;² and (b) separately billable laboratory tests that are not covered by the Medicare composite rate reimbursement and are billed to Medicare by the Lab (”noncomposite rate tests”). Other than the service contracts, there currently are no financial arrangements between the Lab and the Dialysis Facilities.

Under the Proposed Arrangement, the Lab would provide some of the Dialysis Facilities with services consisting of the labeling of test tubes and specimen collection containers that are used by such Dialysis Facilities in sending specimens to the Lab for testing. The Lab would retain sole discretion regarding the selection of which Dialysis Facilities would be offered the labeling services and, according to the Lab, such selection would be based upon whether offering such services would be necessary to obtain or retain the business from a

¹ We note that we have not been asked, and express no opinion, about the application of the fraud and abuse laws to the service contracts between the Lab and the Dialysis Facilities.

² Since the composite rate tests (also called “routine” laboratory tests) are covered by the composite rate payments received by the Dialysis Facilities, the Lab bills the Dialysis Facilities for those tests pursuant to the terms of its service contracts.
particular Dialysis Facility. The Lab would not charge the selected Dialysis Facilities for the labeling services, which are currently performed internally, by such Dialysis Facilities’ own personnel. The Lab represents that its competitors currently offer the same types of services that it would offer under the Proposed Arrangement.

Under the Centers for Medicare & Medicaid Services’s (“CMS”) payment regulations, laboratory test preparation services are included in the Medicare composite rate payments received by dialysis facilities, regardless of whether the preparation services are for a composite rate test or a noncomposite rate test. See Provider Reimbursement Manual (CMS Pub. 15-1) § 2711.1(B)(4). Medicare does not make separate payment for administrative tasks associated with laboratory tests, such as labeling test tubes and specimen collection containers.3

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.

3 However, dialysis facilities must file accurate Medicare cost reports. Accordingly, the selected Dialysis Facilities could face potential exposure if their Medicare cost reports include costs that they do not actually incur.
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 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 safe harbor requires that the compensation paid for services be consistent with fair market value in an arms-length transaction. See 42 C.F.R. § 1001.952(d)(5). The Proposed Arrangement would not fit in the safe harbor because the selected Dialysis Facilities would not pay any compensation to the Lab for the labeling services, despite that fact that the labeling services would have value to the selected Dialysis Facilities, given that laboratory specimen processing costs (including those associated with labeling) are included in the composite rate payments received by the selected Dialysis Facilities. However, the absence of safe harbor protection is not fatal. Instead, the Proposed Arrangement must be subject to case-by-case evaluation.

B. Analysis

The OIG’s position on the provision of free or below-market goods or services to actual or potential referral sources is longstanding and clear: such arrangements are suspect and may violate the anti-kickback statute, depending on the circumstances. For example, in 1994, the OIG issued a Special Fraud Alert describing certain laboratory practices that implicate the anti-kickback statute. See Special Fraud Alert, “Arrangements for the Provision of Clinical Lab Services,” 59 Fed. Reg. 65372, 65377 (Dec. 19, 1994). The Special Fraud Alert explained that when a laboratory offers or gives an item or service for free or less than fair market value to a referral source, an inference arises that the item or service is offered to induce the referral of business. Also, with respect to laboratory pricing at dialysis facilities, the Special Fraud Alert identified suspect “swapping” arrangements where a laboratory offers discounts to a dialysis facility for composite rate tests payable out of the facility’s pocket, in exchange for referrals of all or most of the dialysis facility’s noncomposite rate tests billable by the laboratory directly to Medicare or other Federal
health care programs. For the reasons set forth below, the Proposed Arrangement has all the hallmarks of the disfavored arrangements described in the Special Fraud Alert.

First, the provision of labeling services to the selected Dialysis Facilities at no cost would be a tangible benefit to those Dialysis Facilities. It is likely that most, if not all, of the labeling services would substitute for services currently provided by the selected Dialysis Facilities at their own expense and for which they receive reimbursement through their composite rate payments. Thus, there would be a financial benefit to the selected Dialysis Facilities—the receipt of free labeling services for which they would otherwise be obligated to incur costs. In these circumstances, an inference arises that the free labeling services are intended to influence the selected Dialysis Facilities’ choice of a laboratory. This inference is consistent with, and supported by, the Lab’s representation that the labeling services would be offered to the selected Dialysis Facilities when necessary to retain or obtain their business. By capturing referral streams from the selected Dialysis Facilities, the Lab would likely be able to generate substantial revenue, because dialysis patients typically need lifetime laboratory testing services associated with their receipt of dialysis services.

