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Prohibition on Beneficiary Inducements Hinders Rural Hospital Efforts to Aid Communities During COVID-19 Outbreak

During times of national or local crisis, people often look to the pillars of their communities, local employers, charities and other publicly-supported institutions, to provide much needed resources and stability. In many rural communities, the local hospital fits into all three categories being one of the largest (if not they largest) local employer, charity and publicly-supported institution in the community (other than the local government). As a result, people often look to hospitals during times of crisis, not just for healthcare services but also for the other resources needed in their lives (e.g., food, housing, financial assistance, etc.).

Unfortunately, the prohibition on healthcare providers offering inducements to Medicare and/or Medicaid beneficiaries potentially impedes the ability of rural hospitals (and other hospitals and healthcare providers) to provide these types of assistance to their community during times of crisis.

Under section 1128A(a)(5) of the Social Security Act[1] (the "Prohibition on Beneficiary Inducements"), a healthcare provider who offers or transfers to a Medicare or Medicaid beneficiary any "remuneration" that the healthcare provider knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil monetary penalties (CMPs) of up to $10,000 for each wrongful act. For purposes of the Prohibition on Beneficiary Inducements, the term "remuneration" is defined to include 'the waiver of copayment, coinsurance and deductible amounts (or any part thereof) and *transfers of items or services for free or for other than fair market value*."[2] It is the second part of this definition that potentially impedes rural

hospitals' ability to provide non-healthcare related assistance to the members of their local community during times of crisis.

The Prohibition on Beneficiary Inducements does include a number of exceptions that permit a healthcare provider to offer certain assistance to Medicare or Medicaid beneficiaries without violating the Prohibition on Beneficiary Inducements. [3] These exceptions are relatively narrow and tend to be directly related to the provision of care or the facilitation of the provision of care, e.g., the waiver of, reduction of, or differentials in coinsurance and deductible amounts, the provision of certain incentives to promote the receipt of preventative care, the provision of items of services that improve a beneficiary's ability to obtain medical care, the provision of free or discounted coupons, rebates, or other rewards offered by independent retailers, and the offer of free or discounted items or services that are reasonably connected to the medical care to be received by a Medicare or Medicaid beneficiary.

Separate from these exceptions, the Office of Inspector General ("OIG") (the branch of the Department of Health and Human Services that implements the Prohibition on Beneficiary Inducements) determined that Congress intended that the Prohibition on Beneficiary Inducements not prohibit health care providers from providing Medicare and Medicaid beneficiaries with inexpensive gifts of nominal value.[4] The OIG's current interpretation of "inexpensive" and "nominal value" is a retail value of no more than $15 per item or $75 in the aggregate per patient on an annual basis.[5]

The OIG has also issued a number of Advisory Opinions addressing whether it would choose to enforce the Prohibition on Beneficiary Inducements in certain, specific situations.[6] For the most part, these Advisory Opinions address issues related to "patient assistance programs" or other programs offered by healthcare providers that are specifically tailored to assist patients obtain certain medical items or services, but which otherwise fall outside the exception for such assistance programs provided under the Prohibition on Beneficiary Inducements.

The COVID-19 outbreak (the "Outbreak") presents an extreme example of the type of crisis that could cause members of rural communities to turn to the local hospital for non-healthcare related assistance. Areas of assistance could include meals or other food for seniors without ready access to other food sources, housing for

people displaced due to quarantine and financial assistance for people struggling due to the economic devastation caused by the Outbreak.

Unfortunately, all of these forms of assistance fit within the definition of "remuneration" under the Prohibition on Beneficiary Inducements, if they are provided to Medicare or Medicaid beneficiaries. Even if the hospital's sole reason for providing such assistance is to help the members of the community that it serves overcome the personal and societal harm caused by the Outbreak (not to induce Medicare and Medicaid beneficiaries to obtain healthcare items and services from the hospital), the Prohibition on Beneficiary Inducement is triggered if the hospital "knows or should know" that such assistance could have that impact. Thus, the intention of the hospital is irrelevant to determining whether the Prohibition on Beneficiary Inducements applies. What matters is how the assistance is likely to impact the beneficiaries' thoughts and actions.

