[name and address redacted]

Re: [name redacted]
Advisory Opinion No. 97-2

Dear [redacted]:

We are writing in response to your request for an advisory opinion, which we accepted pursuant to 42 C.F.R. Part 1008.41 on April 28, 1997. Your request asks whether a state-funded program that pays for insurance premiums for financially needy Medicare beneficiaries with end-stage renal disease (the "Arrangement") would constitute grounds for the imposition of a civil monetary penalty under Section 231(h) of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") [42 U.S.C. § 1320a-7a(a)(5)].

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

In issuing this opinion, we have relied solely on the facts and information you presented to us. We have not undertaken any 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 information provided and subject to certain conditions described below, we conclude that the Arrangement would not constitute grounds for the imposition of civil monetary penalties under Section 231(h) of HIPAA. 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

Program X is a State-funded program administered by University A. Program X receives an annual appropriation from the State of Y to fund a variety of programs that assist financially needy State residents to obtain treatment for end-stage renal disease ("ESRD"), including dialysis and kidney transplant services. Program X programs are programs of last resort intended to be used when no other sources of funding for treatment are available. Funds appropriated to Program X can be used only for medical expenses related to ESRD. Program X distributes State funds to qualifying health care

providers pursuant to written contracts ("Facility Agreements") that specify the maximum amount of funds granted to each contract facility and the categorical purposes for which the funds are allocated. Funds are disbursed to contract facilities by Program X in accordance with monthly or quarterly statements submitted by the contract facilities. Any variation from the budget set forth in the Facility Agreement must be approved in advance by Program X. Program X has Facility Agreements with all chronic dialysis providers in the State.

Among the programs administered by Program X is an Insurance Premium Program ("IPP", also referred to as the "Arrangement"). Under IPP, Program X reimburses its contract facilities for payment of Medicare Part B, Medigap, and major medical insurance premiums paid on behalf of indigent ESRD patients.[1] IPP funds are available to all contract facilities; the amount allocated to each contract facility is set forth in the facility's Facility Agreement. Under IPP, a qualifying patient may have his or her premiums paid without regard to where he or she receives treatment, but must apply for IPP benefits through a participating provider. Because the amount of money budgeted to each facility for IPP is fixed in advance, funding may not always be available for otherwise qualifying patients at specific facilities. Patients who receive IPP benefits at one facility and subsequently change providers remain eligible for IPP, but must reapply for funds through the new facility.[2]

To qualify for IPP benefits, patients must meet residency, citizenship, medical condition, and financial eligibility tests prescribed by Program X in a Contract Guidelines and Billing Manual (the "Manual"). Social workers at the contract facilities assess patients' eligibility for Program X programs, including IPP, using guidelines in the Manual. All patients are screened for financial eligibility in accordance with Program X's specific income-expense-total assets means test. Program X also requires that all prospective IPP beneficiaries who appear to be eligible for Medicaid apply for Medicaid benefits; those who qualify for Medicaid are automatically deemed financially eligible for IPP. When evaluating whether to provide IPP benefits to individual patients, contract facilities are required to consider the cost savings that will accrue to Program X. Program X reserves the right to decline to reimburse a contract facility for premium payments where there are no cost savings to Program X and no net benefit to the patient. Contract facility social workers also assist qualifying patients in completing application forms for Program X benefits.

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[1] Premiums are not reimbursed for policies that exclude renal benefits, except for waiting periods for pre-existing conditions.

[2] Program X is working to implement a system that will enable it to allocate IPP funds in a manner that will permit funding to follow patients who switch providers without requiring a reapplication for benefits. Currently, facility changes are infrequent and handled on a case-by-case basis.

II. LEGAL ANALYSIS

Section 231(h) of HIPAA, effective January 1, 1997, provides for the imposition of civil monetary penalties against any person who:

> offers or transfers remuneration to any individual eligible for benefits under [Federal health care programs (including Medicare or Medicaid)] that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, [by a Federal health care program].

Section 231(h) defines "remuneration", in relevant part, as "transfers of items or services for free or for other than fair market value."[3]

We conclude that the Arrangement does not constitute grounds for the imposition of civil monetary penalties under Section 231(h) of HIPAA. A violation of Section 231(h) requires that something of value be given to a beneficiary, either directly or on his or her behalf, that the donor knows or should know is likely to influence the beneficiary's choice of a particular provider. All funds for IPP premium payments are provided by the State and are made available to all chronic dialysis facilities in the State and to all eligible patients. In these circumstances, we do not believe that the State-financed IPP premium payments are likely to influence individual patients in their selection of particular providers. For ease of administration, the State uses the contract facilities as conduits for IPP funds and has them perform certain ministerial functions in accordance with specific guidelines established by Program X. The contract facilities do not have any substantial discretion regarding patient eligibility. To the extent a patient qualifies and premium payments are made, the State, rather than the contract facility, is providing the remuneration. Accordingly, we do not believe that the contract facilities acting within the scope of IPP are providing prohibited remuneration under Section 231(h).[4]

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[3]The statutory definition of remuneration provides an exception, not applicable here, for certain waivers of coinsurance and deductible amounts.

[4]We express no opinion on the legality of any premium payments that are not reimbursable by Program X under the IPP program.

III. LIMITATIONS

The limitations applicable to this opinion include the following:

- This advisory opinion is issued only to Program X, which is the Requestor 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 Requestor to this opinion.

- This advisory opinion is applicable only to the statutory provision 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 which appear similar in nature or scope.

This opinion is also subject to any additional limitations set forth at 42 C.F.R. Part 1008.

The OIG will not proceed against the Requestor with respect to any action taken in good faith reliance upon this advisory opinion as long as all of the material facts have been fully, completely, and accurately presented, and the arrangement in practice comports with the information provided. The OIG reserves the right to reconsider the questions and issues raised in this advisory opinion and, where the public interest requires, modify or terminate this opinion. In the event that this advisory opinion is modified or terminated, the OIG will not proceed against the Requestor with respect to any action taken in good faith reliance upon this advisory opinion, where all of the relevant facts were fully, completely, and accurately presented and where such action was promptly discontinued upon notification of the modification or termination of this advisory opinion.

Sincerely,

D. McCarty Thornton
Chief Counsel to the Inspector General