Second, the free labeling services may be viewed, functionally, as a price reduction or discount on the amount the selected Dialysis Facilities pay the Lab for composite rate tests. In general, there is a risk that the Lab would be offering a functional “discount” to the selected Dialysis Facilities in exchange for the referral of noncomposite rate tests to the Lab. In fact, the circumstances surrounding the Proposed Arrangement demonstrate that a nexus would exist between the free labeling services and referrals of other Federal health care program business. Both parties have obvious motives for agreeing to swap nonmonetary “discounts” on composite rate business for referrals of noncomposite rate business: the selected Dialysis Facilities to maximize expense recoupment under the composite rate system and the Lab to secure lucrative business in a highly competitive market. Evaluation of whether the effect of such a “discount” would result in “swapping” is more difficult where the “discount” is nonmonetary, as it would be here with the provision of free labeling services. Nevertheless, in connection with the Proposed Arrangement, the presence of such a “discount” arrangement would be particularly suspect under the anti-kickback statute.

Based on the facts presented here, under the Proposed Arrangement the Lab would appear to be offering nonmonetary “discounts” to the selected Dialysis Facilities for their composite rate-covered business with the intent to induce referrals of more lucrative

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4 The safe harbor for discounts does not protect price reductions—like those at issue here—that are offered to induce the referral of other tests or that are offered to one payor but not offered to Medicare or Medicaid. See 42 C.F.R. §§ 1001.952(h)(5)(ii) – (iii); 64 Fed. Reg. 63518, 63528 (Nov. 19, 1999).
noncomposite rate business. Further, it appears possible that the selected Dialysis Facilities are soliciting improper nonmonetary “discounts” on business for which they bear risk in exchange for referrals of business for which they bear no risk. Indeed, the Proposed Arrangement poses a significant risk of improper “swapping” of business, especially in light of the Lab’s representation that its competitors are offering such “discounts.” These competitor “discount” arrangements may similarly run afoul of the anti-kickback statute.

III. CONCLUSION

Based on the facts certified in your request for an advisory opinion and supplemental submissions, we conclude that the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute and that the OIG could potentially 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. 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 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 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.

Sincerely,

/s/

Lewis Morris
Chief Counsel to the Inspector General
Considerations for Nursing Facility Provided Transportation

- NFs do not currently need a license when transporting their own residents via ambulette (wheelchair), but would need a license to transport their residents via ambulance (stretcher).

As Rolf & Goffman’s clients are aware, the recent Ohio Budget Bill adjusted the per diem rate for nursing facilities to include a $3.91 add-on for certain consolidated services. Medical transportation services, including wheelchair-accessible vehicle and ambulance services, are included in the new consolidated service requirements. Rather than the provider directly billing the resident for those services, the services are now bundled into the facility’s per diem rate, and the facility is responsible for providing the services to its residents.

We are aware that in response to bundling requirements, some nursing facilities may be contemplating procuring transport vehicles and providing their own medical transportation services to residents. In considering this option, facilities may be wondering whether Ohio licensure and permit requirements will apply to facility-provided transport services.

The Ohio Revised Code requires a “nonemergency medical service organization” to meet certain standards to qualify for a license to provide ambulette services. However, certain health care facilities, including those that provide skilled nursing services, are excluded from the definition of “nonemergency medical service organization” if they only provide ambulette services to patients of their facility. Thus, to the extent a nursing facility only provides ambulette services to its own residents, a license should not be required.

The Ohio Revised Code also delineates the standards for an “emergency medical service organization” to qualify for a license to provide life-support services. However, there is no comparable exclusion of a health care facility from the requirements.