Further, this type of assistance is unlikely to fit within any of the exceptions to the Prohibition on Beneficiary Inducements as the assistance does not directly relate to the provision of care to the beneficiary or otherwise facilitate the beneficiaries ability to obtain care. In addition, if this type of assistance is provided by the hospital for any length of time, the assistance will not qualify as being "inexpensive" and of "nominal value". Finally, although a hospital could apply for an Advisory Opinion from the OIG as to whether it would prosecute the hospital for providing such assistance, the normal Advisory Opinion process takes anywhere from nine (9) to twelve (12) months (far too long to be of use to the hospital during the midst of the Outbreak).[7] Given these facts, hospitals are between a rock and a hard place when it comes to determining whether they can or should offer non-healthcare related assistance to their communities in response to the Outbreak.

The only way this issue can be resolved quickly enough to guide hospitals as they make these decisions during the midst of the Outbreak is for the OIG to issue a Policy Statement or a Notice of Enforcement Discretion specifically addressing this issue. There is precedent for the OIG taking such a step in connection with the Outbreak. On March 17, 2020, the OIG issued "OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak" to clarify its position on whether an offer to waive co-pays for

telehealth visits violated the Prohibition on Beneficiary Inducements.[8] Similarly, on March 20, 2020, the Office of Civil Rights issued "Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency" to clarify its position on the use of publicly-available means of communication for telehealth visits.[9]

Clearly, each of those issues differ from the provision of non-healthcare related assistance in that they directly relate to the provision of healthcare services during the Outbreak. At the same time, the need for healthcare services is simply the first and most immediate need caused by the Outbreak. Very quickly, especially if stay-at-home and work-from-home orders remain in place for long, the other personal and societal costs of the Outbreak will begin to be felt across the nation. As is often the case, such costs will be felt the most quickly and most severely by those on the lower rungs of the economic ladder. Rural communities often have a disproportionate share of such people. As a result, the OIG needs to act now to provide guidance to rural hospitals to allow them to provide much-needed non-healthcare related assistance for their communities.

In the interim, if a rural hospital desires to provide or is called upon to provide non-healthcare related assistance to its community, the hospital should carefully review the Prohibition on Beneficiary Inducements and its exceptions to determine whether the assistance in question might fit within an exception. In particular, the hospital should focus on the exception related to the provision of items or services that facilitate the provision of or relate to the provision of care. The hospital should also review OIG Advisory Opinions on this topic as they provide insight into the OIG's prosecutorial interests in this area. Please note, however, that Advisory Opinions are not binding on the OIG except as to their recipients. As a result, the Advisory Opinions can only be used to gain insight into OIG's thinking on this issue, but not as binding precedent. In addition, the hospital should consult its attorney for guidance in structuring such assistance in a manner to minimize risks under the Prohibition on Beneficiary Inducement.

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[1] 42 U.S.C. 1320a–7a(a)(5)

[2] 42 C.F.R. 1003.110 (emphasis added)

[3] Id.

[4] "Offering Gifts and Other Inducements to Beneficiaries," Office of Inspector General Special Advisory Bulletin, August 2002.

[5] Office of Inspector General Policy Statement Regarding Gifts of Nominal Value To Medicare and Medicaid Beneficiaries, December 7, 2016.

[6] See, e.g., OIG Advisory Opinions 2002-01, 2010-07, 2018-05, 2019-02, 2019-03, 2019-04 and 2019-06.

[7] The OIG recently added a portal to send COVID-19 related questions to the OIG (which could include questions related to the applicability of the Prohibition of Beneficiary Inducements. To date, OIG has not publicly responded to any such questions. Further, it is not clear at this time the impact of such responses from an enforcement standpoint.

[8] https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf

[9] https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html