This alert is intended to be informational only, and it is not intended to be nor should it be relied upon as legal advice. Indeed, Rolf & Goffman Co., L.P.A. shall not be responsible for any actions taken or arrangements structured based upon this alert. The receipt of this alert by an organization that is not a current client of our firm does not create an attorney-client relationship between the reader and Rolf & Goffman Co., L.P.A.
MEMORANDUM

To: Ohio Health Care Association
Date: September 4, 2009 (First issued: July 29, 2009)
Re: Medicaid Bundling

As OHCA’s members are aware, Am. Sub. H.B. 1 (the “Budget Bill”), adjusted the per diem rate for nursing facilities to include a $3.91 add-on for certain bundled services. Instead of the vendor/provider directly billing the resident for these services, facilities are now responsible for providing those services to their residents.

The new Medicaid consolidated service requirements apply to the following “Bundled Services”:

- Medical transportation services, including wheelchair-accessible vehicles and ambulance;
- Medicaid physical, occupational, and speech language pathology/audiology therapy;
- Certain over-the-counter drugs;
- Oxygen (in all forms and delivery methods); and
- Custom wheelchairs, including all parts, options, accessories, and repairs.

The new rules require nursing facilities to revisit their existing contracts to address the fact that vendors/providers may no longer bill Medicaid residents for Bundled Services.

We have attached a sample Bundling Addendum as an educational tool for OHCA’s members that may be used by nursing facilities to conceptualize how to approach the amendment of their existing contracts. As bundling is still in the early stages of implementation, members should also

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The law firm of Rolf & Goffman serves as the legal counsel for the Ohio Health Care Association. This memorandum and sample addendum are being provided as a service to OHCA. They are not meant as legal advice to OHCA’s individual members, and they should not be relied upon as such. Members should seek guidance from competent legal counsel prior to modifying any contracts.
consider any additional information provided by the Department of Jobs & Family Services ("JFS") as it becomes available.

In reviewing the Bundling Addendum, nursing facilities should consider the following:

- This Addendum contemplates that the facility will give further consideration to how to negotiate payment for bundled services and determine its own pricing for the services. The legal considerations and negotiation will likely be similar to Part A consolidated billing.
  - In negotiating prices, a facility will want to consider whether any third party insurance or copayment funds will be available to the facility for the Bundled Services. JFS has indicated that the facility may pursue payment from other third party payors such as Medicare and private insurance, but the nursing facility per diem satisfies the obligations of both the Medicaid program and the consumer. Note that there is a prohibition against the routine waiver of Part B co-payments, so the parties should avoid any agreement to that effect.
  - In addition to clarifying that the Medicaid resident will not be responsible for any coinsurance or deductible payments, JFS stated that the add-on includes dual eligible crossover claims for ambulance services and skilled therapies. Thus, JFS will not pay separate crossover claims for residents receiving those services.

- If the existing contract does not already address how the facility will notify and/or communicate with the vendor regarding the payor status of each resident, the facility may wish to include that information in the Addendum. For example, the Addendum could provide that the facility will include the identification of a resident’s applicable third party insurer on the patient’s chart, but also require the vendor to verify this information with an appropriate facility employee before providing services to the resident.

- The Addendum addresses billing and payment terms for Bundled Services. The facility’s existing contract may already address vendor billing and payment with regard to billing for Medicare residents. If so, the Addendum provides that those existing billing and payment terms will also apply to Bundled Services. If the existing contract does not include vendor billing and payment terms, the Addendum supplies suggested terms that the facility may review and alter as necessary.

- Requirements for vendor invoices to the facility are also included. Because the Addendum is meant to apply for all consolidated services, the invoice terms are fairly generic, and the facility may wish to alter them to account for specific vendor requirements. For example, if the Addendum was used in conjunction with a therapy provider agreement, the facility may want the vendor to also include the amount of time spent providing the service in minutes.
MEDICAID BUNDLING ADDENDUM

This Addendum shall supplement the agreement between ________________ ("Facility") and ________________ ("Vendor") dated August 1, 2009 (the "Agreement").

RECITALS

WHEREAS, Facility is a nursing facility that participates in the Medicaid program and serves residents who may be Medicaid recipients;

WHEREAS, Vendor is a provider of certain services to residents of Facility, including residents who may be Medicaid recipients;

WHEREAS, effective August 1, 2009, Medicaid requirements for certain services provided by Vendor changed so that those services are now included in Facility’s Medicaid per diem rate; and

WHEREAS, Vendor previously had the ability to bill Medicaid residents for those services directly, and Vendor must now be reimbursed by Facility for those services.

In consideration of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties intending to be legally bound hereby agree as follows:

1. **Understanding of the Parties regarding Medicaid Bundling.** Under Medicaid bundling rules, Facility is responsible for the cost of certain services provided by an outside provider. The following checked services of Vendor are included in the Facility’s per diem rate for Medicaid residents ("Bundled Services"):

   - Medical transportation services, including wheelchair-accessible vehicles and ambulance.
   - Medicaid physical, occupational, and speech language pathology/audiology therapy, including coinsurance for Medicare Part B therapy provided to dual eligible residents.
   - Certain over-the-counter drugs, including analgesics, cough and cold preparations and antihistamines, vitamins and minerals, gastrointestinal agents, except histamine-2 receptor antagonists, proton pump inhibitors, and loperamide.
   - Oxygen (in all forms and delivery methods).
   - Custom wheelchairs, including all parts, options, accessories, and repairs.
2. **Facility Authorization.** Vendor agrees not to provide any Bundled Services for which Facility would be responsible to pay without obtaining the prior express permission of Facility. Vendor shall have no right to bill Facility for any Bundled Services rendered to a Medicaid resident where Vendor fails to obtain prior permission from Facility.

3. **Fees for Bundled Services.** Facility shall compensate Vendor for Bundled Services according to the Fee Schedule attached as Exhibit A. Vendor shall not bill any Medicaid resident or any governmental or other third-party reimbursement source for Bundled Services rendered to a Medicaid resident pursuant to the Agreement, except as may be required by applicable Federal or State law, rules or regulations.

4. **Billing of Bundled Services for Medicaid Residents.** To the extent terms regarding Vendor billing to Facility and Facility payment to Vendor are addressed in the Agreement, those terms shall also govern billing and payment for Bundled Services. To the extent billing and payment terms are not addressed in the Agreement, billing and payment for Bundled Services will be addressed as follows:

   Vendor shall submit a monthly invoice to Facility for Bundled Services in a format acceptable to Facility within thirty days of rendering Bundled Services. The invoice shall include, at a minimum, the following: (1) the name(s) of the residents for whom the Bundled Services were provided, (2) a description of the services that were provided, (3) the amount of time spent providing the service, if applicable, (4) the person who performed the service, if applicable, (5) the date services were provided; and (6) the charges applicable to each service.

   Upon receipt of a complete invoice from Vendor, Facility will remit payment in full of all non-disputed charges within __________ (__) days of receipt of Vendor's invoice. Where Facility uses an intermediary in the processing of claims, Facility will promptly furnish to Vendor any information regarding the status of the claim and will grant to any fiscal agency involved the right to discuss the status of the claim with Vendor.

5. **Residents not Covered by Medicaid.** If Facility agrees to engage Vendor for Bundled Services, and it is subsequently determined that the resident was not a Medicaid recipient, Facility shall have no obligation to pay for the services, and Vendor shall directly bill the resident and/or the resident’s third party payor for services rendered. Vendor agrees to fully refund any funds paid by Facility for Bundled Services within thirty days of receiving notice that the resident was not a Medicaid recipient. Facility will use its best efforts to provide Vendor with relevant billing information for such patients. This clause shall survive the termination of the Agreement.

6. **Billing Review.** Facility shall have the right to review (including hiring an outside contractor) to verify the accuracy of Vendor's billing to Facility. Such review shall be at Facility’s sole cost and expense, unless such review determines that Vendor has
overbilled Facility under the terms of the Agreement; in such circumstance, Vendor shall pay all costs of the review. Vendor shall refund all overpaid amounts, and pay the costs of the review, to Facility within __________ (__) days of receiving a copy of the review findings. Failure to provide such refund shall be considered a breach of this Agreement. Notwithstanding the foregoing, at its option, Facility may choose to deduct the amount of the refund and review costs from current amounts owed to Vendor.

7. **Severability.** In the event any provision of this Addendum is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of this Addendum, which shall remain in full force and effect and enforceable in accordance with its terms.

8. **Entire Agreement.** This Addendum, as a modification of the Agreement, constitutes the entire agreement of the parties with respect to the subject matter hereof, and all prior and contemporaneous understandings, agreements and representations, whether oral or written, with respect to such matters are superseded. In the event of any inconsistency between the terms of this Addendum and the terms of the Agreement or any of the other documents or agreements referenced therein, the terms of this Addendum shall govern.

It is the intention of the parties that this Addendum be read in conjunction with the terms and conditions of the Agreement, and that the two documents constitute a single instrument evidencing the terms and conditions of the parties’ business relationship. To the extent that the terms of the Addendum conflict or are otherwise inconsistent with the terms of the Agreement, then the terms of the Addendum shall control the relationship of the parties, unless expressly stated otherwise.

This Addendum shall have an effective date of August 1, 2009.

**ORGANIZATION NAME**

_____________________________
Signature

_____________________________
Print Name

_____________________________
Title

**VENDOR NAME:**

_____________________________
Signature

_____________________________
Print Name

_____________________________
Title
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Medicaid Bundling
Update 2009

Presented by:

Linda Black-Kurek, CPA, President

LBK Health Care Inc.
Certified Public Accountants specializing in the long term care industry
Dayton, Ohio    (937) 296-1550
Email: lblackkurek@lbkhealthcare.com

LBK HEALTH CARE, INC.
Consolidated Services

- A consolidated services rate add-on is provided for services that will now be paid by the nursing facilities instead of being direct billed to Medicaid by the suppliers.
- The rate add-on is 3.91 per Medicaid day statewide, not facility or peer group specific.
Consolidated Services

- Services now paid for by the nursing facility
- Oxygen $0.33
- Wheelchairs $0.66
- Licensed therapy $1.75
- Over-the-counter drugs $0.03
- Resident transportation $1.14
- Total of $3.91
Consolidated Services

- These services were “optional services” under the federal plan guidelines.
- Serves to increase the cost base from which the franchise fee is calculated.
- Estimated to add $.50-$0.60 to existing rates
Contracting

- When contracting with vendors, you are not required to pay the per diem specified for the service that comprises the consolidated services add-on.
- You have $3.91 in total to provide all of the services. How you spend the $3.91 between the services is up to you.
Contracting

➢ If you can provide the services for less than $3.91 in total, that excess is yours to offset the increased franchise fee.

➢ There is no cost settlement of the $3.91 add-on.

➢ We are managing costs that we did not have the financial incentive to manage before.
Oxygen

- Vendors are now offering very competitive rental or service contracts.
- Rental options should also include a service component.
- Watch pricing for ancillary oxygen products such as nebulizers, suction machines, and respiratory therapist time.
Oxygen

- EZ Medical is offering special oxygen pricing to OHCA members.
- Consider buying concentrators versus renting.
- If you buy concentrators, strongly consider a service contract with an oxygen vendor for maintenance.
- Review the number of concentrators in the building for medical necessity.
Medicaid Therapy

- Includes therapy to Medicaid residents with no Part B or other insurance, as well as therapy for residents with no secondary insurance for Part B co-payments
- Review contract therapy pricing for Medicaid only and Part B
- Encourage keeping secondary insurance with pending Medicaid residents.
Medicaid Therapy

- Watch for co-payments from secondary insurance coverage.
- Goal should be to manage the therapy length of stay for these residents, not limit the number of residents who receive therapy.
- Therapy provided still counts in the case mix system that adjusts the direct care payment rate.
Resident Transportation

- Review contract pricing for ambulance
- Ambulance providers are now offering competitive pricing on a per-diem basis for all Medicaid residents, instead of a fee for service basis.
- Regardless of contract pricing, we still need to manage the transportation that we provide to what is medically necessary.
Resident Transportation

- Compare contract cost for wheelchair transports to the cost of doing that in-house.
- For in-house transportation, consider using a state-tested nurse aide as the driver.
- Remember to have all drivers screened through your insurance company.
Custom Wheelchairs

- All wheelchairs purchased by the facility will be the property of the facility, not the resident.
- Future resident specific wheelchairs will be more generic.
- Watch therapy recommendations.
Over the counter Drugs

- Additional expense is only for those over the counter drugs that were previously billed by the pharmacy to the Medicaid program directly.
- Review pricing from the pharmacy vs. medical supplier.
Over-the-counter Drugs

- Review over-the-counter drugs for medical necessity.
- Review the number of types of over-the-counter drugs you are offering, especially vitamins.
Bundling Follow Up

- OHCA will be attempting to monitor the actual cost of the new consolidated services to members.

- Please respond to cost questionnaires from OHCA. All information will be confidential.
1. Are you an At-Price Provider, an Above-Price Provider or a Below-Price Provider? This important information to understand before evaluating your options under bundling. (See At Price, Below Price and Above Price examples, attached.)

2. How is your Medicaid rate being affected outside of the bundling and FPF changes? If you are an At-Price Provider, your rate will be going up or down based on changes in your quality add-on score and Medicaid Only Case Mix Score changes. You may be getting an increase in your “base rate” that will help offset the fiscal risk of bundling. Below-Price Providers will also be receiving increases to their “base rate.”

3. Now that providers are starting to get pricing proposals from the suppliers of bundled services, estimate the actual cost of providing the bundled services using your current supplier relationships, and compare to the reimbursement you will receive for these services. Many suppliers are proposing more attractive pricing than was initially feared.

4. Consider impact on your case mix score of changes in delivery of care. Many providers are under the impression that case mix scores do not affect their rate. If you are an At-Price Provider, your Medicaid rate is dependent on your Medicaid-Only case mix score. If you are an Above-Price Provider, increasing your Medicaid case mix score is the one of the few things that
can increase your price up to your current rate. Part B and Medicaid only therapy services and oxygen use both impact case mix scores directly.

A typical RUG score for a long term resident who receives Part B therapy is an RMB, which has a case mix weight of 2.3328. The same resident receiving restorative nursing services instead of therapy might group as a PD2, which carries a case mix weight of only 1.5821. The decision to utilize restorative nursing instead of Part B or Medicaid therapy will have a detrimental impact on Medicaid Only case mix scores, and therefore provider rates.

5. If bundling will not work for you using your current supplier relationships and you are considering bringing some of the bundled services “in–house,” be sure to evaluate ALL of the costs associated with that decision. For example, if you are considering bringing resident transportation in-house, there are other costs in addition to the cost of the vehicle. Remember to consider maintenance costs, insurance costs, wages of the driver as well as staff who need to accompany the resident, and the time necessary to schedule appointments so that they don’t conflict since you don’t have access to multiple vehicles that transportation companies have.

In addition to costs, also consider the risks and liability associated with taking bundled services “in-house.” For example, some risks to consider related to taking transportation in-house include risk for falls and elopement, driver license validation, liability insurance validation, driving record history, defensive driving training and validated documentation, whether your liability insurance covers this type of transport, tracking and reporting of drivers credentialing annually, tie-down protocols, vehicle safety checks, lift operation training, emergent situations during transport, communication device for driver, non authorized passenger policy, and accident reporting protocols. Refer to the Facility Owned Transportation Safety Planning Guide prepared by the OHCA Disaster Planning Committee (attached) and ensure that you have adequate policies and procedures and
disaster plans in place related to facility provision of any of the bundled services.

Remember that surveyors will still expect facilities to provide all care and services necessary to attain and maintain the resident’s highest practicable level of physical, mental and psychosocial well being. Be sure to have proper assessment, care planning and documentation to support decisions to utilize restorative nursing programs in place of therapy services, decisions to utilize other interventions instead of a customized wheelchair and decisions to switch mobile residents from E-tanks to oxygen concentrators.

6. Be careful to reiterate to your staff that all decisions regarding service delivery will continue to be made on a case by case basis considering resident specific needs, risks, strengths and preferences. Never communicate a policy to never or rarely provide a specific bundled service.

7. Take advantage of opportunities to improve your Medicaid reimbursement over the next year.

If you are an At-Price provider, you can increase your Medicaid rate next year by focusing on opportunities to maximize your Medicaid Only Case Mix Score or Quality Add-On points. One of the changes in the recently passed budget bill allows At-Price providers to remain at price going forward, which means they are not subject to the stop loss/stop gain provisions. This will result in greater swings (both up and down) in rates for providers who are at price than that the 1.75% stop gain limit, or the 1% stop loss limit. Increases in Medicaid Case Mix Scores can increase your rate as early as January 1 – which will reflect the average of the June and September scores. (See attached Strategy – At Price example.)

If you are an Over-Price provider, you can raise your price effective July 1, 2010 by focusing on improving Medicaid Only Case Mix Scores and Quality
Add-On points. Many providers can raise their price by up to $10.00 by implementing a specific plan to work on these areas. Raising your price can turn you into an At-Price provider, or at least minimize the stop loss reduction to your rate in future years. (See attached Strategy – Above Price example).
## Direct Care Rate Calculation

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## Quality Incentive Rate Calculation

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<td>$178.68</td>
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<td>12</td>
<td>Work Force Development Add-On</td>
<td>$5.70</td>
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<td>13</td>
<td>Consolidated Services Rate Adjustment</td>
<td>$3.91</td>
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<td>14</td>
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</table>
## UNDER PRICE PROVIDER

### Direct Care Rate Calculation

<table>
<thead>
<tr>
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<th>FY 2010</th>
<th>FY 2011</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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### Quality Incentive Rate Calculation

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<td>4</td>
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<td>6</td>
<td>Retention &gt; SWA</td>
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<td>7</td>
<td>Occupancy &gt; SWA</td>
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<td>8</td>
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### SUMMARY OF PER DIEM RATES

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<td>6</td>
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<tbody>
<tr>
<td>8</td>
<td>Rate Paid: June 30, 2009</td>
<td>$165.61</td>
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<tr>
<td>9</td>
<td>Maximum Allowable Rate - 1.0175% line 8</td>
<td>$168.51</td>
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# OVER PRICE PROVIDER

## Direct Care Rate Calculation

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</tr>
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<tbody>
<tr>
<td>1</td>
<td>Direct Care Price</td>
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## Quality Incentive Rate Calculation

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</thead>
<tbody>
<tr>
<td>1</td>
<td>No health deficiencies</td>
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<td>2</td>
<td>No health deficiencies &gt; E</td>
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<td>3</td>
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<tr>
<td>4</td>
<td>Family satisfaction survey</td>
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<tr>
<td>5</td>
<td>Nursing hours &gt; SWA</td>
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<tr>
<td>6</td>
<td>Retention &gt; SWA</td>
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<td>7</td>
<td>Occupancy &gt; SWA</td>
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<td>9</td>
<td>Facility average CMS &gt; SWA</td>
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<tr>
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<td>11</td>
<td>Amount per quality point</td>
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<td>12</td>
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## SUMMARY OF PER DIEM RATES

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<td>$2.40</td>
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<tr>
<td>14</td>
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## SUMMARY OF PER DIEM RATES

### Direct Care Rate Calculation

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<tr>
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<th>FY 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Direct Care Price</td>
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<tr>
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<td>1.9953</td>
<td>2.1194</td>
</tr>
<tr>
<td><strong>3.</strong> Direct Care Rate</td>
<td>$88.77</td>
<td>$94.29</td>
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### Quality Incentive Rate Calculation

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<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>1.</td>
<td>No health deficiencies</td>
<td>0</td>
</tr>
<tr>
<td>2.</td>
<td>No health deficiencies &gt; E</td>
<td>0</td>
</tr>
<tr>
<td>3.</td>
<td>Resident satisfaction survey</td>
<td>1</td>
</tr>
<tr>
<td>4.</td>
<td>Family satisfaction survey</td>
<td>0</td>
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<tr>
<td>5.</td>
<td>Nursing hours &gt; SWA</td>
<td>1</td>
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<tr>
<td>6.</td>
<td>Retention &gt; SWA</td>
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<tr>
<td>7.</td>
<td>Occupancy &gt; SWA</td>
<td>1</td>
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<tr>
<td>8.</td>
<td>Medicaid utilization &gt; SWA</td>
<td>1</td>
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<tr>
<td>9.</td>
<td>Facility average CMS &gt; SWA</td>
<td>0</td>
</tr>
<tr>
<td><strong>10.</strong> Total facility points</td>
<td>3</td>
<td>5</td>
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<tr>
<td><strong>11.</strong> Amount per quality point</td>
<td>$0.80</td>
<td>$0.80</td>
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<td><strong>12.</strong> Quality Incentive Payment</td>
<td>$2.40</td>
<td>$4.00</td>
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<td><strong>3.</strong> Direct Care Rate</td>
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<td>$94.29</td>
</tr>
<tr>
<td><strong>4.</strong> Tax Rate</td>
<td>$1.43</td>
<td>$1.43</td>
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<td><strong>5.</strong> Quality Incentive Rate</td>
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<td>$4.00</td>
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<td>$173.85</td>
</tr>
<tr>
<td><strong>9.</strong> Maximum Allowable Rate - 1.0175% line 8</td>
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<td>$177.76  (line 8 * 1.0)</td>
</tr>
<tr>
<td><strong>10.</strong> Minimum Allowable Rate - 99.0% of line 8</td>
<td>$173.85</td>
<td>$172.11</td>
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<td><strong>11.</strong> Total Rate Before Add-Ons</td>
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<td>$186.26</td>
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## Summary of Per Diem Rates

### Direct Care Rate Calculation

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<th>FY 2011</th>
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<td>Direct Care Rate</td>
<td>$94.29</td>
<td>$96.97</td>
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</tbody>
</table>

### Quality Incentive Rate Calculation

- No health deficiencies: 0, 0
- No health deficiencies > E: 0, 0
- Resident satisfaction survey: 1, 1
- Family satisfaction survey: 1, 1
- Nursing hours > SWA: 1, 1
- Retention > SWA: 0, 0
- Occupancy > SWA: 1, 1
- Medicaid utilization > SWA: 1, 1
- Facility average CMS > SWA: 1, 1
- Total facility points: 5, 5
- Amount per quality point: $0.80, $0.80
- Quality Incentive Payment: $4.00, $4.00

### Summary of Per Diem Rates

<table>
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<tr>
<th>Description</th>
<th>Amount</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancillary and Support Price</td>
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<td><strong>$188.94</strong></td>
</tr>
</tbody>
</table>
BEFORE

- Policy/Procedure development / review
- Signed management statement – adoption of policy, filed with corporate auto safety program information
- Signed authorization from resident or authorized representative for facility to transport
- Assign program responsibilities
- Determination of when a Commercial Driver’s License (CDL) is necessary (16+ passenger vehicle)

- Driver Selection process
  - Obtain and review Motor Vehicle Record (MVR)
  - Review driving history
  - Drug screening according to facility policy

- Vehicle Inspection
  - Visual - prior to each use of vehicle
  - Documented inspection weekly
  - Annual inspections as required by authorities
  - Vehicle record retention

- Vehicle Maintenance
  - Documentation of periodic maintenance following manufacturer’s recommendation, including any additional features, equipment (i.e., tie-downs, lifts, fire extinguishers)

- Staff training
  - Personal liability issues if they use their own vehicle
  - Driver Selection
  - Defensive Driving Techniques
  - Cell Phone Usage
  - Wheelchair Lift Operations
  - Wheelchair Tie-Downs & Occupant Restraint Systems
  - Road Test
  - Accident Reporting Procedures
  - Vehicle Inspections
  - Preventive Maintenance and Inspection
  - Accident Investigation

- If the organization allows for use of personal vehicles for business use. While this may be generally discouraged, and staff may always decline, when used:
  - Confer with the attorneys, insurance providers to establish specific policies
  - Require individuals using personal vehicles to maintain insurance coverage
  - Discourage drivers from transporting residents in personal vehicles

DURING

- Accident Reporting & Investigation
  - Secure necessary medical evaluation/treatment for all involved parties, particularly if residents involved
  - Secure the accident scene
  - Report to local authorities, full cooperation with authorities
  - Do not admit fault
  - Complete accident report form
  - Investigate to determine root cause and retraining needs

- Drug testing, according to policy
AFTER - WHEN THE EMERGENCY IS OVER

☐ Reporting
  ☐ Insurance carrier
  ☐ Attorneys, as necessary

☐ Notification
  ☐ Families
  ☐ Physicians
  ☐ Vendors

☐ Recovery/ repair issues

☐ Crisis counseling, as appropriate
  ☐ Residents
  ☐ Staff
  ☐ Families

☐ Complete investigation & retraining

Resources:

Driver CDL Requirements – Department of Transportation http://www.dot.gov

This guide contains information that the LSC/Disaster Planning Work Group feels may be useful for long-term care providers in planning for various disasters. It is provided as a service to OHCA members and other long-term care professionals. Providers should consider this information in conjunction with each facility and its residents' and employees' specific circumstances and their own professional judgment. Use of this guide does not ensure the best potential outcome from any possible disaster that may befall a facility, and the LSC/Disaster Planning Work Group specifically disclaims any liability for any injuries that may result directly or indirectly from use or non-use of the information contained in this guide.